



The Influence of Pre-Marriage Class on Knowledge of Bride and Groom in Prevention of Stunting Toddlers

Dewi Sri Sumardilah¹; Retno Puji Hastuti²; Aprina^{3*})

¹ Jurusan Gizi Poltekkes Tanjungkarang

^{2,3*)} Jurusan Keperawatan Poltekkes Tanjungkarang

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*) corresponding author

Dr. Aprina, S.Kp., M.Kes

Jurusan Keperawatan Poltekkes
Tanjungkarang
Jl. Soekarno Hatta No.1, Hajimena, Kec.
Natar, Kabupaten Lampung Selatan,
Lampung 35145

Email: aprinamurhan@yahoo.co.id

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ABSTRACT

The direct causes of stunting under five are inadequate food consumption and infectious diseases. The two direct causal factors are closely related to the quality of parenting. Efforts to handle stunting toddlers must be carried out as early as possible, not only since the mother is pregnant but must be carried out since the mother is still a prospective bride. In this context, it is necessary to find a model for the development of training for prospective brides that is in accordance with the needs in preventing stunting under five and seeing its effectiveness. This study will use a combination of descriptive observational design and quasi-experimental design. The research population is prospective brides in Kemiling District, and the sample is determined by accident, namely prospective brides who have registered at KUA Kemiling District until July 2021. Data collection for the development of pre-wedding classes is carried out by means of FGD and interviews, while to assess the effect of class pre-marriage used quasi-experimental design with pre and post test approaches. The analysis was carried out descriptively (frequency distribution) to determine the pre-marital class and bivariate analysis (dependent and independent test) to determine the effect of pre-marital class on the knowledge of the prospective bride and groom in preventing stunting under five. The results showed that the standard competencies needed by prospective brides to prevent stunting under five were exclusive breastfeeding, complementary feeding, balanced nutrition, monitoring of toddler growth, infectious diseases in children, pregnancy, and reproductive health. In the case group that was given treatment in the form of leaflets and premarital classes, there was an increase in knowledge scores between 78.9% to 125.6%, while in the control group which was only given leaflets the increase in knowledge scores only rose by 25.9% to 91.6%. The results of the dependent test showed that there was a significant difference in knowledge scores between before and after treatment. Meanwhile, the results of the independent test showed that there was a significant difference in knowledge scores on exclusive breastfeeding ($p=0.000$), complementary feeding ($p=0.019$), child growth monitoring ($p=0.002$), pregnancy ($p=0.001$), and reproductive health ($p=0.001$). = 0.020) between the two groups.

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INTRODUCTION

Currently the problem of stunting under five is still a public health problem in Indonesia. The results of the 2018 Basic Health Research noted that the prevalence of stunting under five was still at 37.2%. The high number is directly caused by inadequate food consumption and infectious diseases. These two causal factors are closely related to the mother's ability in parenting.

Efforts to deal with stunting under-fives should not be late but must be done as early as possible, namely since pregnant women and even since women are still prospective brides so that the understanding of prospective brides on health and nutrition needs to be improved so that the health of their children can be well maintained. Many research results show that the level of knowledge of pregnant women about pregnancy and child nutrition is still low. The results of Diah Ayu Pitaloka's research (2014) show that 54.8% of pregnant

women have low knowledge about exclusive breastfeeding. Then the results of Nurul Qomariah's research (2016) showed that only 60% of pregnant women had knowledge of the danger signs of pregnancy. The results of Nurul Utami's research (2018) also found that only 57.14% of pregnant women had knowledge about the health of pregnant women and postpartum. Furthermore, the results of Haneke Choirunissa's research (2019) stated that only 48.1% of pregnant women had a good level of knowledge about anemia. The results of these studies may indicate that the level of knowledge of the prospective bride and groom will not be better than pregnant women. This can be proven from the results of Rizka Dita Hidayati's research (2016) that 81.3% of brides and grooms have knowledge of reproductive health in the category of sufficient to less. Likewise, the results of Dilla Fitriana Salekha's research (2019) which found 45.9% of brides-to-be have less knowledge about reproductive health.

The prospective bride and groom are a community group that has an important role in improving the quality of their family if they are married and have children. Through his abilities, it is hoped that the prospective bride and groom can be better prepared in maintaining the health of their family, especially the health of their children.

In 2009, the Government through the Ministry of Religion has organized an educational program for prospective brides in the form of a Pre-Marriage Course. This pre-marital course program is motivated by the many cases that arise in domestic life that lead to divorce. Many prospective brides do not understand the purpose of marriage and cannot anticipate the things that will happen during the marriage. The pre-wedding course is the provision of knowledge, understanding, and skills in a short time to the bride and groom about domestic/family life.

In terms of preventing the emergence of health problems in the family in the future, especially maternal and child health problems, the existence of pre-marital courses as programmed by the Ministry of Religion is not sufficient because material on reproductive health is only given in general with very limited learning time. Moreover, some research results indicate that the effectiveness of pre-marital courses is still low. Therefore, it is necessary to look for other learning models that are comprehensive and in accordance with the needs of prospective brides and grooms in improving children's health, especially in preventing stunting under five.

The model for developing courses for brides and grooms in order to increase knowledge about preventing stunting under five must be compiled comprehensively and in accordance with the needs of the bride and groom themselves. One alternative that can be done is through pre-marital classes. The use of the term class in the pre-marital class is closer to the existing term, namely the class for pregnant women or the class for mothers of toddlers. Through pre-wedding classes, it is hoped that prospective brides and grooms can improve their abilities (knowledge, attitudes, and or skills) about pregnancy, childbirth and the postpartum period, as well as child growth so that in the end they can prevent stunting under five.

The pre-wedding class development model for the bride and groom must be based on the right training cycle so that the learning objectives set can be adapted to the needs of the bride and groom. One of the techniques that can be used to develop the training program is the ADDIE (Analyze, Design, Development, Implementation, Evaluation) method, which is to analyze training needs, develop training objectives and designs, carry out training, and evaluate training.

Based on these conditions, the question arises: How is the development of pre-wedding classes as a learning model that

is in accordance with the needs of the bride and groom in preventing stunting under five? Then does pre-wedding classes for prospective brides have an effect on increasing their knowledge in preventing stunting toddlers? The purpose of this study was to obtain information about the premarital class model and its effect on catin knowledge about stunting prevention for toddlers.

METHOD

The research design used was a quasi-experimental approach with a nonrandomized pretest posttest control group design approach, which gave treatment in the form of premarital classes to the case group and control group. Prior to the experiment, the pre-wedding class guidelines were prepared.

The study was carried out from June to October 2021. The location of the research was Kemiling Subdistrict, considering that the largest population and number of prospective brides and grooms registered at the Kemiling Subdistrict KUA was in Bandar Lampung City.

The population in this study were brides and grooms in Kemiling District since the start of this study. In 2019 the number of prospective brides registered with the KUA Kemiling District was 565 pairs (the average is 47 pairs per month). While the determination and selection of samples was carried out by accidental sampling, namely prospective brides who registered at the KUA Kemiling District in September 2021.

Data collection is carried out in several stages, namely:

In the first stage, pre-marital class guidelines were prepared through FGDs and catin interviews to assess discrepancy in catin knowledge, then compiled guidelines for organizing and pre-wedding class modules. In the second stage, a test of the influence of premarital class on knowledge of prospective brides was conducted. Analysis of the influence of the Pre-Marriage Class was carried out with a dependent test to see the differences in the abilities of each group, and an independent test to see the differences between groups. If the data from the pre and post test results are abnormal, the Wilcoxon test is carried out to determine the differences in each group, and the Mann Whitney test to determine the differences between groups.

RESULT AND DISCUSSION

From the results of the FGD, it is known that to prevent stunting under five, the bride and groom must have knowledge about children's food (exclusive breastfeeding, complementary feeding), child parenting (growth monitoring, balanced nutrition), infectious diseases in children, pregnancy, and reproductive health. It is also stated that based on Bloom's taxonomy, the bride and groom have sufficient knowledge to the level of understanding. The results of the FGD are then used as a standard ability that must be possessed by the bride and groom in the context of preventing stunting under five.

To see if there is a difference (discrepancy) between the standard ability and the current ability of the bride and groom regarding stunting prevention, interviews with 5 pairs of prospective brides from Rajabasa District were conducted. The results of the interview with the prospective bride and groom showed that of the 5 questions given for each material

being asked, only 2.86 people answered the questions correctly. This shows that there is a very wide difference between standard competencies and current competencies.

Based on the difference (discrepancy) between the desired standard competencies and the latest competencies, a module is prepared for the needs of the Pre-Marriage Class trial. These modules are Module 1 Exclusive Breastfeeding and Complementary Breastfeeding, Module 2 Balanced Nutrition and Monitoring of Toddler Growth, Module 3 Infectious Diseases in Children, Module 4 Pregnancy and Reproductive Health. The preparation of the module was carried out by the researcher together with the prospective Pre-Marriage Class resource persons.

Research on the effect of Pre-Marriage Class on the knowledge of the prospective bride and groom was carried out in the case group and the control group. Both groups were given leaflets for the bride and groom containing information on exclusive breastfeeding, complementary feeding, balanced nutrition, growth monitoring, infectious diseases in children, pregnancy, and reproductive health. Then only the case group was given Pre-Marriage Class for 2 days (12 Lesson Hours @ 45 minutes). The resource persons were researchers and lecturers from the Department of Midwifery, Department of Nutrition, and Department of Nursing at the Tanjungkarang Health Polytechnic who participated in the FGD.

In this study, the prospective brides who successfully participated were 30 brides, who were divided into 2 groups, 15 as the case group and 15 as the control group. The determination of the members of the case and control group is done randomly

Table 1
Characteristics Responden

Characteristics Responden	Intervention		Control	
	n	%	n	%
Age				
<20	1	6,7	0	0,0
20 – 25	11	73,3	13	86,6
26 – 30	2	13,3	1	6,7
>30	1	6,7	1	6,7
Education				
SD	0	0,0	0	0,0
SLTP	1	6,7	2	13,3
SLTA	9	60,0	10	66,7
PT	5	33,3	3	20,0
Occupation				
Not Work	2	13,3	4	26,7
Work	13	86,7	11	73,3

Most of the bride and groom in the case group and the control group were in the age category of 20-25 years. In the case group the number reached 11 people (73.3%), while in the control group it reached 13 people (86.6%). It is also known that there are still brides who are less than 20 years old (3.3%) and more than 30 years old (6.7%).

Most of the bride and groom in both groups had a high school education level and a PT. In the case group, 9 people graduated from high school (60.0%) and 5 people graduated from high school (33.3%). While in the control group, 10 people graduated from high school (66.7%) and 3 people graduated from PT (20.0%).

Most of the prospective brides in the case group and in the control group were working. In the case group it was up to 86.7%, while in the control group it was 73.3%.

Based on the recommended nutritional adequacy rate in 2019, the protein requirement for pregnant women is 90

g/day, then the Fe requirement is 27 mg per day, the folic acid requirement is 600 mg per day, and the zinc requirement is 12 mg per day.

Table 2
Mean Score Knowledge Intervention Group

Knowledge Score	Intervention Group	
	Pre test (Mean ± SD)	Post test (Mean ± SD)
ASI Eksklusif	1,807±0,939	4,077±0,560
MP-ASI	1,846±0,880	4,038±0,445
Balanced nutrition	2,192±0,801	3,923±0,688
Monitor Growth	2,077±1,017	3,962±0,528
Child Infectious Disease	1,961±0,720	3,923±0,688
Pregnancy	2,038±0,720	3,962±0,599
Reproduction health	1,923±0,744	3,769±0,514

The table 2 can be seen the knowledge score of the prospective bride and groom in the case group. Before being given treatment, the average knowledge score of the bride and groom ranged from 1.807 to 2.192. The lowest average score is knowledge about exclusive breastfeeding. After the bride and groom were given treatment in the form of Bride and Groom Leaflets and Pre-Marriage Class, it turned out that the average knowledge score was in the range of 3.923 to 4.077. This means that after being given treatment in the form of Bride and Groom Leaflets and Pre-Marriage Class, the knowledge of the bride and groom increases. The highest increase in the average score was shown in knowledge about exclusive breastfeeding, which was 2,270, then followed by knowledge about complementary feeding at 2,192. Meanwhile, the lowest increase in the average score was knowledge about pregnancy, which was only 0.824.

Table 3
Mean Score Knowledge Control Group

Knowledge Score	Control Group	
	Pre test (Mean ± SD)	Post test (Mean ± SD)
ASI Eksklusif	1,923±0,744	3,423±0,504
MP-ASI	2,154±0,925	3,385±0,637
Balanced nutrition	1,846±0,880	3,538±0,508
Monitor Growth	2,577±1,065	3,384±0,571
Child Infectious Disease	2,808±0,981	3,538±0,647
Pregnancy	2,038±0,824	3,461±0,508
Reproduction health	2,077±0,744	3,461±0,647

Like the prospective bride and groom in the case group, the average knowledge score of the bride and groom in the control group also increased for all knowledge asked. However, the increase was not as high as in the case group. In the control group who were only given the bride and groom leaflets, the average knowledge score at the beginning of the study was in the range of 1.846 to 2.808, then increased in the range of 3.384 to 3.538. The highest increase in the average score occurred in knowledge about balanced nutrition, which was 1.692, while the lowest increase occurred in knowledge about Infectious Diseases in Children, which was only 0.730.

The results of the normality test of knowledge of the bride and groom (exclusive breastfeeding, complementary feeding, balanced nutrition, growth monitoring, infectious diseases in children, pregnancy, and reproductive health) before and after the pre-marital class were normally distributed because p-value >0.05, so that the analysis of differences in knowledge

of the prospective bride and groom in each group was carried out with a dependent t-test test and the analysis of differences

in knowledge of the bride and groom between groups was carried out with an independent t-test.

Table 4
Distribution of the average knowledge of respondents according to Intervention group and control group

Knowledge	Intervention			Control		
	Mean (\pm SD)	t	P	Mean (\pm SD)	t	p
ASI Eksklusif						
Before	1,8 (\pm 0,9)	5,8	0,000	1,9 (\pm 0,7)	4,07	0,011
After	4,1 (\pm 0,6)			3,4 (\pm 0,5)		
MP-ASI						
Before	1,9 (\pm 0,9)	4,2	0,000	2,2 (\pm 0,9)	3,32	0,019
After	4,0 (\pm 0,4)			3,4 (\pm 0,6)		
Balanced nutrition						
Before	2,2 (\pm 0,8)	3,3	0,012	1,8 (\pm 0,9)	2,18	0,002
After	3,9 (\pm 0,7)			3,5 (\pm 0,5)		
Monitor Growth						
Before	2,1 (\pm 1,02)	3,7	0,000	2,6 (\pm 1,0)	2,01	0,002
After	3,9 (\pm 0,5)			3,4 (\pm 0,6)		
Child Infectious Disease						
Before	1,9 (\pm 0,7)	3,9	0,000	2,8 (\pm 0,9)	2,99	0,017
After	3,9 (\pm 0,7)			3,5 (\pm 0,6)		
Pregnancy						
Before	2,0 (\pm 0,7)	3,8	0,007	2,0 (\pm 0,8)	2,20	0,011
After	3,9 (\pm 0,6)			3,5 (\pm 0,5)		
Reproduction health						
Before	1,9 (\pm 0,7)	4,22	0,001	2,1 (\pm 0,7)	2,45	0,009
After	3,8 (\pm 0,5)			3,0 (\pm 0,6)		

Table above 4 can be seen that in the case group, after being given Pre-Marriage Health Leaflets and Pre-Marriage Classes, the average score of exclusive breastfeeding knowledge increased by 2.3, then followed by MP-ASI by 2.2, Infectious Diseases in children by 1, 9, pregnancy was 1.9, reproductive health was 1.9, growth monitoring was 0.8, and balanced nutrition was 0.8.

The statistical test results show that the p-value for all knowledge is below 0.05. Thus, it can be concluded that there

is a significant difference between the knowledge scores before and after being given the leaflet and the Pre-Marriage Class. The same thing was also shown in the control group that the p-value for all knowledge was below 0.05, meaning that there was a significant difference between the average knowledge score before and after being given premarital health leaflets.

Table 5
Distribution of the average knowledge of respondents according to Intervention group and control group

Knowledge	Before Treatment			After Treatment		
	Mean (\pm SD)	t	p	Mean (\pm SD)	t	p
ASI Eksklusif						
Intervention	1,8 (\pm 0,9)	1,11	0,110	4,1 (\pm 0,6)	1,65	0,000
Control	1,9 (\pm 0,7)			3,4 (\pm 0,5)		
MP-ASI						
Intervention	1,8 (\pm 0,9)	1,02	0,105	4,0 (\pm 0,4)	-0,98	0,019
Control	2,2 (\pm 0,9)			3,4 (\pm 0,6)		
Balanced nutrition						
Intervention	2,2 (\pm 0,8)	-5,03	0,009	3,9 (\pm 0,7)	-5,88	0,112
Control	1,8 (\pm 0,9)			3,5 (\pm 0,5)		
Monitor Growth						
Intervention	2,1 (\pm 1,0)	1,77	0,336	3,9 (\pm 0,5)	2,06	0,002
Control	2,6 (\pm 1,1)			3,4 (\pm 0,6)		
Child Infectious Disease						
Intervention	1,9 (\pm 0,7)	-7,57	0,000	3,9 (\pm 0,7)	-7,91	0,070
Control	2,8 (\pm 0,9)			3,5 (\pm 0,6)		
Pregnancy						
Intervention	2,0 (\pm 0,7)	2,02	0,001	3,9 (\pm 0,6)	3,44	0,001
Control	2,0 (\pm 0,8)			3,5 (\pm 0,5)		
Reproduction health						
Intervention	1,9 (\pm 0,7)	2,44	0,004	3,8 (\pm 0,5)	3,12	0,020
Control	2,1 (\pm 0,7)			3,5 (\pm 0,6)		

Table 5 can be seen that before and after being given treatment, the average knowledge score in the two groups was not much different. The results of the statistical test showed that the p-value for the average knowledge score of exclusive breastfeeding, complementary feeding, growth monitoring, pregnancy, and reproductive health between the two groups was smaller than 0.05, while the average knowledge score of balanced nutrition and infectious diseases in children have a p-value greater than 0.05. Thus, it can be concluded that there is a significant difference in the average knowledge scores of exclusive breastfeeding, complementary feeding, growth monitoring, pregnancy, and reproductive health between the two groups. While the average score of knowledge of balanced nutrition and infectious diseases in children there was no significant difference between the two groups.

DISCUSSION

The population or number of people who get married per year in Indonesia reaches 2 million. Even 80% of them give birth in the first year of marriage. In conditions like this, it is very important to increase the understanding of prospective brides about preventing the occurrence of stunting under five. The reason is that the government has a target of reducing the stunting rate to 14% percent in 2024 from the current condition of 27%.

Most of the prospective brides who took part in the study were found to be in the age group of 20-25 years, as many as 24 people (80.0%), but it was still found that 3.3% of brides were <20 years old. Judging from their age, most of the prospective brides who participated in the study had met the requirements as stated in Law Number 16 of 2019 that the minimum age for marriage for both male and female brides was 19 years.

The age limit for marriage as stated in Law no. 16 of 2019 is intended to prevent early marriage. For brides-to-be, early marriage can have serious health consequences because they are not physically ready to conceive and give birth. Early marriage can increase the risk of cervical cancer and osteoporosis in the mother and increase the risk of stunting in children. Reporting from Kompas.com, July 21, 2021, cases of stunting in toddlers (under three years) in Indonesia reached 43.5% in mothers aged 14-15 years and 22.4% in mothers aged 16-17 years.

From the results of this study, it can be seen that most of the prospective brides in the case group and the control group have a high level of education, namely graduating from high school until graduating from PT. Education is the main factor that plays a role in increasing the information and knowledge of a person and in general. The higher a person's education, the easier it is to receive information (Notoadmodjo, 2008). The higher the level of education of a person, the level of knowledge will also be better.

Stang's research (2011) states that people with low education are more likely to marry early because they have less knowledge of the impact of early-age marriage.

In this study, it was found that 86.7% of the bride-to-be in the case group had a job, and 73.3% of the bride-to-be in the control group also had a job. Work is one of the factors that influence the occurrence of early marriage. This statement is supported by Sah, et al (2014) which states that there is a relationship between the job of the prospective husband and the incidence of early marriage.

Family guidance given before the marriage takes place has been regulated in the Regulation of the Director General of Islamic Community Guidance No. DJ.11/491 of 2009 concerning the Bride and Groom Candidate Course. Then in 2013 the regulation was perfected with the issuance of the Director General of Islamic Community Guidance Regulation No. DJ.II/542 of 2013 concerning Guidelines for the Implementation of Pre-Marriage Courses. In 2009 this family guidance program was known as the prospective bride and groom course. Basically, these two programs have the same goal, only the technical implementation is slightly different. This equation can be seen from the understanding of the guidance program itself as in the Regulation of the Director General of Islamic Guidance in 2009 it is stated that what is meant by the prospective bride and groom course (hereinafter referred to as suscatin) is the provision of knowledge, understanding, and skills in a short time to the bride and groom about life. household/family. Meanwhile, the Regulation of the Director General of Islamic Community Guidance in 2013 states that pre-marital courses are the provision of knowledge, understanding, skills and raising awareness to adolescents of marriageable age about domestic and family life. In the attachment to chapter 1 letter d of the Regulation of the Director General of Islamic Community Guidance in 2013, it is explained that not only teenagers of marriageable age are given pre-marital courses, but all brides and grooms must receive the course because older age or not being a teenager is no longer a guarantee that they have understood the concept of marriage. household matters, therefore all prospective brides and grooms must take this course. From the explanation above, it is clear that although the terms are slightly different, they have the same meaning.

The pre-marital course is an effort made by the government to provide understanding about marriage to prospective married couples and the skills to create a *sakinah*, *mawaddah*, and *rahmah* family and suppress the high divorce rate in society.

In terms of preventing the emergence of health problems in the family in the future, especially maternal and child health problems, the existence of pre-marital courses as programmed by the Ministry of Religion is not sufficient because material on reproductive health is only given in general with very limited learning time. Therefore, it is necessary to look for other learning models that are comprehensive and in accordance with the needs of prospective brides in improving children's health, especially in preventing stunting under five.

The model for developing courses for brides and grooms in order to increase knowledge about preventing stunting under five must be compiled comprehensively and in accordance with the needs of the bride and groom themselves. The material provided must be able to answer the need for knowledge in preventing stunting under five. One alternative that can be done is through pre-marital classes. The use of the term class in the pre-marital class is closer to the existing term, namely the class for pregnant women or the class for mothers of toddlers. Through pre-wedding classes, it is hoped that prospective brides and grooms can improve their abilities (knowledge, attitudes, and or skills) about pregnancy, childbirth and the postpartum period, as well as child growth so that in the end they can prevent stunting under five.

Pre-wedding classes or brief debriefing are given to the bride and groom with a certain time, namely for 12 (twelve) hours of study (JPL) for 2 (two) days or made several meetings with the same JPL. Execution time can be adjusted to the opportunities that are owned by the participants.

Several important things that must be present in the implementation of pre-wedding classes, namely learning facilities, learning materials and methods, resource persons or teachers, and costs. Facilities for organizing pre-wedding classes include teaching and learning facilities, in the form of modules and other teaching materials needed for learning. The modules for the pre-marital class consist of exclusive breastfeeding, complementary feeding (MP-ASI), balanced nutrition, monitoring of child growth, infectious diseases in children, pregnancy, and reproductive health. The materials mentioned above can be given using lecture, discussion, question and answer methods, and assignments whose implementation can be adjusted to the conditions and needs in the field. The resource person or teacher who provides material to the bride and groom must be professional in their field. Class financing can be sourced from participant fees or assistance from the community which is lawful and non-binding and has a strong commitment to help participate in family development.

Prevention of stunting under five must start early, that is, since a man and a woman enter the age of marriage, especially before marriage. By increasing their knowledge, it is hoped that the bride and groom can play a role in preventing stunting under five. The knowledge required is knowledge of the factors associated with the occurrence of stunting in toddlers.

Several research results show that the level of knowledge of the prospective bride and groom about pregnancy is still low. The results of Hamsih's research (2015) on 30 prospective brides at KUA Waru Sidoarjo District showed that only 7% had good knowledge about Tetanus Toxoid immunization. Then the results of Rizka Dita Hidayati's research (2016) that 81.3% of brides-to-be have knowledge of reproductive health in the category of sufficient to less. Likewise, the results of Dilla Fitriana Salekha's research (2019) which found 45.9% of brides-to-be have less knowledge about reproductive health.

Almost the same condition is shown from several studies on the knowledge of pregnant women. Diah Ayu Pitaloka's research (2014) shows that 54.8% of pregnant women have low knowledge about exclusive breastfeeding. Then the results of Nurul Qomariah's research (2016) showed that only 60% of pregnant women had knowledge of the danger signs of pregnancy. The results of Nurul Utami's research (2018) also found that only 57.14% of pregnant women had knowledge about the health of pregnant women and postpartum. Furthermore, the results of Haneke Choirunissa's research (2019) stated that only 48.1% of pregnant women had a good level of knowledge about anemia. The results of these studies may indicate that the level of knowledge of the prospective bride will not be better than pregnant women.

Health education is a process of change so as to create a new knowledge and behavior. Ali (2011) revealed that the health education provided will provide a process of change so as to create a new behavior. The basic concept of health education is a learning process that This means that in education there is a process of growth, development or change towards a more mature, better, more mature individual, group or community. Health education is the addition of one's knowledge and abilities through practical learning techniques or instructions, with the aim of remembering facts or real conditions, by giving encouragement to self-direction, actively providing new information or ideas. Health education is carried out to help individuals control their health independently by influencing, enabling and reinforcing decisions or actions in accordance with the values and goals they plan. A person can be said to be

learning if there is a change in him from not knowing to knowing or from not being able to do something to being able to do something.

The Pre-Marriage Class is an innovative effort made to complement the existing Pre-Marriage Course. Pre-marriage class is a learning process by providing more specific material to help increase knowledge of prospective brides and grooms on preventing stunting under five. The learning materials provided are tailored to the needs of the bride and groom.

From the results of this study, it can be seen that in the case group that was given treatment in the form of prospective bride and groom leaflets and pre-wedding classes, there was an increase in the average score on all the topics of knowledge measured. The highest increase occurred in the average score of exclusive breastfeeding knowledge, which was 125.6% (from 1.8 to 4.1). Then followed by the average MP-ASI knowledge score which increased by 118.7% (1.8 to 4.0). The lowest increase was shown in the average score of knowledge about balanced nutrition, which was only 78.9%. In the control group, which was only given leaflets for the bride and groom, there was also an increase in all knowledge topics measured, but the increase was not as high as in the case group. The highest increase occurred in the average score of balanced nutrition knowledge which increased by 91.6% (from 1.8 to 3.5), followed by an average score of knowledge of exclusive breastfeeding of 78.0% (from 1.9 to 3.4). The lowest increase was shown in the average score of knowledge about infectious diseases in children, which was only 25.9%.

After statistical testing, it can be seen that in both the case group and the control group there was a significant difference between the average knowledge score before and after being given treatment. However, the increase in the average knowledge score was greater in the case group.

An increase in the average knowledge score in both groups could occur because both groups were given leaflets for the bride and groom. Meanwhile, the factor that is thought to cause a greater increase in the average knowledge score in the case group compared to the control group is the provision of Pre-Marriage Class. The Pre-Marriage Class is given for 12 lesson hours @ 45 minutes, with details of the Exclusive Breastfeeding Module and MP-ASI for 4 lessons, the Balanced Nutrition and Toddler Growth Monitoring Module for 3 lessons, the Infectious Diseases Module in children 2 lessons, and the Pregnancy and Pregnancy Module. Reproductive health for 3 hours of lessons. The learning method used is lecture, question and answer, and discussion.

The results of this study are in line with the quasi-experimental research conducted by Dewi Susanti (2018) on 19 pairs of brides and grooms at KUA Lubuk Begalung Padang which found that there was an effect of premarital health education on the knowledge of the bride and groom (p-value 0.001). A quasi-experimental study was also conducted by Djina (2020) on 13 pairs of prospective brides at the Pringgasela Health Center, East Lombok and the results showed that there was an influence between health education on knowledge of reproductive health of the bride and groom (p-value 0.000). Using the same design, research conducted by Marisa Lia Anggraini and Ade Nurhasanah Amir (2021) on 38 brides and grooms at KUA, Central Pariaman District, showed that there was an effect of premarital education on readiness in facing the first pregnancy in prospective brides (p-value 0.001).

Before being given treatment, the average knowledge score in the case group and the control group was not much different. After being given treatment, the average knowledge score in both groups both showed an increase, but in the case

group the increase was higher. In the case group, the increase was from 78.9% to 125 %, while in the control group it was from 25.9% to 91.6%.

The results of independent t-test showed that the p-value for the average score of knowledge about exclusive breastfeeding, complementary feeding (MP-ASI), monitoring child growth, pregnancy, and reproductive health between the two groups was less than 0.05. So it can be concluded that there is a significant difference between the average score of knowledge about exclusive breastfeeding ($p = 0.000$), about complementary feeding ($p = 0.019$), about growth monitoring ($p = 0.002$), Pregnancy ($p = 0.001$), and Reproductive health ($p = 0.020$) between the two groups. As for the average score of balanced nutrition and infectious disease in children between the two groups there was no significant difference because the p-value was greater than 0.05.

No difference in the average score of knowledge about balanced nutrition and infectious diseases in children could be found due to the presence of confounding variables, but this study did not analyze the confounding variables.

CONCLUSION AND RECOMMENDATIONS

1. That in the case group and the control group there was an increase in the average knowledge score of the prospective bride and groom between before and after treatment.
2. That the average increase in knowledge scores in the case group reached 78.9% to 125.6%, while in the control group the increase reached 25.9% to 91.6%.
3. That there was a significant difference between the two groups for the average score of knowledge about exclusive breastfeeding ($p = 0.000$), complementary feeding ($p = 0.019$), growth monitoring of children under five ($p = 0.002$), pregnancy ($p = 0.001$), and reproductive health ($p = 0.020$), and there was no significant difference between the two groups for the average score of balanced nutrition ($p = 0.112$), and infectious diseases in children ($p = 0.070$).

From the conclusions obtained, several recommendations can be given:

1. To increase the knowledge of prospective brides and grooms in preventing stunting under five, the Pre-Marriage Class can be collaborated with the Pre-Marriage Course that already exists.
2. The Puskesmas can organize pre-marital classes as well as classes for pregnant women or classes for mothers under five.
3. To improve the skills of the prospective bride and groom, the learning method in the Pre-Marriage Class needs to be developed through practice.
4. To deal with the Covid pandemic, Pre-Marriage Class Materials can be developed through the android application

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