Experience of Mother in Taking Care of Children with Stunting at Majene Regency, Indonesia

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Abstract

INTRODUCTION: Health officials have the role and responsibility to provide a promotive, preventive, curative, and rehabilitative action for children who are stunted. However, in fact, the role will be taken over entirely by parents, especially the mother. Therefore, the mother’s experience needs to be explored to know the extent of a mother’s efforts in treating her child who is stunted.

MATERIALS AND METHODS: This research used a qualitative method with a phenomenological approach. Data were collected through deep interviews using a questionnaire that was prepared and then the researcher recorded the process of interview. The sampling technique used was purposive sampling then proceed with snowball sampling. Then, data would be analyzed using the thematic analysis method.

RESULTS: Mothers of children who were categorized as stunting did not have clear knowledge about stunting, performed exclusive breastfeeding for 6 months but breastfeeding was not optimal until the children are 2 years of age, complementary feeding was not balanced because it did not contain carbohydrate, protein, and fat sources, families with incomes below the minimum income experience stunted their children. Husband’s support to all participants was very good in overcoming health problems that occur in children, but her husband’s support was very lacking in efforts to prevent children from experiencing stunting, mothers of children who were categorized as stunting had good personal hygiene behaviors in children.

CONCLUSION: Health education about stunting with interactive and sustainable extension methods can increase the understanding of parents and families in caring for stunted children.

Introduction

Stunting is a chronic condition of malnutrition for a long time in a critical period of growth and development early in life. Stunting is defined as the percentage of children aged 0–59 months who are of height for ages under −2 standard deviations (moderate and severe stunting) and −3 standard deviations (severe stunting) of the median [1]. Data from the United Nations International Children’s Emergency Fund in April 2019 from estimates of joint malnutrition show that the prevalence of stunting has decreased since 2000, almost 1:4 of 149 million children under the age of 5 were stunted in 2018, and more than 49 million suffer from malnutrition [2].

Based on the 2015 PSG results, the prevalence of short toddlers in Indonesia is 29%. This figure has decreased in 2016 to 27.5%. However, the prevalence of short toddlers again increased to 29.6% in 2017. The prevalence of toddlers is very short and short at the age of 0–59 months in Indonesia in 2017 is 9.8% and 19.8%. This condition increased from the previous year, in which the prevalence of very short toddlers was at 8.5% and short toddlers at 19%. The province with the highest prevalence of toddlers who was very short and short at the age of 0–59 months in 2017 was East Nusa Tenggara, while the province with the lowest prevalence was Bali [3]. Riskesdas data in 2018, for children aged 0–23 months the short percentage was 24.5% and very short was 12.6%, and for ages 0–59 months the short percentage was 25.4% and very short was 16.0%. West Sulawesi ranks second nationally [4].

Stunting affects the short and long term. The short-term impact is that motor, cognitive, and verbal development is not optimal and the incidence of illness and death increases so that it will also increase health costs. In the long term, it will have an impact on suboptimal posture in adulthood, an increased risk of disease and obesity, decreased reproductive health, reduced learning ability, and less optimal work productivity [5]. Factors that cause stunting are the provision of undernutrition in children, mothers who are in their adolescents experiencing malnutrition and during pregnancy, lack of optimal latency which affects the decline in body and brain growth, and low access to health services, sanitation, and clean water [5].
The contributing factors to stunting are lack of nutritious food intake [6], infectious diseases [7], and Health Services and Environmental Health [8]. With those factors, health officials have the role and responsibility to provide promotive, preventive, curative, and rehabilitative measures for children who are stunted. However, in fact, the role will be taken over entirely by parents, especially the mother. Therefore, the mother’s experience needs to be explored to know the extent of a mother’s efforts in caring for her child who is stunted.

Methods

This research used a qualitative method with a phenomenological approach. This research was carried out in Majene Regency in July 2019 and the research data collection began on July 15, 2019. Data were collected through deep interview using a questionnaire that was prepared and then recorded the process of interview the study population was all mothers with stunted children in the Totoli Community Health Center, Banggae District, Majene Regency. The sampling technique used was purposive sampling with minimum high school education criteria, could be invited to communicate for a long time, and has children with stunting. Then proceed with snowball sampling with a total sampling of 5 mothers in Pamboborang Village, Totoli Community Health Center, Banggae District, Majene Regency. Data would be analyzed using the thematic analysis method developed by Braun dan Clarke (2006). The stages consisted of (1) listening to recorded interviews, (2) understanding the data, (3) compiling the code to find the main thoughts, and (4) looking for themes [9].

Results and Discussions

Characteristics of respondents

All participants resided in the work area of the Totoli Public Health Center, especially in the village of Pamboborang, Banggae District, Majene Regency and according to the criteria desired in this research. In general, the informant’s age is 20–35 years and has a high level of education with a number of children, 2–3 people (Table 1).

Table 1: Participant characteristics

| Informant | Characteristics | Number of children | Children affected by stunting |
|-----------|-----------------|--------------------|-------------------------------|
| SP1       | 30 High         | 2                  | Second                        |
| SP2       | 31 High         | 2                  | First                         |
| SP3       | 22 Middle       | 2                  | First                         |
| SP4       | 34 High         | 3                  | Third                         |
| SP5       | 26 High         | 2                  | First                         |

Theme 1: What do you or your family know about stunting?

Based on what participant said in Table 2, the health officials have made an effort to conduct health education in the posyandu (integrated healthcare center). However, most mothers misunderstand information about stunting. A mother’s understanding of stunting is a mismatch between age and weight. This misunderstanding results in that the mother not knowing that her child is stunted, which is the mismatch between age and height. The mothers who know about stunting are mothers who take counseling and pay close attention to explanations from health officials and realize that their children are stunted, so they try to get more information to overcome the problem of stunting in their children [10]. Wrong knowledge can trigger stunting in children [11].

Health officials should introduce this health problem in accordance with the language recognized by the community, especially mothers, stunting which is a foreign language that is still new and difficult for mothers to understand. Researchers carry out interactive and continuous counseling methods. Interactive means extension participants are directly involved in counseling so that the information delivered is not misunderstood. Continuity means that the provision of information does not stop at the health service, posyandu but is carried out until it reaches the family’s home. The method can be in the form of giving brochures in the form of household items such as calendars, forming community-based stunting care groups that routinely discuss prevention, and handling stunting. Mother’s knowledge must always be evaluated by conducting question and answer or surveys so that it is easy to identify mothers who lack of knowledge about stunting [12].

Theme 2: Utilization of health services

Table 3 shows that there are mother do not yet know the importance of utilizing health services as a means of information to prevent health problems, especially stunting. The closest primary health service in the mother’s environment is posyandu. Posyandu is the most accessible facility for mothers to obtain health services. Posyandu consists of posyandu cadres who are people who have received posyandu cadre training and also attend 1–3 health workers. Activities in the Posyandu consist of weighing, documentation of the results of weighing and health consultations. Posyandu activities are carried out once every month [13].

For mothers who have stunted children, mothers rarely or never have access to health services and attend health education [14]. In the understanding of our society, posyandu only functions in the curative sphere. The family or mother takes her child to the posyandu or other health facilities only to treat her sick child [15]. The understanding of preventive is
only limited to immunization. In fact, posyandu is the foremost source in obtaining health information for preventing disease (preventive) [16].

**Theme 3: Fulfillment of nutrition and ASI (breastfeeding) in Children**

Table 4 shows that the mother maintains the hygiene of their children by paying attention to personal hygiene every day at least bathing twice a day, but there are mothers who do not give breast milk until the age of 2 years because of interference with the breast so that milk production is low, and the mother does not provide complementary foods consisting of carbohydrates, protein, and fat.

Most apply exclusive breastfeeding at the age of 0–6 months. However, breastfeeding does not continue optimally until children are 2-years-old. WHO and UNICEF (2003) that is to reduce infant and child morbidity mortality can be done by giving exclusive breastfeeding given at the age of the 1st 6 months of life, and adequate nutrition according to the body’s needs, using native and local food ingredients up to the age of 2 years or more [17], [18].

All mothers have applied exclusive breastfeeding, namely breastfeeding to infants without additional food from 0 months to 6 months. All mothers have realized the importance of exclusive breastfeeding for children’s health. However, breastfeeding is not done until the child is 2-years-old. Most mothers experience a decrease in the amount of breast milk at the age of 4 months to 1 year. The decrease in the amount is caused by a lack of nutrition from the mother. In nursing mothers, it is recommended to add 400–600 kcal/day of nutrient intake to support optimal milk production throughout the day. Providing complementary feeding (MP-ASI) most mothers have done it right. The health service has tried to introduce the composition of the MP ASI (complementary feeding) balanced nutrition for children with the nutritional program providing balanced nutrition MP ASI (complementary feeding). There are still mothers who give MP ASI in the form of carbohydrate sources, even though protein and fat cannot be ignored. Health officials have introduced eggs and green beans as a source of protein and fat that are cheap and easy to get around the mother’s environment. This gift is intended so that mothers and families can imitate the menu in providing daily food for children.

Information from interviews also shows that children prefer to eat snacks and tend to refuse home-based food (Table 4). This happens because children are immediately introduced to snacks before the age exceeds 2 years. So that the golden period of growth and development of a child’s baby that is the 1st 1000 days the child becomes disrupted [19]. Lack of maternal knowledge about substitute food sources also affects here, for example, carbohydrate sources, according to the mother can only be obtained from rice even though it can be filled through potatoes and bread. Providing additional food in the 1st 1000 days greatly supports the growth and development of children at a later age [20].

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Income is also one of the factors in efforts to build family nutrition [23]. In addition, in an effort to maintain and improve family nutrition, awareness of all family members is needed in prioritizing the use of income to improve family nutrition. This is not easy, because the family has other needs that they think are no less important. However, if the family can get to know sources of nutrition that is cheap and easily accessible, this can be achieved. For this reason, health officials should introduce to families and the wider community about food sources that are of high nutritional value but cheap and easy to obtain [24]. Inclusion should ideally be used to build a family to be

Table 4: Fulfillment of nutrition and ASI (breastfeeding) in children

| Code | Description |
|------|-------------|
| 1 | I maintain the hygiene of my children by paying attention to personal hygiene every day at least bathing twice a day |
| 2 | Breast milk is given until the age of 2 years without interruption |
| 3 | Breast milk is given to children from 0–6 months of age without providing other foods |
| 4 | I do not give breast milk until the age of 2 years because of interference with the breast so that milk production is low |

Table 5: Financial of family

| Code | Description |
|------|-------------|
| 1 | Income > 1,000,000 rupiah is sufficient to meet the nutritional needs of the family |
| 2 | Income < 1,000,000 rupiah is sufficient to meet the nutritional needs of the family |

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https://www.id-press.eu/mjms/index
Income is prioritized for daily food consumption when it is used to meet family nutritional needs instead of purchased for other needs. For instance, a husband might allocate income towards buying foods for his family, which supports the growth and development of children, instead of using the income to purchase non-nutritional items. This is crucial in stunting prevention efforts because the provision of good nutrition for families, especially children, is essential for healthy growth.

**Theme 5: Husband support to family**

Table 6 shows that income is prioritized for daily food consumption and the husband supports in maintaining family health by taking our children to the nearest health facility. The husband's support is crucial in stunting prevention efforts because the husband is a source of family income. Husbands need to be given additional knowledge about the dangers of smoking and the importance of using income in a more productive direction such as diverting cigarette consumption by buying nutritious food for the family.

On the other hand, the husband's support for the family is very good because they are ready to provide medicine for the child, take the child if they are sick to health services, and spend time with the child. The relationship between husband and children in the five families is very close, often playing with children, taking time to go home for lunch and meeting with children, and sleeping with children. This certainly can support the growth and development of children, but still, the husband must anticipate other factors, which is the provision of good nutrition for families, especially children.

**Conclusion**

Mothers of children who are categorized as stunting do not have clear knowledge about stunting, apply exclusive breastfeeding for 6 months but breastfeeding is not optimal until 2 years of age, complementary feeding is not balanced because it does not consist of carbohydrate, protein, and fat sources, families with incomes below the minimum income experience stunting in their children. Husband's support to all participants is very good in overcoming health problems that occur in children, but her husband's support is very lacking in efforts to prevent children from experiencing stunting, mothers of children who are categorized as stunting have good personal hygiene behaviors in children. Based on this, it is suggested to improve health education about stunting, by introducing an easy-to-understand language and an interactive and sustainable counseling method. The introduction of complementary foods for breastfeeding should still be improved for families especially mothers to increase education about food replacement foods and families.
should prioritize the use of income for the supply of nutritious food.

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