Universal Journal of Public Health 10(6): 606-619, 2022 http://www.hrpub.org
DOI: 10.13189/ujph.2022.100608

# Patriarchal Culture in the Family and Stunting Children Incidence at Kulon Progo (Indonesia)

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*Received September 12, 2022; Revised December 7, 2022; Accepted December 22, 2022*

***Cite This Paper in the Following Citation Styles***

***(a):*** *[1] Ratnawati, Yoga Putra Prameswari , "Patriarchal Culture in the Family and Stunting Children Incidence at Kulon Progo (Indonesia)," Universal Journal of Public Health, Vol. 10, No. 6, pp. 606 - 619, 2022. DOI: 10.13189/ujph.2022.100608.*

***(b):*** *Ratnawati, Yoga Putra Prameswari (2022). Patriarchal Culture in the Family and Stunting Children Incidence at Kulon Progo (Indonesia). Universal Journal of Public Health, 10(6), 606 - 619. DOI: 10.13189/ujph.2022.100608.*

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**Abstract** This study aimed to determine the influence of patriarchal culture in the family on the stunting incidence in children. Stunting has always been explained to occur due to health factors, although recent studies showed that non-health factors also play a role. The methodology involved case studies, focus group discussions (FGD) conducted with key informants, in-depth interviews, and documents. Furthermore, the documents were used to confirm the primary data that was previously obtained through the triangulation mechanism to ascertain valid data and information. The results showed that patriarchal culture as a non-health factor affects stunting in children because it creates gender inequality in children care. This is a new perspective in explaining the incidence of stunting. Also, some limitations only apply to people with a strongly patriarchal culture. The theoretical implication is to fill in the gaps in the stunting theory which can be explained by non-health factor. The practical implication involves a change in the community mindset. Therefore, the husband or man must also be responsible for the upbringing of children.

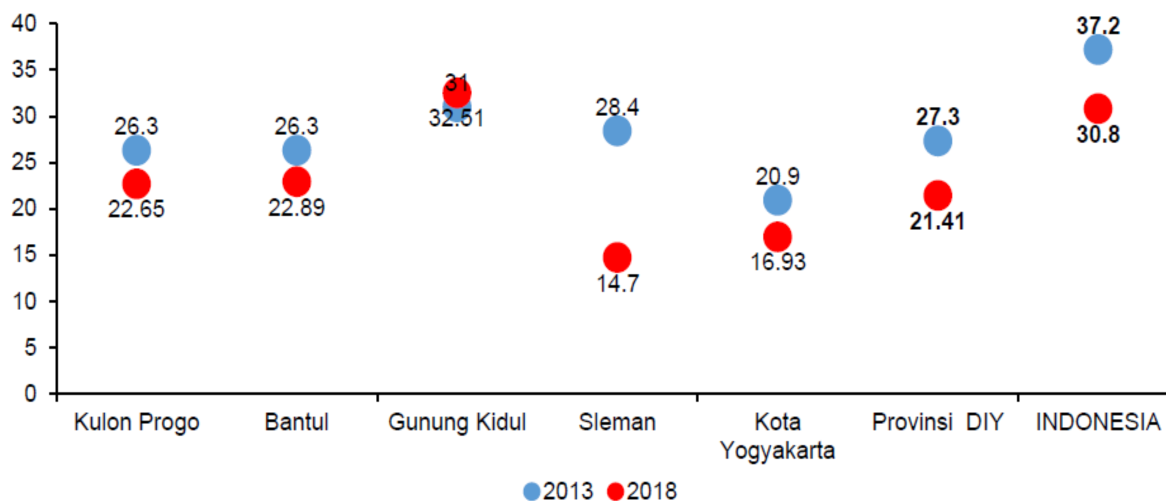
**Keywords** Gender, Patriarchal Culture, Stunting

## 1. Introduction

This study aimed to determine the influence of patriarchal culture in the family on stunting in children. Stunting is a threat to the quality of human resources and the nation's competitiveness. These children do not only experience physical growth disorders (short stature), but also their brain intelligence does not grow optimally. In some cases, stunted children are vulnerable to disease attacks. When entering a productive age, impaired brain growth accompanied by susceptibility to disease affects the cognitive ability, achievement, productivity, and creativity of individuals. Therefore, stunting broadly inhibits economic growth, increases poverty, and widens inequality.

Stunting has become an urgent health issue worldwide, including in Indonesia. The World Health Organization (WHO) records that no less than 22.2% of children in the world are stunted. Furthermore, 55% are from Asia, and the prevalence rate in Indonesia is quite high, around 30.8% [1]. According to WHO data, Indonesia is the country with the highest prevalence in Southeast Asia, with 36.4% or about 9 million stunted children. This signifies that 1 in 3 children experience stunting.

This study is important because stunting has become an urgent health issue worldwide, and prevention is not a national but a global program. The United Nations (UN) includes the stunting issue in Goal 2 of Sustainable Development Goals/SDG's, concerning nutrition fulfillment, ending malnutrition to eliminate hunger, leading to food security, improving nutrition, and promoting sustainable agriculture. These goals and conditions must be achieved in 2030 by countries that signed the SDGs declaration, including Indonesia. To accelerate the decline, the Indonesian government is strengthening coordination and consolidation across sectors, starting from the ministry level, local government, and village government. This involves conducting a pilot project to reduce stunting rates in 100 regencies/cities starting in 2018.




Source: [1]

**Figure 1.** The Proportion of Stunting Status in Children by Regency/City at Yogyakarta Province in 2013 and 2018

For stunting cases in Yogyakarta Province, the data are shown in Figure 1.

Figure 1 shows that in 2013 and 2018 the prevalence of stunting in Kulon Progo Regency was the third lowest in the DIY Province after Yogyakarta City and Sleman Regency**.** Kulon Progo Regency is one of eight regencies/cities in Indonesia that was selected as a pilot project of the Indonesian Ministry of Health's Stunting Prevention and Handling Acceleration Program in 2017. This is due to the high stunting rate political/public policy commitment, as well as having good practices in health issues [2].

Based on the profiling conducted by the Kulon Progo Regency Health Office on stunting children in 2019, important data were obtained. These included parents of stunting children with high school education and below (94.43%), stunting children from poor families (43.74%), stunting mothers who have Chronic Energy Deficiency (KEK) during pregnancy (29.68%), and stunting children who cared for by other people (4.65%) [3]. Referring to the previous data, interesting questions occurred such as how to care for stunting children, which involves both parents themselves? Is parenting a stunted child the domain of one parent? Furthermore, is unequal parenting caused by patriarchal culture in the family?

This study elaborates on the problem of stunting in children from a non-health perspective. Furthermore, it emphasizes that this incidence is not only caused by health factors, but also due to the inequality of power relations between husband and wife as a result of a patriarchal culture that is still deeply rooted in Indonesian society.

## 2. Theoretical Framework

### *Gender and Patriarchal Culture*

Gender is the differentiation of roles, positions, and characteristics between men and women, attached to a person's identity through social construction. This difference is neither biological nor divine [4]. Gender is formed based on the political, social, and cultural situation of the community, and is liable to change. Gender can change from time to time, place to place, and even from class to class [5].

**Table 1.** Sex and Gender Difference

| Sex | Gender |
|---|---|
| • Cannot change<br>• Innate from God<br>• Permanent<br>• Not interchangeable<br>• Valid all the time | • Can change/be changed<br>• Interchangeable<br>• Depends on time and local culture<br>• Human construction |

Source: [5].

**Table 2.** Division of Roles by Gender

| Gender | Role | | |
|---|---|---|---|
| | **Reproduction** | **Production** | **Community** |
| Women | Role :<br>• Mother<br>• Wife | • Additional breadwinner | • Social services<br>• Voluntary/unpaid |
| Men | Role :<br>• Father<br>• Head of the family | • Main breadwinner | • Leader<br>• Decision maker<br>• Security/defense |

Source: Data processed from various sources.

Table 1 shows that there are differences in the concept of sex and the concept of gender, where sex is fixed and does not change, while gender is a social construction that changes according to the context. Previous studies state that the role division based on gender differences will always occur everywhere, although the form is not (always) the same. This gender difference creates a role division. Each cultural system does not give different roles and behaviors to complement each other's physical differences between men and women. The division serves to complement the shortcomings of both types of people. Therefore, the problems at hand can be solved in a better way [6].

In a patriarchal society, there are 3 divisions of roles that are "agreed on" in a hegemonic manner. This gender-based role differentiation is perpetuating, and as if it cannot be changed. The perpetuation of this gender-based role differentiation causes inequality. It occurs because there is a burden on one party and an advantage on the other. Therefore, it has implications for the imbalance of power structures between men and women. Moreover, gender inequality will always be criticized by feminists.

Table 2 shows that in fact, the gender differences that give rise to gender roles are not problematic. Several roles can be performed by men and women, including cooking, working in the public sector (politicians, public officials, gardening, trading, professional/office work, construction workers, and others), as well as raising/educating children in the family. However, this condition has not fully occurred in society due to the strengthening of the hegemonic patriarchal culture. There is a lot of ridicule and contempt from society when someone performs a gender role. For example, men do domestic work which is usually carried out by women, or women who are tough, firm, and strong considered unusual.

The structure of gender inequality tends to harm women due to unequal power relationsand, forms of gender inequality or injustice are as follows:

**Table 3.** Forms of Gender Inequality/Inequity

| Forms of Inequality | Description and Examples |
|---|---|
| Negative Labeling (Stereotype) | Attaching the situation/condition to a certain gender. Usually, this stereotype is always detrimental and causes injustice.<br>Example: Women tend to be thorough, detailed, talkative, emotional, gentle; while men are not careful, think global/big, quiet, use reason, and hard. |
| Marginalization | Efforts to marginalize / impoverish the economy of women, caused by gender differences in the household, community, and state.<br>Example: Men are marginalized in kitchen work, while women are marginalized in jobs related to land and security. |
| Subordination | Subordination does not appear in an empty space, but refers to the role and position of women who are lower than men. The subordination to women stems from the gender-based division of labor associated with women's functions as mothers. This ability of women is used as an excuse to limit their role in the domestic sphere and child care.<br>Example: Men work in the public sector, while women work in the domestic sector. |
| Double Burden | The division of roles based on gender in the family, is perpetuated by cultural processes. This causes women to experience double work/burden as well as domestication. Although women are already working outside the home, women are forced to do housework because it is considered the essence of women by patriarchal culture. Furthermore, there is no agreed division of roles.<br>Example: After coming home from work, women still complete domestic work, while husbands are reluctant to do the work (washing, cooking, and so on). |
| Discrimination | Different treatments for one party<br>Example: Parents send their boys to a higher educational level, without doing the same for girls. |
| Gender Based Violence | Violence starts from physical (beating, rape, torture), non-physical (sexual harassment, verbal harassment, catcalling), and systemic (prostitution, forced sterilization, human trafficking). |

Source: [5]

Table 3 shows that various realities regarding gender inequality or injustice are caused by the division of roles based on gender in the family, which are then perpetuated by cultural values.

Therefore, it is often said that the division of sexual roles is caused by a patriarchal system [7]. Millet stated that the relationship between men and women is a political relationship based on the power structure in a social system where one human group is controlled by another group [7]. Millet further stated that the power structure in which men control women is called patriarchy, and the main institution of this system is the family. Patriarchy is a cultural system that emphasizes the psychological aspect, as well as the meeting between psychology (spiritual) and culture (way of life). Therefore, it does not appear as an explicit political system but as the essence of man himself [8]. According to Simone, gender inequality occurs in educating/raising children in the family [9].

The patriarchal culture still attaches the children care definition as a woman's job and not a joint work between men and women in a husband-wife relationship. Patriarchal practices discriminate against women's roles, one of which attaches women's roles to domestic work/domestication. Discrimination in the woman's role is then glorified by a patriarchal culture, by not tolerating their disability in children care/education.

### *Stunting*

Stunting is the failure of children under five/toddlers to achieve optimal growth measured by height according to age [10]. It is often referred to as chronic malnutrition or the failure to thrive. In the case of stunted children (toddlers), chronic malnutrition occurs from the 1st day of life (in the womb) until the 1000th day (approximately 2 years old). Malnutrition is the direct result of an imbalance in growth factors, both internal and external, that occur during the growth period starting from pregnancy, the perinatal period, breastfeeding, infancy, and the growth phase (childhood). The conditions can also be caused by deficiencies in nutrients, such as micronutrients, protein, or energy [10]. Physical growth disorders in stunted children are in form of a decrease in the speed of growth and development in humans.

The indicators to determine whether a toddler is experiencing stunting are: first, the short length or the height; and second, the normal development of brain tissue and volume. This disease is one of the threats to the quality of human resources, as well as to the country's competitiveness in the globalization era.

Stunting in a country has 3 impacts, namely health, population growth, and economy. First, the health impacts include failure of growth and development, stunted cognitive and motor development, metabolic disorders as adults, as well as increased risk of non-communicable

diseases such as diabetes mellitus, stroke, and heart disease [11]. Second, it will reduce the productivity of human resources. However, for the next 15 years, Indonesia will experience a demographic bonus. Third, this incidence has the potential to harm the economy of a country. According to World Bank records in 2016, the potential economic loss of a country caused by stunting is around 2 – 3% of Gross Domestic Product (GDP). Hence, if Indonesia's GDP is Rp. 13,000 trillion, then the potential economic loss is between Rp. 260 – 390 trillion/year.

In another study, this disease can reduce labor market productivity which implies a loss of 11% of GDP, as well as reduce the income of adult workers by 20%. This contributes positively to the widening of the gap or inequality up to 10% of the total lifetime income, as well as triggers the occurrence of intergenerational/structural poverty [12]. The potential economic benefits from investment in reducing stunting in Indonesia are 48 times [13].

***Gender, Patriarchal Culture, and Stunting***

In this study, there were 4 working variables, namely: independent, moderate, intermediate, and dependent variables. Referring to the study question, the independent variable was a patriarchal culture, the dependent variable was stunted children, the moderate variable was gender inequality, and the intermediate was the perception of gender roles in the families of stunted children. Furthermore, how are these four variables related? This study aims to answer this question through the construction of patriarchal culture in the family towards the stunting incidence. The work of patriarchal culture in the family causes gender inequality which contributes positively to stunting. Gender inequality in the family causes the absence of gender roles, which also causes stunting. One indication of gender equality in the family is fairness in domestic work, including children care. Figure 2 illustrates the framework of this study.

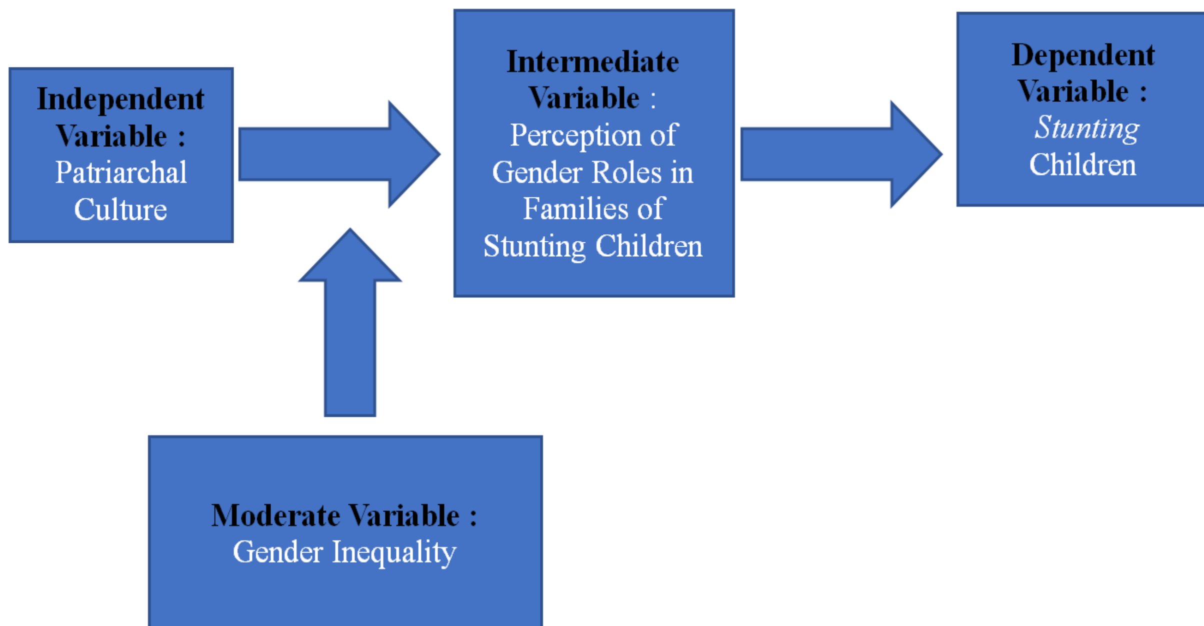



**Figure 2.** Thinking Framework

## 3. Previous Studies

There have been many studies on stunting, including a study titled "Providing Education for a Mother in Stunting Prevention: A Collaborative Study through Action Research". It concluded that one of the attempts to perform in efforts to prevent stunting is to improve the public's understanding of stunting through education, especially through I-CARE model. Apart from that, I-CARE bears caring values and a jargon that needs to be instilled in every academic community [14]. A study titled "Factors Influencing the Prevalence of Stunting Among Children Aged Below Five Years in Bangladesh" concluded that the child's gender, child's age, mother's age, mother's education, mother's occupation, wealth, economy, nutritional status before and after childbirth, clean water sanitation, latrine management, hygiene, environmental factors could affect stunting and could inhibit the growth and development of children in the future [15]. Another study on "Determining the Factors That Influence Stunting during Pandemic in Rural Indonesia: A Mixed Method" observed that their findings suggest that the state of cleanliness inside the house and the quality of the drinking water are important predictors of stunting in the population of Indonesian children aged 0 to 23 months. Concerns have also been raised over the use of sweetened condensed milk and the absence of gender parity in the decision-making procedures. The findings of this study suggest that policies and programs to combat stunting in Indonesia should devote more attention to WASH interventions in order to be effective. This is because more national and international evidence is emerging, demonstrating a link between water, sanitation, and hygiene (WASH) and linear growth in early childhood [16]. Moreover, a study on "Risk Factors of Stunting in Developing Countries: A Scoping Review" concluded that that risk factors for stunting in developing countries could be divided into three categories, *first,* the parental factors (neonatal factors and maternal nutritional status at the early 1000 days of birth, social differences, mother's education level, parent's occupation, and the height of mother or parent's relatives with short posture), *second*, the children factors (nutrition, children's infection, the weaning process within 6 months or more, children's gender, and children's age), and *third*, the environmental factors (water sources, shared toilets, and environmental influences on fetal life) [17]. Also, a study titled "Correlation between maternal factor and stunting among children of 6-12 months old in Central Lombok". There was a significant association between maternal height and stunting incidence among children aged 6-12 months. Meanwhile, other maternal factors, such as pregnancy factor and childbirth factor, did not have a significant association with stunting incidence [18]. Hastuti Marlina (et.al) in their study "Causes of Stunting in Toddlers: Literature Review" concluded that stunting is a health problem in toddlers that needs attention both from the government and especially parents, because stunting has long-term effects if not handled properly. The role of parents, especially mothers, is very important because it is the mother who usually prepares the nutritional intake of the child [19].

Based on previous studies, this study focuses more on first, health factors, including exclusive breastfeeding, age of giving breast milk substitutes (MP-ASI), level of iron adequacy, history of infectious diseases, and genetic factors from parents. The second involved the socio-economic factors that exist within the mother and the family of the toddler. However, there have been no studies that explain the values and cultural factors of patriarchy in the family.

## 4. Methodology and Study Method

The case study methodology was used to explain the contribution of patriarchal culture in the family to stunting in children. This agrees with Yin that the case study was a methodology for holistically understanding the contemporary phenomena in real-life contexts [20]. Therefore, it is the right methodology as this study aims to explain in-depth and comprehensively the contribution of patriarchal culture in the family towards stunting in children. This patriarchal culture is still very strong in the Indonesian society, and the process cannot be explored using survey methods [21].

The methodology involved focus group discussions (FGD), in-depth interviews, and document/secondary data. The reason for FGD and interview was because it is a qualitative study. According to [22], interviews are used in qualitative studies to gain facts and understanding of opinions, attitudes, experiences, processes, behaviors, or predictions.

These methods were used to obtain primary data and were carried out on key informants selected using the purposive sampling technique. The criteria determined the study aim which explained the contribution of patriarchal culture in the family to stunting in children. Therefore, the key informants consisted of families of stunted children, Community Health Center officers, Integrated Service Post cadres, as well as female figures and activists. For informants, stunted children were from 5 families, namely Siti Rondhiyah (Banjararum Village), Saridah (Banjararum Village), Nafsiyah (Banjarasri Village), Haryanti (Banjarasri Village), and Yulianti's (Banjarharjo Village) families. The number of key informants was 15 people, therefore, the discussion/interview was more focused[1]. These key informants influenced the quality of the results [22].

In-depth interviews were conducted with selected and potential FGD participants to explore the information provided in the FGDs. Since this study was qualitative, semi-structured in-depth interviews were used (Gubrium,

1 *Focus group discussion* (FGD) is also known as focus group interviews.

Holstein, Marvasti, & McKinney, 2012). Furthermore, 6 questions as a guide were prepared and the informants were given the freedom to answer [23]. For conducting interviews, several key informants were interviewed. Once several respondents were successfully interviewed, then the snowballing technique was used to find other informants by asking for contact/phone numbers or recommendations of other potential informants.

Regarding the duration of the interview time, the saturation point principle was used, when no new information is obtained and no new themes emerge [24], or when sufficient information has been obtained to perform data analysis [25]; [26]; [27]. The saturation point principle is also known as knowledge saturation [28]. Furthermore, this study used documents or secondary data such as articles in journals, mass media (both printed and online), and statistical data on stunting published by the Indonesian Ministry of Health and the Kulon Progo Regency Health Office.

The importance of qualitative data analysis is the data validity and reliability, namely how information from informants can be trusted. Therefore, it is necessary to confirm information among informants [29]. To obtain validity and reliability in the qualitative method, a triangulation process or mechanism is performed [30]. This process is carried out by checking the validity through the utilization of data sources and other data collection techniques, time, as well as theory [29], [30] and [31]. In this study, the triangulation process was carried out through cross-checking the information data that had been previously obtained from FGDs and interviews with key informants.

For the data analysis stage, the steps involved were to reduce or select data relevant to this study, categorize data based on specific themes, and then check the validity and interpretation of the existing data. The steps taken were in accordance with the opinion that the data analysis process consists of three streams of activity. These include data reduction, data presentation, and drawing conclusions or verification [32].

# 5. Results and Discussion

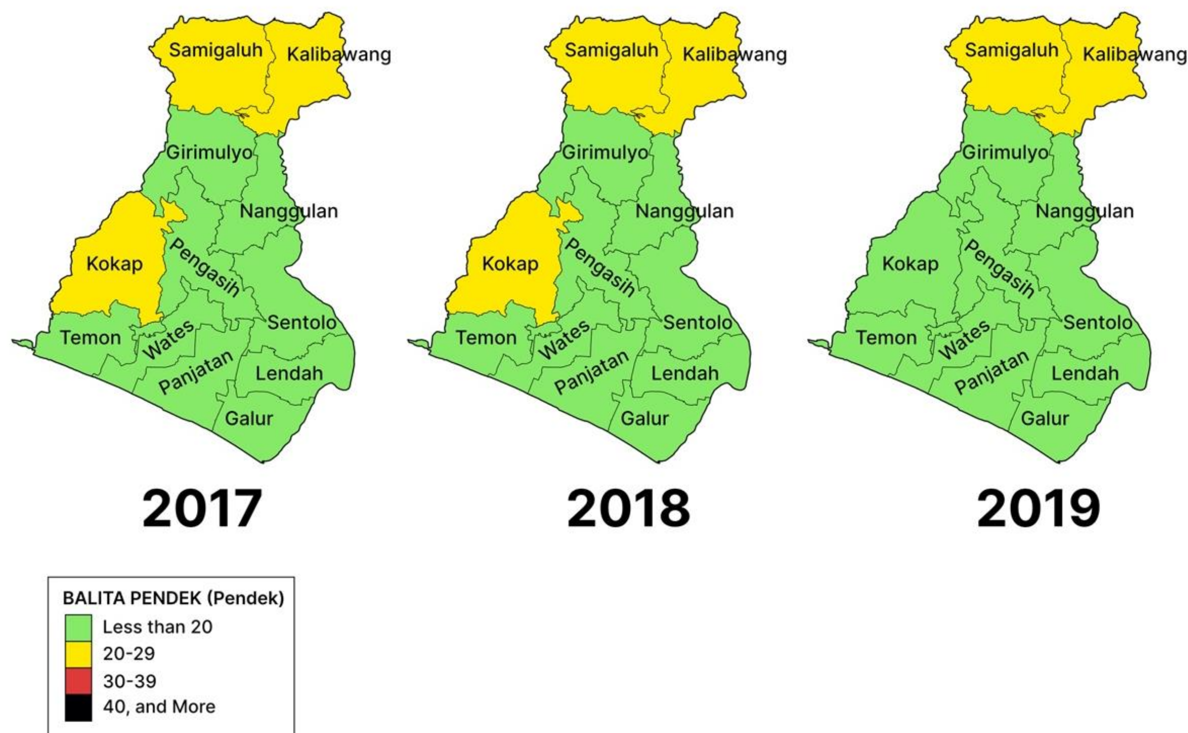
### *Stunting Demographics in Kalibawang*

Kalibawang is one of the sub-districts in the Kulon Progo Regency (Yogyakarta) with a relatively high stunting prevalence. Based on data from the Kulon Progo Regency Health Office for the last 3 years, Kalibawang has consistently ranked in the top 3 of the prevalence of stunting in the Kulon Progo Regency. Furthermore, in 2017, it was ranked at the top with an absolute number of 385 events and a percentage rate of 27.40% as can be seen in Table 4 and Figure 3.

**Table 4.** Prevalence of Stunting Rates at Kulon Progo Regency in 2017 – 2019

| ***Kapanewon*/Subdistrict** | **2017** | | **2018** | | **2019** | |
|---|---|---|---|---|---|---|
| | **Absolute** | **Percentage** | **Absolute** | **Percentage** | **Absolute** | **Percentage** |
| Temon | 192 | 15.11 | 157 | 10.32 | 159 | 10.48 |
| Wates | 314 | 11.69 | 187 | 7.69 | 212 | 8.72 |
| Panjatan | 194 | 10,34 | 248 | 13.10 | 225 | 12.25 |
| Galur | 201 | 12.05 | 241 | 14.61 | 155 | 9.71 |
| Lendah | 325 | 14.33 | 296 | 12,54 | 269 | 11.86 |
| Kokap | 403 | 22.88 (3) | 382 | 20.66 (3) | 308 | 17.45 |
| Pengasih | 467 | 18,29 | 376 | 16.66 | 262 | 10.36 |
| Sentolo | 473 | 17,68 | 398 | 14.4 | 339 | 13.54 |
| Nanggulan | 110 | 8,35 | 108 | 7.33 | 97 | 6.63 |
| **Kalibawang** | **385** | **27.4 (1)** | **310** | **20.82 (2)** | **303** | **20.58 (3)** |
| Girimulyo | 179 | 17,18 | 152 | 13,84 | 82 | 20,65 (2) |
| Samigakuh | 321 | 26.03 (2) | 302 | 23.78 (1) | 301 | 22,96 (1) |
| **Kulon Progo Sub-district** | **5,998** | **16.27** | **3,157** | **14.31** | **2,712** | **12.57** |

Source: [33]




Source: [33]

**Figure 3.** Stunted Children at Kulon Progo Regency in 2017 – 2019

**Table 5.** Stunting Rate Prevalence (Based on Village) in Kulon Progo Regency in 2017-2019

| Sub-district/ Kapanewon | Village | Update Data on Length/Height Measurement Results for Children Under Two Years (0 - 23 Months) | | | | | % Stunting Prevalence = (Children Under Two Years with Very Short Category + Children Under Two Years with Short Category) x 100% Total Children Under Two Years | Village Category |
|---|---|---|---|---|---|---|---|---|
| | | Very Short | Short | Normal height | Tall | Total Children Under Two Years (0 - 23 Months) | | |
| Samigaluh | Banjarsari | 6 | 3 | 42 | - | 51 | 17.65% | Red |
| Samigaluh | Purwoharjo | 1 | 11 | 57 | - | 69 | 17.39% | Red |
| Samigaluh | Sidoharjo | 9 | 6 | 90 | - | 105 | 14.29% | Red |
| Samigaluh | Gerbosari | 8 | 14 | 52 | - | 74 | 29.73% | Red |
| Samigaluh | Ngargosari | 6 | 9 | 60 | - | 75 | 20.00% | Red |
| Samigaluh | Pagerharjo | 5 | 4 | 83 | - | 92 | 9.78% | Green |
| Kalibawang | Banjararum | 3 | 33 | 167 | - | 203 | 17.73% | Red |
| Kalibawang | Banjarasri | 1 | 10 | 60 | - | 71 | 15.49% | Red |
| Kalibawang | Banjarharjo | 1 | 17 | 99 | - | 117 | 15.38% | Red |
| Kalibawang | Banjaroyo | 5 | 20 | 157 | - | 182 | 13.74% | Green |

Source: [3]

Table 4 and Figure 3 show that the number of under-fives stunting in Kalibawang is quite high, although the rate of low birth weight babies is the highest in Kulon Progo (Rimawati, 2021).

In general, there are 2 sub-districts in Kulon Progo with a high stunting prevalence (≥ 14%), namely Samigaluh and Kalibawang. In Kalibawang, there are 3 villages with a prevalence rate of 14% which became the red village in this incidence, namely Banjarharjo (15.38%), Banjarasri (15.49%), and Banjararum (17.73%). Meanwhile, another village, Banjaroya, is not in the red category (stunting), but the prevalence rate is close to 14%. More detailed data

are shown in Table 5.

**Table 6.** Total stunted children in 4 villages within the red and green categories in Kalibawang in 2020.

| No. | Village | Number of children under 5 years old | Number of stunted children under 5 years old |
|---|---|---|---|
| 1. | Banjaroya | 139 | 32 |
| 2. | Banjarharjo | 109 | 15 |
| 3. | Banjarasri | 47 | 7 |
| 4. | Banjararum | 163 | 29 |
| | Total | 458 | 83 |

Source: (Kalibawang Public Health Center, 2020)

Table 5 shows that there are 2 sub-districts in Kulon Progo Regency with a high stunting prevalence rate (≥ 14%), namely Samigaluh and Kalibawang District. Further, Table 6 displays the number of stunted children in Kalibawang District.

Table 6 shows that of the four villages, Banjararum Village is the village in Kalibawang District with the highest number of stunted children.

With the condition of stunted children in Kalibawang, there have been several programs carried out to handle and prevent it as described in the following section.

### *Prevention and Handling of Stunting in Kalibawang*

Prevention and handling of stunting are one of the national strategic issues in Indonesia. In the context of Kalibawang, the programs carried out are as follows:

**Table 7.** Stunting prevention and handling program at Kalibawang in 2020

| Service Pack | Indicator | Problem | Program |
|---|---|---|---|
| 1. Maternal and Child Health Services (KIA) | 1. Pregnancy test<br>2. Fe/Iron Pills<br>3. Postpartum Check<br>4. Weigh Measure<br>5. Height Measure<br>6. Complete Immunization<br>7. Development Level | 1. Vulnerable category household<br>2. High-Risk Pregnancy (Risti);<br>3. Children 0-23 months have less and poor nutrition, as well as indicated to be stunting | 1. Increasing the frequency of Supplementary Feeding (PMT) and monitoring<br>2. Cadre training<br>3. Exclusive Breastfeeding Campaign<br>4. Procurement of growth mat<br>5. Transportation fee for Human Development Cadre (KPM)<br>6. Mentoring High-Risk Pregnancy in mothers and children aged 0 – 23 months<br>7. Under Five Years Old (Toddler) Malnutrition/stunting class |
| 8. Integrated Nutrition Counseling | 1. Nutrition Counseling<br>2. Home Visit | | 1. Training for Infant and Child Feeding cadres (PMBA)<br>2. PMBA socialization to mothers<br>3. PMT Toddler<br>4. Village facilitation for cadre counseling and training<br>5. Youth health socialization |
| 6. Sanitation and Clean Water | 1. Access to Adequate Drinking Water<br>2. Family Toilet | 1. Households do not have clean water sources<br>2. Households do not have latrines<br>3. Smoke-free area | 1. Clean water supply<br>2. Latrine<br>3. Water quality test kit<br>4. Socialization of Clean and Healthy Life Behavior (PHBS)<br>5. Construction of SPAL (Wastewater Sewerage)<br>6. Procurement of Trash |
| 7. Social Protection | 1. Birth certificate<br>2. Health insurance<br>3. Access Food consumption | 1. Pregnant women do not have Health Insurance<br>2. Children aged 0-23 months do not have Health Insurance<br>3. Children aged 0-23 months do not have a birth certificate | 1. Facilitate Health Insurance application<br>2. Facilitate birth certificate management<br>3. Mass birth certificates production |

Table 7 Continued

| | | | |
|---|---|---|---|
| 8. Early Childhood Education Services (PAUD) | 1. Parenting children aged 0 – 2 years<br>2. Children aged 2-6 years are active in Early Childhood Education | 1. Lack of knowledge on parents about the importance of Early Childhood Education<br>2. Parents object to sending their children to Early Childhood Education<br>3. Facilities for teaching and learning activities do not fulfill the standards<br>4. Limited learning tools<br>5. Lack of knowledge about making Early Childhood Education curriculum<br>6. There are children aged 2-6 years who are not registered and are not active in Early Childhood Education services | 1. Establishment of Early Childhood Education Building<br>2. Establishment of New Early Childhood Education<br>3. Addition of Early Childhood Education Educators (there are only 33 teaching staff in Banjarharjo)<br>4. Parenting<br>5. Socializing the importance of Early Childhood Education to the community<br>6. Provision of Supplementary Food (PMT) for Early Childhood Education |

Source: (Kalibawang Public Health Center, 2020)

Table 7 above shows that there are many types of service packages and programs to prevent and treat stunting in Kalibawang District. These programs are dominated by the health approaches, as there are no other factors aside from the health factor. According to this study, many other factors, apart from health contribute to this incidence. These include gender inequality in the family as a result of a patriarchal culture as will be discussed in the following section. The government needs to open a discourse on the stunting problem from various factors and rearrange the prevention and handling program in Kalibawang, as this incident in Kalibawang can be solved immediately. Therefore, the Kalibawang community took the initiative to form a Human Development Cadre (KPM) at the village level to assist the Kalibawang Regency Government in accelerating, handling and preventing.

KPM is the selected community cadre that comes from health cadres, Integrated Service Post cadres, and Early Childhood Education teachers who live in villages in the Kalibawang area. It plays a role in human development at the village level, particularly in providing facilitation and monitoring of stunting prevention. Therefore, KPM coordinates intensively with village midwives, Public Health Centers, Early Childhood Education teachers, and village governments.

At first, the Public Health Center rejected the existence of KPM in the village, emphasizing that prevention and handling had become one of the tasks, principals, and functions of the Public Health Center. Furthermore, KPM in Banjararum Village stated that the Public Health Center was hostile to KPM and assessed that it did not have the ability (capacity) to prevent and handle stunting. The relationship between the Public Health Center and KPM, which initially deteriorated, has gradually improved and is even now considered a strategic partner of the Public Health Center at the village and community levels in the context of prevention and handling.

***The Impact of Patriarchal Culture on the Incident Stunting in Children in Kalibawang***

Gender inequality has long been an unresolved issue. Both developed and developing countries experience gender inequality problems which lead to an increase in discriminatory behavior towards people who are marginalized due to this inequality, specifically women. Furthermore, Indonesia is a country with a patriarchal cultural heritage which until now is still permeates quite strongly in some communities, where they believe in the sole control of men over everything.

Some Indonesian communities still adhere to this sexist perception, therefore, various forms of restrictions and discrimination arise against women in various fields and activities. The division of domestic and public sectors makes the space for women to be limited when they want to be on an equal level with men in the public sphere. These discriminatory actions include harassment, restriction, or exclusion of individuals with racial, religious, or gender factors as the basis [34]. The discriminatory treatment of women is a manifestation of rampant gender inequality and patriarchal culture. The patriarchal culture that affects the gender inequality experienced by women, makes them vulnerable to experience discriminatory behavior in the community described the forms of discrimination against women into five forms, namely stereotypes, subordination, marginalization, excessive workload, and violence [35]. In the context of stunted children in Kalibawang, the discrimination against women as a result of patriarchal culture is excessive workload and violence.

In the context of stunting in children in Kalibawang, the discrimination and gender inequality experienced by women during pregnancy significantly influences the incidence of stunting in children. This was observed from these respondents:

**Table 8.** Gender discrimination obtained by the family/woman of stunted children

| Name | Discrimination and Treatment received during patriarchal pregnancy | Condition of stunted children |
|---|---|---|
| Siti Rondiyah | Heavy workload:<br>• When she was pregnant, she helped her husband work on the chicken farm.<br>• 1 month after giving birth by cesarean section, she returns to help her husband work on the chicken farm, and continues to perform domestic work, such as washing and cooking. | • Child born with normal weight and length at the age of 14-24 months experienced growth and development barriers.<br>• Every month, the height only increased by 1 centimeter |
| Saridah | Excessive workload:<br>• as a housemaid to finance family life and economy<br>• take care of domestic work.<br>• taking care of their first child's school. | • The child was born with a weight of 2900 grams and a length of 48 centimeters.<br>• Growth and development was always under the red line. |
| Nafsiyah | Heavy workload:<br>• single parent | • The child was born with a weight of 1900 grams.<br>• From birth to 4 years of age, growth was always below the red line.<br>• Every month, the weight only increased by 100-200 grams.<br>• Posture looks smaller than other children their age. |
| Haryanti | Sexual harassment/violence:<br>• unwanted pregnancy, because she was impregnated by a man who is not her husband<br>• received intimidation and terror from the family of the man who impregnated her. | • Weight and height are within normal limits.<br>• At the age of 17 months, the height increased only 78 centimeters |
| Yulianti | Psychological and Emotional violence<br>• experiencing emotional shock, because husband cheated with another woman | • The child was born normal.<br>• Low growth. |

Source: Research data by the author (2020)

Table 8 shows that gender-based discrimination and treatment received by women or wives during pregnancy as a manifestation of patriarchal culture has an impact on stunting.

To discuss the influence of patriarchal culture on the incidence of stunting in children, there were 2 cases observed in this study.

*First, the unequal division of labor or double workload was experienced by women or pregnant women with stunted children.*

*In the first case*, the incident is experienced by Saridah[2]. The economic life of Saridah and her husband is very mediocre. This economic problem often triggers quarrels and arguments between them. Her husband is quite temperamental and puts all the domestic work on her. When he is angry, everything is slammed and damaged. ‘Never once did my husband handle dirty dishes’, Saridah’s statement describing her husband who did not want to help with domestic work. Every day, she wakes up at 4 am, and if she has an order to make a bag or basket, she will wake up early around 3 am. Daily activities start from cooking water, preparing breakfast, taking her eldest child to school, cooking, washing clothes, and cleaning the house until 9 am. Furthermore, she was weaving a bag/basket while taking care of her youngest child. If the woven results reach 7 or 8 bags/baskets, she delivers them to the collector. The results of her hard work are used for the needs of children, specifically to buy toddler milk. Every afternoon, she prepares hot water for her youngest child's bath, cooks or heats vegetables, and washes the dishes. When night fell, she would continue weaving bags or baskets until midnight.

After giving birth to her second child, she began performing her domestic work again. When the second child was 3 months old, she started to take up bag/basket weaving work to supplement the family's income. She applied exclusive breastfeeding while her second child was growing well, but her efforts were not successful. At every checkup at the Integrated Service Post or Community Health Center, their second child was consistently under the Red Line (BGM). Since then, she observed that her

2 Saridah and her husband decided to get married when she was 28 years old, while her husband was 30 years old. Both were residents of Banjararum Village, Kalibawang. During their marriage, they were not required to receive pre-marital counseling. Saridah's husband works as a smallholder farmer daily, on his parents' 600 square meter rice field. Saridah works weaving bags/baskets from ropes made from pandan leaves or water hyacinth. Saridah's second child was born with a weight of 2900 grams, a length of 48 cm, and a head circumference of 32 cm; therefore it was categorized as Low Birth Weight (LBW).

child was categorized as stunted and was convinced that it was due to her short height and below normal weight, and not because of a bad diet.

*The second case* was the incident experienced by Siti Rondhiyah. When she was pregnant with her first child, she helped her husband work on a chicken farm. During pregnancy, she rarely ate nutritious food, therefore she was categorized as a pregnant woman with chronic energy deficiency. During her pregnancy, she obtained additional nutritious food from the Community Health Center, but never ate it, as it made her nauseous and vomit. From birth until the baby was 1 month old, her husband helped with some of the domestic work, including washing clothes. However, after that, she returned to helping her husband work on the chicken farm, while still doing the domestic work. Although the child was born normal, at the age of 14-24 months experienced growth and development barriers with the 1 centimeter height increased every month.

*The third case* was the incident experienced by Nafsiyah. This is a woman who takes care of her own household because he works outside Kalibawang and only occasionally returns home. Like Siti Rondhiyah, she was also pregnant with chronic energy deficiency. When going to give birth at the Community Health Center, in the middle of the road the membranes ruptured and the baby's head was about to come out, therefore she was forced to give birth by asking for help from a neighbor's house without the help of health workers. Her son was born with a yellow condition and low weight (1900 grams). Furthermore, growth and development were very hampered, because every month the bodyweight only increased by 100-200 grams. The body posture also looked smaller compared to other children at his age.

*The second is domestic violence experienced by women or pregnant women with stunted children.*

*The first case* was the incident of a stunted child named Anisa Lutvia Zahara, a 3-year-old girl cared for by her mother, Yulianti, her grandmother, and her grandfather in Banjarharjo Village, Kalibawang. Her father currently works as a security guard for a shopping complex in Karawang, West Java. The child, called Anisa, was born healthy with a weight of 3300 ounces and a length of 50 cm. Unfortunately, Anisa's growth is not good enough. At the age of 6 months, she had gained only 6 ounces instead of at least 8 ounces. Her mother became pregnant when she was 35 years old. Based on interviews, when she was 2 months pregnant, Yulianti experienced spots and dizziness, and her husband had another ideal woman. This information was obtained through a WhatsApp message from another woman who claimed to be her husband's partner. This information shocked her absolutely, thereby causing her health and psychological condition to be disturbed. She ignored her condition by not seeing a doctor and violent fights began to occur in her household. Furthermore, she actually admitted that she wanted a divorce, but canceled when she saw her son (first child) crying. She saw a similar case experienced by her neighbor, who later died because she could not bear to hold her feelings after she fell sick. Finally, she decided to return to her parents' house in Kalibawang.

After Anisa's birth, Yulianti's emotions were not stable. She always gets anonymous messages that make her mind even more confused, to the point that she has no appetite. Anisa often cries, even though she has been fed breast milk 3-4 times a day. Even though she had been exclusively breastfed, Anisa's growth was slow. Bodyweight was always below the red line (BGM) from the age of 2-12 months. This was due to her chaotic psychological condition, therefore, she did not pay attention to her nutrition. Furthermore, she was too focused on thinking about the fate of her tumultuous marriage.

While still living with her husband, all domestic work including cooking, washing, and childcare, was borne by her even during pregnancy. Her husband only performed housework when he is sick or in labor, while the rest was left to her. She wanted to work again to supplement the family's income, but her husband strictly forbade it.

*The second case* was experienced by Haryanti. She experienced an unwanted pregnancy with unclear marital status, as she was impregnated by a married man who was not her husband. Therefore, she received oblique talk from her neighbors as well as intimidation from the man who impregnated her. She maintained her pregnancy but gave birth to a baby whose growth and development were abnormal. This occurred even though she received additional nutritious food from the Community Health Center and Integrated Service Post. At the age of 17 months, the child's height was only 78 centimeters, whereas the normal height is 81.2 centimeters.

Based on the case studies described above, the incidence of stunting is not only due to health factors. Non-health factors including the imbalance of power relations between husband and wife, and the patriarchal culture that is still deeply rooted in Indonesian society also contribute significantly to the condition of stunted childrent. In this context, the aspects of a patriarchal culture are domestic violence experienced by wives/women and the unbalanced workload between them (women and men).

# 6. Conclusions

The results confirmed this study's hypothesis that stunting is not only caused by health factors but also the inequality of power relations between husband and wife. This inequality occurs due to the patriarchal culture which is still deeply rooted in Indonesian society which creates gender inequality in children care. The results are a novelty of perspective in explaining the incidence of stunting in children, where further it is almost always explained from a health perspective.

Theoretically, this study completes the gap of the stunting theory that stunting in children can be explained

from a non-health perspective. Practically, this study is expected to change people's mindset, therefore, husbands or men must also be responsible for raising children.

# 7. Limitations

This study has limitations from a comparative perspective. This is because it did not examine by comparing societies with a strong and weak patriarchal culture. Therefore, further studies are promoted to examine it from a comparative perspective. It is expected that there will be a more detailed understanding of how patriarchal culture influences the stunting incidence in children.

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