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Research Article

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Maternal Knowledge and Responsive Feeding Practices in Relation to Nutritional Status among Toddlers with a History of Low Birth Weight

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Abstract

Toddlers with a history of low birth weight (LBW) are particularly vulnerable to nutritional problems, and appropriate feeding practices play an important role in supporting their nutritional needs. Responsive feeding emphasizes caregivers' ability to recognize and respond to children's hunger and satiety cues. This study aimed to examine the associations between maternal knowledge, responsive feeding practices, and nutritional status among toddlers aged 6–36 months with a history of LBW. A cross-sectional observational study was conducted in March 2026 in the working area of a primary health care center in Probolinggo Regency, East Java, Indonesia. A total of 102 mothers were recruited using purposive sampling. Maternal knowledge was assessed using a responsive feeding knowledge questionnaire, feeding practices were evaluated using the Responsive Feeding Practices Assessment Tool (RFPAT), and nutritional status was assessed using WHO Anthro software. Data were analyzed using Spearman's rank correlation test with a significance level of $p < 0.05$. The results demonstrated significant positive correlations between maternal knowledge and categorized nutritional status ($\rho = 0.493$; $p < 0.001$) and between responsive feeding practices and categorized nutritional status ($\rho = 0.558$; $p < 0.001$). These findings indicate that maternal knowledge and responsive feeding practices were significantly associated with nutritional status among toddlers with a history of LBW. Integrating responsive feeding education and counseling into maternal and child health services may be considered, although further longitudinal and interventional studies are needed to establish causal relationships and evaluate effectiveness.

INTRODUCTION

Nutritional problems remain an important public health challenge in Indonesia because childhood undernutrition can affect growth and later human development [1]. Toddlers aged 0-5 years are particularly vulnerable to nutritional deficiencies [1,2] . Adequate nutrition during this period supports growth and development [2], whereas inadequate nutrient intake and inappropriate feeding practices can

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contribute to malnutrition [1]. A history of low birth weight (LBW) further increases vulnerability to nutritional and growth problems during childhood [3,4].

Children's nutritional status reflects multiple determinants, including caregiving and feeding practices. Responsive feeding is grounded in reciprocal caregiver-child interaction, and less responsive or otherwise suboptimal feeding practices may adversely affect dietary behavior and growth-related outcomes [5-7].

National data indicate that LBW remains a relevant maternal and child health problem in Indonesia; the reported prevalence in 2024 was 3.9%, while East Java recorded 4.31% [8]. Children with a history of LBW have a higher risk of nutritional deficits and growth problems [3,4]. This concern is consistent with international priorities to improve care and nutrition for preterm and low-birth-weight infants [9] and with national health priorities [8], underscoring the need to identify modifiable caregiving factors associated with nutritional status in children with an LBW history.

Responsive feeding is a reciprocal caregiver-child approach that emphasizes recognizing and responding appropriately to hunger and satiety cues while supporting age-appropriate autonomy during meals [5,10]. Evidence indicates that responsive feeding can support healthier dietary patterns, self-regulation, and developmentally appropriate mealtime interactions [6,7,10]. Research involving low-birth-weight infants has also shown that feeding practices may be shaped by infant and family factors [11]. However, evidence specifically examining both maternal responsive-feeding knowledge and practices in relation to nutritional status among Indonesian toddlers with an LBW history remains limited. Therefore, this study examined the associations of maternal responsive-feeding knowledge and practices with nutritional status among toddlers aged 6-36 months with a history of LBW in the working area of a primary health care center in Probolinggo Regency, East Java, Indonesia.

Various studies indicate that toddlers with a history of Low Birth Weight (LBW) are at higher risk of nutritional problems, whereas responsive feeding plays a role in supporting children's eating patterns and growth. A link between responsive feeding behaviors and the incidence of stunting in toddlers aged 6–36 months [12]. Association between mothers' knowledge and attitudes regarding responsive feeding and toddlers' nutritional status [13]. However, research specifically examining the relationship between knowledge and practices of responsive feeding and the nutritional status of toddlers aged 6–36 months with a history of LBW remains limited. Previous studies have largely focused on toddlers in general or on premature/LBW infants in hospital settings, and have tended to assess only specific aspects of responsive feeding. Therefore, the novelty of this study lies in its focus on the relationship between mothers' knowledge and practices of responsive feeding and the nutritional status of toddlers with a history of LBW within the household environment. This study aims to analyze the relationship between mothers' knowledge and practices of responsive feeding and the nutritional status of toddlers aged 6–36 months with a history of LBW in the working area of a primary health care center in Probolinggo Regency, East Java, Indonesia.

METHODS

Study Design

This study used a cross-sectional observational design to examine associations between maternal responsive-feeding knowledge, maternal responsive-feeding practices, and the nutritional status of toddlers with a history of low birth weight (LBW).

Setting and Period

The study was conducted in the working area of a primary health care center in Probolinggo Regency, East Java, Indonesia. Data were collected in March 2026.

Population, Sample, and Sampling

The study population comprised mothers and toddlers aged 6–36 months with a history of low birth weight (LBW) in the working area of a primary health care center in Probolinggo Regency. The accessible population consisted of 112 mother–child pairs identified from health-center records of toddlers aged 6–36 months with a history of LBW

The sample size was calculated using Slovin's formula with an error margin of 3%. The calculation was as follows: $n = N/[1 + N(e^2)]$, where n represents the required sample size, N represents the accessible population, and e represents the error margin. With $N = 112$ and $e = 0.03$, the calculation resulted in $n = 112/[1 + 112(0.03^2)] = 101.81$, which was rounded to 102 participants. Therefore, the target sample size was 102 mother–child pairs.

Participants were recruited using purposive sampling based on predetermined eligibility criteria. The inclusion criteria were mothers who resided in the study area, were able to read and write, and cared for toddlers aged 6–36 months with a history of LBW, very low birth weight (VLBW), or extremely low birth weight (ELBW), including children born at term or preterm. The toddlers were also required to be directly cared for by their mothers. Toddlers with comorbid chronic diseases, chronic infections, or digestive system disorders that could affect nutritional status were excluded.

Potential participants were identified from records of toddlers aged 6–36 months with a history of LBW obtained from a primary health care center. The selected mothers were subsequently invited to participate in the study. Data collection was conducted on 6–7 March 2026 at the study site. A total of 102 mother–child pairs participated in the study and constituted the final analytical sample.

Low birth weight status and gestational age were verified using the Maternal and Child Health Book (Buku KIA). Low birth weight was defined as a birth weight of less than 2,500 g according to the World Health Organization (WHO). Low birth weight was further categorized as very low birth weight (VLBW) when birth weight was less than 1,500 g and extremely low birth weight (ELBW) when birth weight was less than 1,000 g, according to established neonatal classification [14]. Gestational age was classified according to the recommendations of the American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM), with preterm birth defined as delivery before 37 completed weeks of gestation and term birth defined as delivery at or after 37 completed weeks of gestation [15]. The presence of chronic disease, chronic infection, or digestive system disorders was assessed based on Puskesmas records and health personnel confirmation. Participants who met any of the exclusion criteria were excluded from the study.

Variables, Instruments, and Measurements

The study variables consisted of maternal knowledge of responsive feeding, maternal responsive feeding practices, and the nutritional status of toddlers with a history of LBW. Data were collected using questionnaires that had undergone validity and reliability testing. The instruments were considered valid when they met the criterion of $p < 0.05$, while instrument reliability was determined based on a Cronbach's alpha value >0.60. Based on these tests, all research instruments were

considered appropriate for use as data collection tools.

Maternal Knowledge of Responsive Feeding

Maternal knowledge of responsive feeding was assessed using a 13-item questionnaire based on responsive-feeding indicators from the World Health Organization (WHO) and the International Food Policy Research Institute (IFPRI), modified from Nurfitri 2021 [20]. The original instrument was available in Indonesian; therefore, no translation or back-translation process was required. The questionnaire consisted of three domains: understanding of responsive-feeding concepts (4 items), knowledge of responsive-feeding practices (7 items), and the mealtime environment and interaction (2 items).

Each item used a dichotomous response format with "true" and "false" options. Favorable items were scored 1 for a correct answer and 0 for an incorrect answer, whereas unfavorable items were scored 0 for a correct answer and 1 for an incorrect answer. The total score was calculated by dividing the number of correct responses by the total number of items and multiplying by 100%. Knowledge was categorized as poor (≤55%), moderate (56–75%), or good (76–100%). For the bivariate analysis, the categorized knowledge variable was used as an ordinal variable rather than the raw item score.

The questionnaire was validated among 30 mothers caring for toddlers with a history of LBW who were not included in the main study sample and were recruited from the working area of Puskesmas Gending. Item validity was assessed using Pearson's product-moment correlation. An item was considered valid when the calculated *r* value was greater than the critical *r* value of 0.361 and the significance value was <0.05. All 13 items met these criteria, with *r* values ranging from 0.404 to 0.540. The instrument demonstrated acceptable internal consistency, with a Cronbach's alpha coefficient of 0.687.

Maternal Responsive-Feeding Practices

Maternal responsive-feeding practices were assessed using the Responsive Feeding Practices Assessment Tool (RFPAT), consisting of 15 items and adapted from Tsaabitah 2025. The original instrument was available in Indonesian; therefore, no translation or back-translation process was required. The instrument assessed three domains: proactive preparation (4 items), attention to child cues and appropriate feeding (5 items), and responsive communication (6 items).

Each item was rated using a five-point frequency scale: always = 4, often = 3, sometimes = 2, rarely = 1, and never = 0. The total score ranged from 0 to 60, with higher scores indicating more frequent responsive-feeding practices. Based on the study's scoring system, responsive-feeding practices were categorized as low (0–34), moderate (35–36), good (37–40), and very good (41–60). For the bivariate analysis, the categorized responsive-feeding practice variable was used as an ordinal variable rather than the raw total score.

The RFPAT was validated among 30 mothers caring for toddlers with a history of LBW who were not included in the main study sample and were recruited from the working area of Puskesmas Gending. Item validity was assessed using Pearson's product-moment correlation. An item was considered valid when the calculated *r* value was greater than the critical *r* value of 0.361 and the significance value was <0.05. All 15 items met these criteria, with *r* values ranging from 0.466 to 0.935. The instrument demonstrated high internal consistency, with a Cronbach's alpha coefficient of 0.934.

Anthropometric Measurement and Nutritional Status

Nutritional status was assessed using anthropometric measurements of body weight and length/height. Body weight was measured using a digital scale or baby scale. Length was measured using an infantometer for children who could not stand independently, while height was measured using a microtoise for children who could stand independently. The measurements were processed using WHO Anthro software to obtain the child's anthropometric z-score.

Nutritional status was assessed using the weight-for-length/height indicator and categorized according to the applicable growth standard: severe wasting (<−3 SD), wasting (−3 SD to <−2 SD), normal (−2 SD to +1 SD), possible risk of overweight (>+1 SD to +2 SD), overweight (>+2 SD to +3 SD), and obesity (>+3 SD). For the bivariate analysis, nutritional status was analyzed as a categorized ordinal variable.

Intervention or Procedure

This was an observational study; no intervention was administered to participants.

Data Collection

Before data collection, the research team coordinated with the coordinating midwife at the primary health care center to identify toddlers aged 6–36 months with a history of LBW. Eligible mothers were invited to participate and received an explanation of the study objectives, procedures, and their rights before providing informed consent.

Maternal knowledge of responsive feeding was assessed using a 13-item Indonesian-language questionnaire based on responsive-feeding indicators from the World Health Organization (WHO) and the International Food Policy Research Institute (IFPRI), modified from Nurfitri 2021 [20]. Maternal responsive-feeding practices were assessed using the 15-item Responsive Feeding Practices Assessment Tool (RFPAT), adapted from Tsaabitah 2025. Participants completed the questionnaires independently with assistance from the researcher or trained enumerator when clarification of an item was required. The completed questionnaires were checked for completeness before data entry.

Anthropometric measurements were performed during the same data-collection session. Body weight was measured using a digital scale or baby scale, while recumbent length was measured using an infantometer for children unable to stand independently and standing height was measured using a microtoise for children able to stand independently. The equipment was checked and ensured to be properly calibrated before measurements were taken. Measurements were conducted by the research team with assistance from trained health personnel/cadres according to the study measurement procedure.

The anthropometric measurements, together with the child's date of birth and sex, were entered into WHO Anthro software to calculate the corresponding anthropometric z-scores. Nutritional status was classified according to the weight-for-length/height indicator using the following cutoffs: severe wasting (<−3 SD), wasting (−3 SD to <−2 SD), normal (−2 SD to +1 SD), possible risk of overweight (>+1 SD to +2 SD), overweight (>+2 SD to +3 SD), and obesity (>+3 SD).

Data Analysis

For the primary bivariate analysis, Spearman’s rank correlation test was used to examine the unadjusted association between categorized maternal responsive feeding knowledge, categorized responsive feeding practices, and categorized nutritional status. Nutritional status was coded ordinally as 1 = severe wasting, 2 =

wasting, 3 = normal, 4 = possible risk of overweight, 5 = overweight, and 6 = obesity, based on the predefined anthropometric z-score categories. A significance level of $p < 0.05$ was applied. Because the nutritional status categories included both undernutrition and overnutrition, the ordinal coding was used to represent the predefined category sequence and was not interpreted as a continuous measure of nutritional health or as a linear "better–worse" continuum. Therefore, the Spearman correlation findings were interpreted as unadjusted exploratory associations, with the direction and magnitude of the correlation interpreted cautiously.

Ethical Considerations

The study was conducted in a district in Probolinggo Regency, East Java. Ethical approval was obtained from the Health Research Ethics Committee of a Faculty of Nursing (Reference No. 4124-KEPK; February 9, 2026). All participants received information about the study objectives, procedures, benefits, and participant rights and provided informed consent before participation. Participant identities and personal information were kept confidential and used only for research purposes.

RESULTS

Table 1 summarizes participant characteristics. Of the 102 toddlers, 55 (53.9%) were female, 46 (45.1%) were aged 25-36 months, 93 (91.2%) were in the 1,500-2,500 g birth-weight category used in the study, 73 (71.6%) had a birth length of 47-53 cm, 57 (55.9%) were born at term, and 45 (44.1%) were second-born children. Among the mothers, 84 (82.4%) were aged 20-35 years, 90 (88.2%) were housewives, and 44 (43.1%) had completed senior high school or an equivalent level of education.

As shown in Table 2, 85 mothers (83.4%) were classified as having good responsive-feeding knowledge and 91 (89.1%) as having very good responsive-feeding practices. At the time of assessment, 86 toddlers (84.3%) were classified as having good nutritional status, 10 (9.8%) as undernourished, 2 (2.0%) as severely malnourished, and 4 (3.9%) as at risk of overnutrition.

Table 3 presents the cross-tabulation of maternal responsive-feeding knowledge and categorized nutritional status. Among the 85 mothers classified as having good knowledge, 83 toddlers (97.6%) were categorized as having good nutritional status. The Spearman analysis yielded $\rho=0.493$ and $p<0.001$. According to the prespecified magnitude thresholds, this coefficient was in the low range.

Table 3 also presents the cross-tabulation of maternal responsive-feeding practices and categorized nutritional status. Among the 91 mothers classified as having very good practices, 85 toddlers (93.4%) were categorized as having good nutritional status. The Spearman analysis yielded $\rho=0.558$ and $p<0.001$, corresponding to a moderate correlation magnitude according to the prespecified thresholds.

Table 1
Characteristics of Mothers and Children (n=102)

Characteristics	Category	n	%
Child's Sex	Male	47	46.1
	Female	55	53.9
Child's Age	6-12 Months	22	21.6
	13-24 Months	34	33.3
	25-36 Months	46	45.1
Birth Weight	<1,500 grams (VLBW)	9	8.8
	1,500-2,500 grams (LBW)	93	91.2
Birth Length	Abnormal (<47 cm)	29	28.4
	Normal (47-53 cm)	73	71.6
Gestational Age at Birth	Term	57	55.9
	Preterm	45	44.1
Child's Birth Order	First	38	37.3
	Second	45	44.1
	Third	18	17.6
	Fourth	1	1.0
Maternal Age	<20 Years	3	2.9
	20-35 Years	84	82.4
	>35 Years	15	14.7
Maternal Occupation	Housewife	90	88.2
	Farmer/Entrepreneur/Trader	9	8.8
	Teacher/Civil Servant	3	2.9
Maternal Education	Elementary School or Equivalent	17	16.7
	Junior High School or Equivalent	31	30.4
	Senior High School or Equivalent	44	43.1
	Higher Education	10	9.8

Table 2
Distribution of Maternal Responsive Feeding Knowledge, Maternal Responsive Feeding Practices, and Nutritional Status of Toddlers with a History of Low Birth Weight

Variable	Category	n	%
Maternal Responsive Feeding Knowledge	Poor	14	13.7
	Fair	3	2.9
	Good	85	83.4
Maternal Responsive Feeding Practices	Low	2	2.0
	Fair	7	6.9
	Good	2	2.0
	Very Good	91	89.1
Nutritional Status of Toddlers with a History of Low Birth Weight	Severely Malnourished	2	2.0
	Undernourished	10	9.8
	Good Nutritional Status	86	84.3
	At Risk of Overnutrition	4	3.9
	Overnutrition	0	0.0
	Obesity	0	0.0

Table 3
Spearman Rho Correlation Test of Maternal Responsive Feeding Knowledge and Maternal Responsive Feeding Practices with the Nutritional Status of Toddlers with a History of Low Birth Weight

Variable	Nutritional Status										Spearman Rank Test
	Severely Malnourished		Undernourished		Good		At Risk of Overnutrition		Total		
	f	%	f	%	f	%	f	%	f	%	
Maternal Responsive Feeding Knowledge											
Poor	2	14.3	9	64.3	1	7.1	2	14.3	14	100	p<0.001
Fair	0	0.0	1	33.3	2	66.7	0	0.0	3		rho=0.493
Good	0	0.0	0	0.0	83	97.6	2	2.4	85		
Maternal Responsive Feeding Practices											
Low	2	100	0	0.0	0	0.0	0	0.0	2	100	p<0.001
Fair	0	0.0	7	100	0	0.0	0	0.0	7		rho=0.558
Good	0	0.0	1	50.0	1	50.0	0	0.0	2		
Very Good	0	0.0	2	2.2	85	93.4	4	4.4	91		

DISCUSSION

Maternal and household characteristics have been identified in prior literature as factors related to feeding practices and child nutritional status [18,19]. In the present study, these characteristics were described but were not included in the reported association models. Therefore, the main findings should be interpreted as unadjusted associations rather than effects independent of maternal or child characteristics.

Most mothers were classified as having good responsive-feeding knowledge, and maternal knowledge was statistically associated with categorized nutritional status. This pattern is consistent with evidence linking caregiver nutritional knowledge and practices with child nutritional outcomes [14]. A plausible behavioral explanation is that caregivers who recognize hunger and satiety cues and understand age-appropriate feeding may be better positioned to organize feeding interactions around the child's needs [5,10]. However, because exposure and outcome were measured at the same time, the temporal direction of this association cannot be established.

Responsive-feeding practices were also associated with categorized nutritional status. Prior work among toddlers has linked responsive-feeding practices with healthier dietary intake [6], and an Indonesian study examined responsive feeding in relation to household-level nutritional problems [19]. A study in Ghana likewise reported associations of caregiver nutritional knowledge and practices with nutritional status among children aged 6-59 months [17]. These findings provide contextual support but do not establish that responsive feeding alone explains nutritional status, which is influenced by multiple biological, dietary, socioeconomic, and health-related factors.

The correlation coefficient for responsive-feeding practices (ρ=0.558) was numerically larger than that for knowledge (ρ=0.493); however, the two coefficients were not formally compared and should not be interpreted as evidence that practices have a statistically stronger or independent effect. Conceptually, knowledge may facilitate appropriate feeding decisions, whereas practice reflects how those principles are implemented during meals. The highly concentrated distributions of knowledge and practice categories, particularly the large proportion of participants in the highest categories, may also affect rank-based estimates and should be considered when interpreting these coefficients.

These findings have potential relevance for nurses and primary care providers who support families of toddlers with a history of LBW. Counseling can emphasize recognition of hunger and satiety cues, appropriate responses to child signals, and a supportive mealtime environment. However, the present cross-sectional associations do not demonstrate that an educational intervention would improve nutritional outcomes; prospective or interventional studies are needed to evaluate such effects.

Strengths and Limitations

A strength of this study is its focus on toddlers with a history of LBW, a clinically relevant population in primary care. Important limitations include the cross-sectional design, which precludes temporal or causal inference; purposive sampling from a single health-center catchment, which limits generalizability and may introduce selection bias; reliance on maternal self-report for feeding measures, with possible recall and social-desirability bias; highly imbalanced exposure categories and sparse cells; the broad 6-36-month age range and heterogeneity between term and preterm LBW children; and the absence of reported multivariable adjustment for potential confounders. This study did not conduct a confounding analysis.

CONCLUSION

In this single-site cross-sectional sample of mothers and toddlers aged 6-36 months with a history of LBW, maternal responsive-feeding knowledge and responsive-feeding practices were statistically associated with categorized nutritional status in unadjusted analyses. There is a significant relationship between a mother's knowledge of responsive feeding and her child's nutritional status. It can be concluded that the higher the mother's knowledge of responsive feeding, the better the child's nutritional status. The findings support further attention to responsive feeding in counseling and future research, but they do not establish causality or an intervention effect. Prospective studies with clearly defined anthropometric outcomes and adjustment for relevant maternal and child characteristics are needed to determine the direction and independence of these associations.

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