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Editorial Team

Family Challenges in Stunting Care: Identifying four main barriers and additional risk factors

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ABSTRACT

Parental stress is related to children's mental health and well-being. The success of stunting care is influenced by the family's acceptance and coping response in caring for stunted children. The inability to accept a diagnosis of stunting in children is often responded to with denial as an emotional coping strategy that has an impact on decreasing childcare patterns. The purpose of this study is to explore the problems faced by parents in caring for children with stunting. The study employed qualitative research methods, including semi-structured interviews, focus group discussions, and brainstorming sessions. One hundred eight experienced Integrated Service Post (Posyandu) cadres were participants, and data analysis was measured based on credibility, transferability, confirmability, and dependability. The study's results revealed four key indicators of problems: issues related to nutrition management, negative responses to educational and counseling services, negative responses to child growth and development evaluations, and negative responses to integrated health post visits. Additional problems included picky eaters, lack of information or knowledge of stunting care, not visiting integrated health posts, and not accepting or caring about children's growth and development. Readiness to be a parent who can choose coping mechanisms that solve problems can impact the care of stunted children.

KEYWORDS: *denial, negative coping, nutrition, stress, stunting*

INTRODUCTION

Child stunting remains a significant problem in the world, especially in poor and developing countries. The prevalence of stunting in the world in 2017 reached 22.2%, with half of the children with stunting in Asia (55%), and one-third in Africa (39%).

In 2017, the number of stunted toddlers in Indonesia was ranked 4th in the world after Nigeria, Pakistan, and India. Before 2015, there had been a decrease in the number of stunting, namely; 2007 (36%); 2010 (35%); 2013 (37.2%); 2015 (29%) (Kemenkes RI, 2016), However, the decline was still high above the national target at that time, namely 28% (Laporan Nasional Riskesdas, 2018).

According to the 2017 Ministry of Health research, stunting in East Java showed a prevalence of 26.7%. Batu had the second-highest incidence of stunting (35.1%), after Bondowoso (38.3%), while Malang had a lower prevalence, at 27.4% (Riskesdas Jatim, 2018).

Stunting will have short-term and long-term impacts. The short-term impacts include brain development disorders, intellectual disorders, physical growth disorders, and metabolic disorders. The long-term impacts include decreased cognitive function and learning achievement, compromised immunity, an increased risk of disease, and suboptimal work quality. The assessment conducted by the OECD PISA (Organization for Economic Cooperation and Development - Programme for International Student Assessment), a prestigious global organization, which held a competition for 510,000 15-year-old students from 65 countries, including Indonesia (2012), in the fields of reading, mathematics, and science, ranked Indonesia 64th out of 65 countries. Stunting also has an impact on decreasing productivity, inhibiting economic growth, and increasing poverty and inequality (Kementerian Keuangan, 2018). Ultimately, this will have an impact on the nation's future productivity and the quality of its human resources (Kemenkes RI, 2016).

The government has prepared a National Strategy for Accelerating Stunting Handling for 2018-2024. The government aimed to reduce the stunting rate from 27.67 percent in 2019 to 14 percent by 2024, in line with WHO regulations (WHO, 2018). The government intervenes in two categories. The first category is specific nutrition intervention, namely monitoring toddlers at integrated health posts, providing immunizations, providing vitamin A, providing additional food (PMT), and others. The second category is sensitive nutrition intervention, which includes providing drinking water and proper sanitation, post-natal family planning (KB) services, information related to stunting, social food assistance, conditional cash assistance, and other services (KEMEN-PMK, 2018). Specific nutrition interventions are generally carried out in the health sector, but they only contribute 30%, while 70% are attributed to sensitive nutrition interventions (Kemenkes RI, 2016).

The prevalence of stunting in Indonesia decreased from 24.4% to 21.6% in 2022. However, this decrease is still overshadowed by the prevalence of wasting and underweight, which tends to persist and even increase from the previous year (Kemenkes, 2022). Indonesia targeted the prevalence to decrease to 14% by 2024, referring to WHO regulations, but to achieve the target of 14% by 2024, Indonesia needed to work hard because it must achieve a target of decreasing 3.8% per year, while the results of the decrease from 2019 to 2021, were only able to decrease 3.2%, and in 2022, it only decreased by 2.8% (Kemenkes, 2022).

The success of child care for stunted children is influenced by the family's acceptance and coping response in caring for these children. The inability to accept a diagnosis of stunting in children can cause parental stress, which results in a decrease in child care patterns. Parenting stress is conceptualized by Abidin (1992). Stress is caused by characteristics related to both the child and the parent (e.g., parent personality and pathology, attachment patterns, adaptability, child demands, mood, or any current illness), which can cause distress due to perceived parental roles. In addition, parental stress is associated with lower

levels of mental health, psychopathology, and well-being in both parents and children (Barroso et al., 2018; Menon et al., 2020).

Parental stress negatively impacts children and adolescents. Menon et al.'s (2020) findings suggest that potential child neglect and child behavior are related to parental stress. Children's social competence deficits may explain the presence of child neglect and parents who need services to reduce stress (Crum & Moreland, 2017). Stress in parents can reduce the quality of parenting behavior.

A depressed mother may experience fatigue, impaired concentration, and psychomotor retardation, all of which can affect feeding practices and increase psychological stress for the child, affecting growth via the hypothalamic-pituitary-adrenal (HPA) axis extending to risk factors for poor parenting (Shay et al., 2020; Frith et al., 2009) and interfering with children's rights to live in a safe, supportive, and loving family (Black et al., 2020). Susiloretni et al. (2021) stated that mothers who experience distress increase the risk of mild stunting by 33% (HAZ <-1) and moderate by 25% (HAZ <-2), while fathers' distress increases the risk of mild stunting by 37% and moderate by 28%. Distress experienced by both parents increases the risk of moderate stunting by 40%. Mothers', fathers', and parents' distress (mothers' and fathers' distress) influence stunting by 8.6%, 11%, and 19% respectively.

This condition cannot be ignored; however, the root of the problem must be identified, which can serve as the basis for efforts to resolve it. Based on the above phenomenon, this study aims to dig deeper into the issues that arise in families with stunted children, which can interfere with the care and development of stunted children.

METHODS

This research is an exploratory qualitative study, a design that examines a phenomenon based on empirical facts in the field (Nursalam, 2020). This design was chosen to explore more deeply mothers' experiences caring for children with stunting. Due to limited knowledge about the research problem, this research design was needed to help analyze the dimensions of the problem. It was a valuable initial step to investigate the issue, ensuring that subsequent research projects would be on target and help set priorities for future research (Holloway & Wheeler, 2013). The data were collected through a Focus Group Discussion (FGD) and brainstorming.

1. Participant characteristics, sampling procedure, and sample size

The population in this study was all Integrated Service Post (Posyandu) cadres who assisted mothers with stunted children in the Sisir Health Center work area, Batu, East Java. Samples were taken using the total sampling technique of 108 cadres.

2. Measures and covariates

The measuring instrument in this study was a structured questionnaire that contained issues of problems often faced by stunted families who were assisted by cadres. Cadre demographic data complemented the data presentation. After the data were collected, they were processed and analyzed using frequency tabulation (Siregar, 2017).

3. Data analysis

To ensure that data collection and interpretation accurately reflect the phenomena being investigated, data analysis was used to provide scientific rigor in this qualitative research, which was measured based on credibility, transferability, confirmability, and dependability (Shenton, 2004). The researchers conducted three things to develop credibility (Shenton, 2004). First, the researchers developed an initial understanding of the culture, values, and situations applicable in the participants' environment and established a relationship of mutual trust by conducting several visits to the integrated health post and interviews with integrated health post cadres and local community leaders to obtain relevant information. Second, the researchers allowed participants to refuse to participate in the study, and respondents to provide data voluntarily. Finally, internal validity was ensured by returning the interview transcripts to participants to verify the accuracy of the research findings. Transferability provides a comprehensive and detailed description, offering a broad framework for comparison with what participants observe in their own situation (Shenton, 2004). Conformability and dependability ensure the stability and objectivity of research results, where researchers collect data through semi-structured interviews with potential participants designated as data sources, who are asked the same central questions (Shenton, 2004). Next, the researchers conducted an audit trail by documenting the process in detail, including the contextual, methodological, analytical, and personal responses required to achieve the research results (Rodgers & Cowles, 1993, as quoted in Holloway & Wheeler, 2013).

RESULTS AND DISCUSSION

Results

The research results are presented in three sub-chapters: respondent characteristics, four indicators of the main problems families face in caring for stunted children, and supporting findings on problems in caring for stunted children.

a. Respondent characteristics

1. **Characteristics of respondents based on age**

   A study conducted on 108 respondents in the Sisir sub-district, Batu, on September 20, 2022, revealed the following characteristics of the respondents.

2. **Distribution of respondent characteristics based on age**

   Based on the research results, the ages of the respondents are presented in Figure 1.

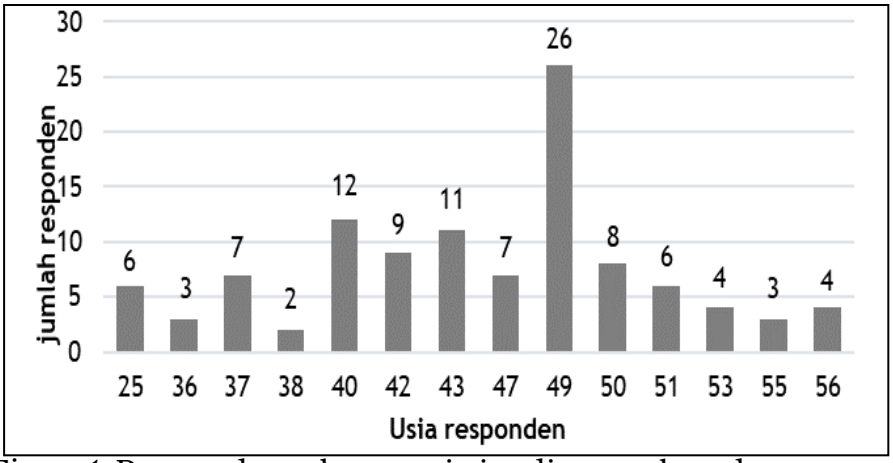

Figure 1. Respondent characteristics diagram based on age
Source: Primary data, 2024

Based on Figure 1, it appears that the most respondents (26) are 49 years old. The second high proportion is that of individuals aged 40 to 43 years old, with 9-12 respondents each. The youngest respondents were 25 years old, and the oldest were 56 years old.

3. **Respondent characteristics based on the distribution of integrated health posts**

   The characteristics of respondents based on the distribution of integrated health posts are presented in Figure 2.

Figure 2. Distribution of cadres based on integrated health posts

Based on Figure 2, the respondents were cadres from 13 integrated health posts, with the number of respondents per post ranging from 7 to 9. This indicates that the issues identified by the cadres in their respective health posts were relatively similar in both nature and frequency.

b. Four indicators of main family problems in caring for stunting children

A Focus Group Discussion (FGD) was conducted by simultaneously forming three groups from the total population as a triangulation effort. The FGD revealed several issues across four main themes: education/counseling problems, nutritional care issues, challenges with integrated health post visits, and concerns regarding growth and development evaluations. These problems are presented descriptively in Figure 3.

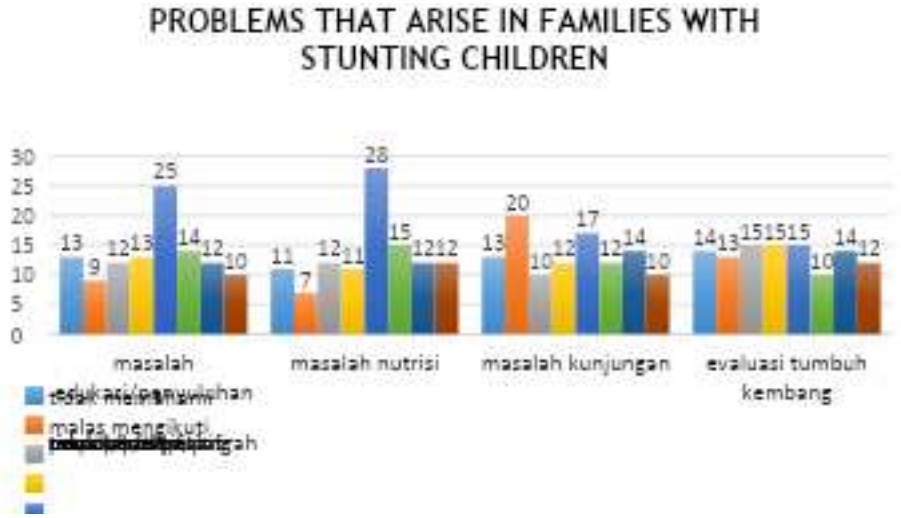

Figure 3. Distribution of family problems with stunted children based on four themes

Figure 3 shows that most families with stunted children tend to reject counseling or educational activities related to stunting (25 respondents) and nutrition problems (28 respondents). Twenty respondents were reluctant to participate in integrated health post activities, and 17 respondents even refused to attend. Furthermore, 15 respondents experienced difficulties in evaluating their children's growth and development, often displaying indifferent, resigned, or avoidant behaviors. Although less frequent, several respondents exhibited anger or aggressive reactions toward health services—14 respondents in response to counseling, 15 regarding nutrition management, 12 toward integrated health post visits, and 10 concerning growth and development evaluations.

Despite these challenges, some respondents (aged 10–14 years, with an average age of 12) demonstrated positive engagement, such as following health instructions, regularly visiting the integrated health post, participating in counseling sessions, improving nutritional practices, and consistently monitoring child growth and development.

c. Supporting findings of problems in child stunting treatment

In addition to the four themes above, the results of brainstorming conducted at various times revealed several new findings related to problems in child stunting care, which strengthen the results presented in Figure 3 above, in the form of a word cloud.

1. **Problems of caring for stunted children in parenting patterns, eating behaviors, and nutrition management**

Figure 4. Problems of caring for stunted children in terms of parenting patterns, eating patterns, and nutrition

Figure 4 suggested the problems most often faced by parents are children with difficulty eating, picky eater children, and "lack of food creativity, followed by the statement that parents do not understand stunting care, parents are busy working, and parents are impatient in implementing nutritional parenting patterns.

2. **Problems of parents caring for stunted children in terms of receiving education/counseling**

Figure 5. Problems of caring for stunted children in terms of receiving education/counseling

Based on the interview results in Figure 5, the most common problems faced by parents do not seem to be specific. However, it can still be synthesized that the most frequently occurring word in the word cloud that is meaningful is "Less", be it less capable, less time, less accepting, less awareness, less nurturing, which can be caused by economic factors and mothers who have to work so they do not have time to attend counseling.

3. **Problems of caring for stunted children regarding visits to integrated health posts**

Figure 6. Problems of caring for stunted children in terms of visits to integrated health posts

Figure 6 illustrates that the problems most frequently reported by parents are varied and non-specific. However, analysis of the word cloud indicates that the word “no” appears most prominently, reflecting recurring expressions such as “not wanting to take them,” “no one to take them,” “unable to take them,” or “unwilling to take them.” Other related reasons include being bored, busy, forgetting the integrated health post schedule, or having a sick child.

4. **Problems of caring for stunted children in evaluating growth and development**

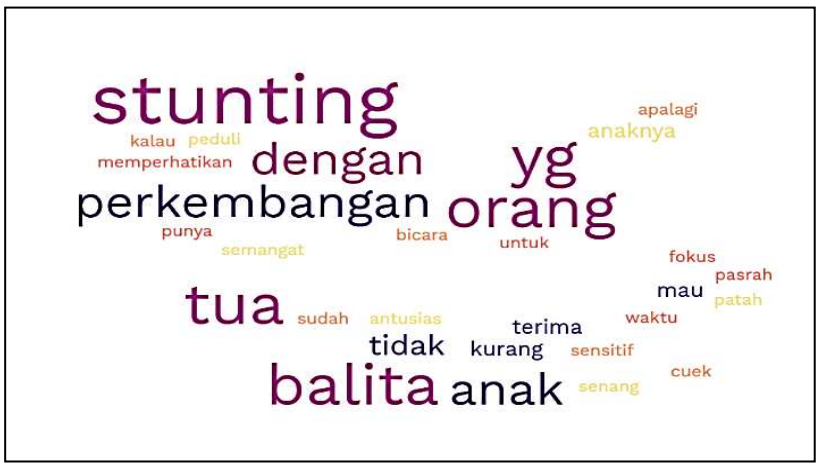

Figure 7. Problems of caring for stunted children in terms of evaluating growth and development

In Figure 7, the most common problems parents face in evaluating child development are also not specific. However, it can still be synthesized that the most frequently occurring words that are meaningful in the word cloud are "No" and “Less", such as not/less accepting, not care, not paying attention, not enthusiastic, not happy, indifferent, sensitive, or denial to the results of the children’s growth and development evaluation.

Discussion

a. Respondent characteristics

Based on Figure 1, the age of respondents as volunteers/stunting cadres is mostly 49 years old, followed by 40-43 years old. The age of 40 years is adulthood. Adulthood encompasses a person's attitude, personality, behavior, mindset, intellectual intelligence, emotional intelligence, and spiritual intelligence (Menon, 1999). This can be seen from one’s understanding of how the person loves socializing, understands a person's character and personality, and makes the person likable to others when socializing (Christiana, 2018; Santrock, 2012). Adult stunting health cadres must have high social awareness. Awareness as a social being, where socialization agents are needed in the interaction process to transmit specific values or norms, both directly and indirectly, in efforts to improve health behavior (Karim et al., 2013).

b. Four indicators of main family problems in caring for children with stunting

In assisting families affected by stunting, cadres encountered numerous challenges in addressing the problem. As shown in Figure 3, the most common issue was parents’ refusal to participate in counseling or educational activities on stunting and nutrition management. Many parents were reluctant or unwilling to attend integrated health post sessions, often displaying indifference toward their toddlers’ growth evaluations or denying that their children were stunted. Expressions of anger were also evident across these issues, reflecting forms of denial and rejection behavior—specifically self-deception—as a means of protecting themselves from perceived or real threats (Lazarus & Folkman, 1984). Denial, while sometimes regarded as a coping or defense mechanism, is more accurately understood as a self-protective response rather than an adaptive coping strategy.

Freud states that denial is potentially psychologically dangerous because someone who refuses to accept what is happening in reality will cause neglect, so therapy is needed to facilitate acceptance (Foster et al., 2023). This neglect can occur in the care of stunted children, so that the behavior that appears can be resignation, not caring, and even not carrying out the recommendations of health workers by avoiding and denying, as if everything is fine.

One of the most fundamental psychological processes distinguishing denial from efforts to overcome problems is a person's compliance with reality. During the denial process, a person can show an attitude of dispositional pessimism, namely a negative view of oneself, by distancing themselves from activities that are a source of threat (Aldwin, 2007), for example, refusing to come to the

integrated health post, refusing to receive health information, even giving negative feedback to someone, or exhibiting some form of unpleasant information that is directly related to the person's self-concept, such as being angry (Lazarus et al., 1980) or even rejecting reality when receiving information that the child is stunted. Meanwhile, coping strategies focus on solving problems. Optimistic individuals seek help from others and try to examine existing problems. In contrast, their pessimistic counterparts withdraw from the goal of solving the problem and attempt to mitigate negative aspects by denying them (Ritchie, 2014).

Etymologically, denial refers to the refusal to acknowledge or accept certain problems, in which unpleasant information is repressed, dismissed, ignored, or reinterpreted. Alternatively, the information may be consciously recognized but its cognitive, emotional, or moral implications are avoided, neutralized, or rationalized (Cohen, 2001).

On the other hand, neglect means that someone or something is treated carelessly, without proper attention, or with disrespect or indifference (Glasgow, 2009). In the context of (in)justice, neglect does not necessarily mean outright rejection or denial. Rather, neglect implies disinterest, for example, in a situation, environment, or geographic area related to a topic/theme that is considered threatening. Indeed, because it attempts to avoid blame, neglect has a negative moral dimension related to the dereliction of responsibility. This means a failure to extend the duty of care to the problem. This can manifest itself in apathy or, at a societal level, as institutional neglect.

c. Supporting findings of problems in child stunting care

(i) Problems of child stunting care in parenting patterns of eating behavior and nutrition intake

The problems faced by parents that appear most often in the word cloud are children with difficulty eating, picky eaters, and a lack of food creativity among parents who do not understand stunting care. Additionally, parents are busy working and impatient in implementing nutritional parenting patterns. Children who have difficulty eating or are picky eaters are one of the key factors contributing to growth failure. There is a significant influence of picky eating behavior on height, weight, body fat index, or fat mass index; children who are picky eaters are predicted to become thin at some point in their lives (Taylor et al., 2019; Taylor & Emmett, 2019).

The research of Ji et al. (2020) suggests that eating problems can be attributed to several factors, including, in sequence, a lack of attention during eating, irregular eating positions, picky eating habits, excessive meal times, excessive snack intake, and high carbohydrate/sugar content. The mother's education level, family income level, primary caregiver, and family members' attitudes towards children's eating behavior are factors related to eating behavior problems in children. Mothers with high education levels and families with high income levels are protective factors against children's bad eating behavior. The concern of

grandparents, persuading or forcing children to eat, is a risk factor for poor eating behavior in children (Ji et al., 2020). Readiness to become a parent is a sociopsychological phenomenon that encompasses knowledge, emotional evaluation, perception, and individual beliefs about parenting, which are reflected in the components of parenting behavior (Biktagirova & Valeeva, 2015). In other words, readiness to become a parent encompasses the knowledge, emotional evaluation, perception, and individual confidence necessary to respond positively to the presence of a baby when a person assumes the role of a parent. Readiness to become a parent is a free translation of several English terms, including parenting readiness, parental readiness, and readiness for parenthood, among others. Readiness refers to the willingness or openness to participate in a specific process or adopt certain behaviors (Proctor et al., 2018). Other research indicates a negative relationship between avoidant and ambivalent attachment styles on readiness to become parents in early adulthood (Izza & Andromeda, 2019).

(ii) Problems of parents caring for stunted children in terms of receiving education/counseling

The most frequently appearing word that is meaningful in word clouds is "Less", be it less able, less time, less accepting, less awareness, less care, or receiving counseling, which can be caused by economic factors and mothers who have to work so that there is no time to attend counseling. Research indicates a relationship between work, education, and sources of information and the knowledge of mothers of toddlers about stunting (Rahmandiani et al., 2019).

Refusal to attend counseling can be understood as part of the broader process of grief and loss. Coping with stress by ignoring or avoiding problems may serve as a temporary means of emotional relief (Cohen, 2008). Individuals experiencing pressure often struggle to overcome denial, confront reality, and accept the circumstances they face (Cohen, 2001).

(iii) Problems of caring for stunted children in terms of visits to integrated health posts

The most frequently appearing meaningful word in the word cloud is “No,” reflected in phrases such as “do not want to take them,” “no one to take them,” “cannot take them,” and “not willing to take them.” Other reasons identified include boredom, busyness, forgetfulness, or the child being unwell. Overall, these statements represent various forms of avoidance and may also indicate denial — a refusal to acknowledge that something is wrong with the child — which leads parents to withhold special attention. In this stage of denial, individuals experiencing grief often feel disbelief or reject the reality of the situation that causes their distress. Denial serves as a psychological buffer or coping mechanism, allowing individuals to maintain emotional stability and gradually mobilize less extreme defenses to process their grief at a manageable pace (Kübler-Ross, 2009).

(iv) Problems of caring for stunted children in evaluating growth and development

The meaningful words most often occur in the word cloud regarding parents' attitude towards the growth and development evaluation are "No" and "Less," such as not/less accepting, not caring, not paying attention, not enthusiastic, not happy, indifferent, sensitive, or denial of the child's growth and development evaluation.

The attitude and behavior of not caring is part of an effort to cope with a mechanism or self-defense mechanism. Someone under threat or pressure will choose a defense mechanism that is considered to reduce the stress response (Foster et al., 2023). Coping mechanisms in the form of avoidance are coping mechanisms that focus on emotions by processing grief as if there were no problems. Coping strategies that focus on emotions like this can only provide temporary solutions, but they help prepare oneself for change. It is essential to develop healthy emotion-focused coping strategies, enabling individuals to promptly address problems (Nur et al., 2018; Lazarus & Folkman, 1984).

CONCLUSION

Problems in caring for stunted children mainly refer to four indicators, with the first indicator on the issue of ignorance, unwillingness, and inability to fulfill the nutrition of stunting children, the next is rejection of counseling or education about stunting and nutrition management, rejection and avoidance of visits to the integrated health post, and indifference to the evaluation of the child growth and development. This behavioral indicator is supported by other behaviors, namely anger towards or attack on visits or invitations from cadres to pay attention to children with stunting. A family's response to stunting is often caused by an attitude of denial, which is a stress response that can also serve as a coping strategy or self-defense mechanism to deal with threatening situations. Someone with a coping strategy that focuses on emotions will be pessimistic, withdraw from the goal of solving the problem, and try to fix negative things by denying them. The underlying problem of denial can also be caused by a lack of preparedness to become a parent, resulting in neglect, injustice, and a lack of responsibility, so that attention to nutrition, growth, development, and the continuity of child growth is not the primary focus of parental attention.

ETHICAL CONSIDERATIONS

Funding Statement

This research is fully funded by the faculty, and there are no other sponsors or grants from the government. The research obtained a research location permit from partners in the Sisir sub-district, Batu, East Java. The ethical feasibility test was conducted at the Ethics Committee of the Faculty of Medicine, University of Muhammadiyah Malang, under the Ethics Decree number. E.5.a / 087 / KEPK-UMM / IV / 2024.

Conflict of Interest Statement

This research has no conflict of interest with any party, and no ethical issues were violated. In fact, the research officially received a research permit from the relevant party, number 070/113/422.105/SKP/2024.

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ABOUT

SALASIKA etymologically derived from Javanese language meaning 'brave woman'. SALASIKA JOURNAL (SJ) is founded in July 2019 as an international open access, scholarly, peer-reviewed, interdisciplinary journal publishing theoretically innovative and methodologically diverse research in the fields of gender studies, sexualities and feminism. Our conception of both theory and method is broad and encompassing, and we welcome contributions from scholars around the world.

SJ is inspired by the need to put into visibility the Indonesian and South East Asian women to ensure a dissemination of knowledge to a wider general audience.

SJ selects at least several outstanding articles by scholars in the early stages of a career in academic research for each issue, thereby providing support for new voices and emerging scholarship.

AUDIENCE

SJ aims to provide academic literature which is accessible across disciplines, but also to a wider 'non-academic' audience interested and engaged with social justice, ecofeminism, human rights, policy/advocacy, gender, sexualities, concepts of equality, social change, migration and social mobilisation, inter-religious and international relations and development.

There are other journals which address those topics, but SJ approaches the broad areas of gender, sexuality and feminism in an integrated fashion. It further addresses the issue of international collaboration and inclusion as existing gaps in the area of academic publishing by (a) crossing language boundaries and creating a space for publishing and (b) providing an opportunity for innovative emerging scholars to engage in the academic dialogue with established researchers.

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All articles will be preceded by an abstract (150-200 words), keywords, main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list); and a contributor biography (150 words). Word length is 4,000-10,000 words, including all previous elements.

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