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MODAL SOSIAL DAN STATUS GIZI BALITA DI DAERAH PEDESAAN DI INDONESIA DAN THAILAND

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Abstrak

Prevalensi gizi kurang balita di pedesaan pada satu dasawarsa terakhir terdapat kecenderungan penurunan, yaitu di Thailand (0.3%) lebih cepat secara signifikan dibanding di Indonesia (3,5%). Diduga ada perbedaan pola pemanfaatan modal sosial dalam upaya perbaikan gizi balita. Permasalahan dalam penelitian ini adalah apakah ada perbedaan pengaruh modal sosial yang berhubungan dengan status gizi balita pada urban area di Indonesia dan Thailand. Penelitian ini menggunakan pendekatan kualitatif, dengan strategi penelitian lapangan studi kasus di wilayah kerja Puskesmas Kajen 1, Kabupaten Pekalongan, Indonesia dan di Ongkharak Thailand. Fokus penelitian berupa aspek modal sosial yang terdiri dari: (1) citizenship, (2) asosiasi/organisasi sosial, (3) sosial suport yang mempengaruhi status gizi balita di masyarakat. Teknik penentuan informan dengan cara purposive sampling dan snowball sampling. Hasil penelitian modal sosial yang berkaitan dengan status gizi balita di desa di Indonesia dan Thailand mempunyai corak sejenis. Dimana unsur-unsur modal sosial yang mempengaruhi berupa: 1) cytizenship, dalam bentuk partisipasi aktif dan kreatif terutama dari para kader atau relawan, 2) organisasi sosial berupa Posyandu dan Pusat Pengembangan Balita. Sedangkan perbedaan yang tergambar adalah: 1) Organisasi sosial di Thailand merupakan program yang lebih pro aktif, 2) Di Indonesia aspek cytiznship yang berkaitan dengan unsur resiprocyti atau semangat untuk membantu sangat menonjol, dan 3) Program pemerintah Thailand yang sangat menentukan status gizi balita diperlemah dengan banyaknya masalah bencana alam dan situasi politik.

SOCIAL CAPITAL AND NUTRITIONAL STATUS OF CHILD UNDER 5 YEARS IN RURAL INDONESIA AND THAILAND

Abstract

In Indonesia and Thailand, the prevalence trend of malnutrition of children under five in rural area in the last decade has declined, in Thailand (0.3%) was significantly faster than in Indonesia (3.5%). So the problem in this study is whether the different effect of social capital associated with nutritional status of children in rural area in Indonesia and Thailand. This study used a qualitative approach, in Kajen 1 health center, Pekalongan, Indonesia and in Ongkharak, Thailand. The focus of this study was the form of social capital aspect which consists of: (1) citizenship, (2) the association/social organization, (3) social support that affect the nutritional status of children in society. Informants consisted of village heads, heads of health center, village midwives, IHC cadres, community leaders and children's families. The technique of determining the informant by purposive sampling and snowball sampling. Based on result, social capital related to the nutritional status of children in rural area in Indonesia and Thailand had similar patterns. The elements of social capital that influence as follows: 1) citizenship, in the form of active and creative participation, especially from the cadre or volunteers, 2) social organizations such as IHC and Children Development Center. While the differences were illustrated: 1) social organization in Thailand was a more proactive programs, 2) In Indonesia, citizenship aspects related to the elements reciprocity or passion to help each other was very prominent, and 3) The Thailand government programs that determine the nutritional status of children had been weakened with the many problems of natural disasters and political situation.

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Introduction

Malnutrition, other than as a impact, as well as risk factors for the disease and may increase the risk of morbidity and mortality. Based on Blossner & Onis (2005), although it is rarely the direct cause of death (except in extreme situations, such as famine), child malnutrition was associated with 54% of child deaths (10.8 million children). The result of prospective study by Pelletier et al. that cited by Blossner & Onis (2005) showed that anthropometric was associated with child mortality in developing country. In addition, child under 5 years with malnutrition in hospital usually besides suffers from malnutrition, also suffers from other disease such as tuberculosis, respiratory infections, and diarrhea (Adger N, 2003).

Based on WHO (2012), the latest prevalence estimates of severe and moderate among children under-five years of age worldwide suggest that there have been decreases 2.2% eachyear since 1990. While progress has been made, it is insufficient-leaving millions of children at risk of lower chances for survival. Between 1990-2000, prevalence of malnutrition at low income country was always higher than lowermiddle income country. Nevertheless, between 2000- 2010, its prevalence at lower-middle income country was higher than low income country.

In South East Asia developing country, include Indonesia and Thailand, malnutrition is one of factors related to child morbidity. Prevalence of malnutrition is higher in urban area (Olack et al., 2011). Based on Indonesian WHO Health Statistics 2012, Indonesia as lower-middle income country had prevalence of child malnutrition (percent underweight under age five) by 18,6%. In Thailand, its prevalence was 6,9%. From this data, prevalence of child malnutrition in Indonesia was higher than in Thailand.

Research that was conducted by Pongou et al. (2006) stated that the determinant factors that affect children's nutritional status were a determinant of socio-economic households, community, and environment. Children who live in the driest regions of the country are the most likely suffer malnutrition status compared to those who live in big cities. Various studies related to nutrition also stated that nutritional status can be caused by medical conditions, family socioeconomic status, and other environmental factors such as community and culture, including social capital in community (Rahim, 2014; Mitra M, 2007).

Social capital is defined as social determinants in the community associated with the social elements that exist in the structure of society that facilitate individuals and groups to perform various social activities is the social capital (Adger, 2003). Social capital is naturally owned by the community as a local substance that is able to facilitate the residents to interact. Networks formed in community will be able to encourage the sustainability of the local network that includes 3 main forms, i.e. the emergence of trust and reciprocity, information distribution, and as well as norms and sanctions agreed upon between citizens themselves (Garces I.C, 2006). Social capital is often defined as the norms, networks and associations that facilitate cooperative actions in society, and social capital has been shown to be positively associated with a variety of health effects. It is agreed with the research conducted by De Silva et al. (2007) that compares social capital between four countries.

That research used data from the Young Lives study consisted of 7242 children from Peru, Ethiopia, Vietnam, and the state of Andhra Pradesh in India. From this research found that there are significant differences in the rate, especially structural social capital (group membership and citizenship) between countries. In the meantime, there was a positive and consistent relationship between structural social capital, individual support, and cognitive social capital (eg. Trust and social harmony) with the nutritional status of children in the four countries.

When it is compared between Indonesia and Thailand, where the two countries are developing countries that have an urban society with socio-economic and cultural characteristics are almost the same, but different from nutritional. It is possible the differences in the social value of the two countries. Therefore, it is needed a qualitative study to know how patterns of social capital utilization sublime the

limitations of rural communities into capital in order to improve children nutrition. So, the problem in this study is whether there are differences of the effect of social capital associated with nutritional status of children in rural areas in Indonesia and Thailand.

Metode

This research requires a holistic understanding of the aspects of social capital for supporting of nutritional status of children in community of rural areas in Indonesia and Thailand. Therefore, this study uses a qualitative approach.

The strategy used in this study is field research strategy of case study that was conducted in Pekalongan, Central Java Province, Indonesia (village with high malnutrition cases in Central Java) and one of rural area in Thailand.

The focus of this research is social capital aspect which consists of: (1) citizenship, (2) group membership, (3) social support affecting the nutritional status of children in the community. Data collected are qualitative and quantitative data, so that the instruments in this study are questionnaires, food recall, and supporting instruments such as guidance of observation, interviews, and focus group discussions. Beginning informants consist of head of village, head of public health centers, village midwives, Posyandu (post of integrated health service) cadres, community leaders, and children families.

In Indonesia, the chosen research area is in Yanjungsari Village in the region of health center of Kajen 1. Tanjungsari village is chosen by the village with the highest malnutrition at area of health center of Kajen 1. Informants of headman is represented by secretary of the village, because the village leadership is still in transition. Initial informant is about 10 people and at the end of data collection turn into 16 people, with the addition of 4 informant of the family of a children under 5 and 2 posyandu cadres.

While in Thailand, area research is in Ongkharak District, Nokhorn Na Yok Province, Thailand. This villages were selected based on the presence of nutritional problems that are considered quite high in Thailand. Informants consisted of 13 people, consisting of 10 families of children under 5, 2 health volunteers, and 1 person from TAO (Tambon Administration The Organizer). Data analysis techniques use analytical models of Miles and Huberman (Basrowi, 2008), which includes three concurrent activities which consists of data reduction, presentation (display) of data, and conclusion (verification).

Result and Discussions

Social capital is a resourced that arisen from lack of trust, norms and networks within the community, allowing community members achieve target both individuals and communities in the region. Based on the results obtained in this study, the social capital that influenced the nutritional status of children in Indonesia are as follows:

(1) The active participation of IHC cadres, especially from the head of the neighborhood health center. Cadre members would run what he was told. The influenced of the position of chairman of the IHC cadre was very dominant. This could happen because : 1) the Chairman of the cadres already have a very long experience in having IHC, 2) in terms of age was also the oldest cadre, 3) she have spare time because all children are married, and 4) like activity performed. So that's ideally chairman IHC cadres have the ability, willingness and a good time as a condition of becoming a cadre IHC. This active participation can be said to be supported by the active participation of some members of cadres in performing activities ordered by the chairman of the neighborhood health center and community participation that have a children under 5 to carry their babies to IHC. Active participation of member volunteers to carry out activities assigned by the chairman IHC arise because of the presence of the charismatic chairman IHC, respect, trust, respected as an elder person. While the active participation of the people who have children under 5 occur because:

There is very high confidence that the growth monitoring sessions to be able to sup-

port the health and development of their babies, which can be inferred from the statement:

> Mrs. Iza: IHC important to know body weight of child, knowing child development, to ask midwife if there is a problem with the child's health.
>
> Mrs. Eka: at home can actually weigh yourself, but it is not recorded in the KMS development so do not know and can't input from midwives and cadres.

The existence of values especially with regard to children, where Children especially young parents need assistance and should be considered and treated, met all his needs, especially for a meal (including milk and snacks), for the treatment to become healthy child. A healthy child will be reflected on her weight when weighed always go up, not limp, would eat, a lot of motion, no fuss, no frequent pain, all of which can be served in IHC. It can be concluded qualities IHC active participation of the chairman, members and cadres at different levels of society.

(2) Proactive, visible protruding from the head of the neighborhood health center. In all activities associated with children under five and IHC, always to success initiative to come from the mother's activities as chairman IHC: Juwariah. Including completing tasks assigned to him by the health center. This is evident, for example, when tasked to find the data needed children under five, the mother immediately contacted Juwariah other budget heading by way of via sms (short message send), ride a bike or walk to the house mother who carries the data book, so when I had to collect the children under 5's mother Juwariah walk straight toward the house and within a minute, children under 5 already collected.

(3) Reciprocity high level, which is described in the spirit of mutual help and social care high. Spirit of mutual help in the form of:

(1) If the children under 5's mother was unable to bring a children under 5 to the neighborhood health center, the grandmother or relative or even a neighbor willing to take him.
(2) Mother children under 5 eating children under 5 neighbors willing to feed one plate and a spoon with a children under 5. This is considered to increase appetite children under 5.
(3) Often neighbors offer dishes for their babies, as expressed by Ms. Fatir (one a mother with children under 5 malnutrition) "Masak mboten? Sayure mendet teng buri" (did not cook? Take the vegetables in the back/ kitchen)

Reciprocity high level is influenced by: (1) the existence of family ties, which in most rural communities between the family still has ties with other families, (2) there is still a high sense of kinship, (3) the existence of mutual trust and norm-norms that reflect a habit of giving each other, helping each other in society.

(4) The only social organization that plays a role in the development of the nutritional status of children is IHC. IHC in a village Tanjungsari community organizations under the coordination of the health center Kajen 1. The IHC Group has operational work (Pokjanal) IHC, where the patron is the head of the village. Pokjanal IHC has 8 post (one post each RW) , which is heading jasmine 1 to 8, with each consisting of 5 mother is 1 mother board chairman and four members of the so-called mother IHC cadres. This growth monitoring sessions include: 1) Prepare a place and food supplementation (PMT), 2) Register with a children under 5 who came, 3) Considering, record the weight and nutritional status, 4) Sharing the PMT, 5) Conducting Build of child under five year family (BKB). Where children under 5 while waiting weighing playing with props educative and consulted on the development and growth of children under 5.

It can be said IHC not a purely social organization, therefore there IHC under the coordination of community health centers (government health agency) and the head of the village, running and helping government health programs . But it can also be said of social organization by serving as a cadre of community members who volunteered to help with the activities without being rewarded.

Growth monitoring sessions can be managed and run every month because of: 1) awareness and activeness of the cadres , 2) good cooperation from village officials , 3) the figure

of the village leader and respected dominant , 4) an awareness of the public about the value-value associated with the growth and development of infants that are considered important, to make the child healthy and quality, one of them by looking at the development of the child's weight in neighborhood health center, 5) coordination, good cooperation with the health center Kajen 1.

IHC cadres, especially the head of a neighborhood health center right hand of the health center, all the activities / programs, the need for data pertaining to children under five always ask the help of the head of cadres and cadres highly visible chairman children under 5 master the problems that exist in the region exceeds the existing clinic staff. IHC in the village Tanjungsari often awarded or won in activities related to the program IHC and children under 5.

IHC and Health centers as the coordinating government institution will work together to succeed in the program related to health status, including nutritional status of children, among others, by: 1) providing training to the cadres, 2) provide funds PMT Rp 100,000, - for one year per post, 3) provide immunization services, treatment, medical consultations through the village midwife, 4) up communication and coordination to the cadre continuously through the head of the neighborhood health center, 5) require reporting on the state of its children under five in the region, especially the data weight, height, nutritional status of children.

The headman coordinate institutionally, because the neighborhood health center ware in the territory administration work, so all existing activities is the responsibility of the village government.

(5) Social support in the village Tanjungsari very high, which comes from the family, neighbors, community leaders, but there is no meaningful support from lead of political and NGOs. Support in the form of:

(1) Family support in the form of: IHC activities, mothers would bring their babies for the associated management, to see the growth and development of their babies. If the mother is absent, then it is usually a grandmother who would replace him. Dad can help maintain, feed and bathe a children under 5 when the mother is busy working or sick.
(2) Support your neighbors and friends in the form of: (1) helping to bring a children under 5 to a neighborhood health center associated management when the mother is absent, (2) feeding a children under 5 along with her children under 5, (3) supervise children under five play when the mother was working on another job up., (4) help child under five year to the hospital when he sick and need a car to take him, (5) split a side dish for children under five neighbors when children under 5's mother did not cook.
(3) Support community leaders such as: (1) Village-level governance, facilitating the growth monitoring sessions in terms of funding, although in limited numbers, and almost all the activity was attended by Head of village or his wife or his secretary, as well as the close coordination and communication in the implementation of activities which tend to be traditional/ familial , such as rural habits (oral communication, word of mouth without the written letter).

In research village, Thailand , social capital affects the nutritional status of children under five are the elements of:

(1) Participation, in the form of participation of the family of children and community members. It can be said that striking the active participation of community members who come from a role as health volunteers, who are members of the organization of village health volunteers (VHV). The volunteer activity should also be pro- active or creative to be able to carry out their duties properly, especially finding children in need of care or treatment to be taken to a hospital that has been designated by the government, as well as to obtain immunization services.
(2) While the participation of a family of children, some mothers cook the food supply during the child development center in the village. But most family children under five

participate by running programs that have been set by the government, which leave their children at the Child Development Center and work optimally as a farmer to produce rice.

(3) Reciprocity, the spirit to help each other with regard to nutritional status of children can be said to be not much affect. This could be due to the children under five are cared for during the day at the Child Development Center in the village for the elderly to work, so any help on children under 5 care is done by the Child Development Center.

(4) Social organization, in this case the Child Development Center Ongkharak TAO. This organization is not a purely social organization, therefore is a program of the government and the provincial government is under, with members consisting of health volunteers. This organization is an important part in reducing nutritional problems that exist in Thailand.

The programs that run this organization mindful of health conditions that can be said to form a children under 5 parenting children under 5 in research village. Parenting can be a pattern of care in health care and food consumption. Nevertheless, there remains the problem of nutrition. In this case, not found children under five with poor nutritional status, but there is still a children under 5 with less nutritional status. This incident caused a children under 5 who does not like a lot of types of food including milk displeased in any form and kind. It can be said to be in line with the results of a study that found that the factors of race, ethnicity, tradition and socio-economic conditions affecting nutrition parenting (Horowitz, 2000; Garces). Here the problem of malnutrition that occurs due to individual factors themselves or children under five who do not like a lot of food, whereas factors related to ethnic, traditions and economy have been addressed in a parenting nutrient contained in the Child Development Center and the existing programs of Thai government.

Social support, which is very significant in maintaining the nutritional status of children is the support of the Thai government, either: (1) support directly related to the nutritional status of children through a program at the Children's Center The floating villages, and (2) indirect support, but it is a fundamental factor, which is related to the economic support of the family of children, through the guarantee price of rice produced by the farmers in the village.

Basic determinants that can affect picture of health status and nutritional status is an economic level. Cause of low economic level of education, knowledge and ignorance, the consumption of foods that are available in the family, the family becomes the form of health care is not good. Low economic level can be said to affect the pattern of care provided by family nutrition which then can influence the nutritional status of children.

Social capital that determines the nutritional status of children in rural areas in Indonesia and Thailand is actually a similar pattern. Where modalsosial elements that affect the form:

(1) Citizenship, be active and creative participation of community members who become cadres / volunteers to help deal with health and nutrition in infants. Good in Indonesia mupun Thailand is very helpful.

(2) Social organization, social organization whose role is under the coordination of government programs that assist the government in the health sector, the cadre / volunteers drawn from the community with certain conditions . The cadres / volunteers is a society without a social worker be rewarded . So it can be said is not a purely social organization. The organization called IHC (in Indonesia) or the Child Development Center (Thailand)

The difference is illustrated:

Social Organizations in Thailand (Child Development Center) is a program that is more pro- active, for example: (1) the volunteer search and find children in need of care or health services (being sick) and impaired nutritional status to be referred to the pain that has been determined, (2) social organization in the form of the Child Development Center took over child care during the day while their parents worked on their farm. While in Indonesia , the mother should be more active children under 5 who bring their babies

to IHC scheduled once a month, or bring their babies to the Public Health Center (Puskesmas) unruk nearest medical treatment free of charge if the sick children under 5. Sometimes cadre IHC reported cases of health and nutrition that is found in its region to the clinic to get treatment. Or sometimes cadres also doing the weighing directly into the children under 5, children under five if not present in the growth monitoring sessions. But this is not a program of activities that are required, so a lot depends on the creativity of the existing cadre.

2) Excess in Indonesia is to cytizeship aspects related to the elements reciprocyti or spirit to help the support nutritional status children under five look very prominent. Like for example: (1) Lend a car with a neighbor volunteered to bring the family to the hospital (2) If the children under 5's mother was unable to bring a children under 5 to the neighborhood health center, the grandmother or relative or even a neighbor willing to take him. (3) Mother children under 5 eating children under 5's neighbors willing to feed one plate and a spoon with a children under 5. (4) Often neighbors offer dishes for her children under 5.

Reciprocity element is a characteristic of most rural communities still have family ties. According to research by Handy (2011), in the village of Pecuk, Central Java, Indonesia, the spirit of mutual help preformance nutrition parenting referred to as mutual aid and mutual help arises because of the family ties, which exist in most villages. Only in Thailand for reciprocity not have much effect on the nutritional status of children, but on the activities of other such religious activities and marriage. This is understandable because for handling related nutritional upbringing had a lot of help from the child development center.

3) Another difference between Indonesia and Thailand is that the Thai government programs and policies that strongly support the nutritional status of children weakened by the many natural disasters such as flooding

Conclusions

Based on the results, social capital related to the nutritional status of children in rural area in Indonesia and Thailand have similar patterns. The elements of social capital that influence as follows: 1) citizenship, in the form of active and creative participation, especially from the cadre or volunteers, 2) social organization, such as Integrated Health Center (IHC) and Children Development Center that helps the government health program is the only social organization that is very influence the development of nutritional status of children uner five. While the differences are illustrated: 1) Social organization in Thailand is a more proactive programs, 2) In Indonesia, citizenship aspect that is related to the element of resiprocity or passion/spirit to help is very prominent, and 3) The Thailand government programs that determine the nutritional status of children are weakened with the many problems of natural disasters and political situation.

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Bibliography

Adger, N. 2003. Social Capita, Collective Action, and Adaptation to Climate Change. Economic Geography, 79: 387-404.

Blossner, M. & Onis, M. 2005. Malnutrition Quantifying The Health Impact at National and Lovcal Level. Prüss-Üstün, A., Campbell-Lendrum, D., Corvalán, C., & Woodward, A., eds. Available from < http://whqlibdoc.who.int/publications/2005/9241591870.pdf> [Accessed February 26, 2013].

De Silva, M. J. & Harpham, T. 2007. Maternal Social Capital and Child Nutritional Status in Four Developing Countries. Health Place, 13(2): 341-55.

Garces, I. C., Scarinci Isabel C, Harrison Lynda. 2006. An Axamination of Sociocultural Factors Associated With Health and Health Care Seeking Among Latina Immigrants. Journal Immigrant Health, 8: 377-385.

Handayani OW. 2011. Nilai Anak dan Jajanan Dalam Konteks Sosiokultural (Studi Tentang Status Gizi Balita pada Lingkungan Rentan Gizi di Desa Pecuk Kecamatan Mijen Kabupaten Demak, Jawa Tengah). Unnes Press.

Horowitz, C. R., Davis, M. H. etc. 2000. Approaches to Eliminating Sociocultural Disparities in Health. Health Care Financing Review, 21 (4): 57-72.

Mitra, M., Sahu, P. K. etc. 2007. Nutritional and Health Status of Gond and Kawar Tribal Pre-school Children of Chhattisgarh, India. Journal Hum. Ecol, 21 (4): 293-299.

Olack, B., Burke, H., Cosmas, L., Bamrah, S., Dooling, K., Feikin, D. R., Talley, L. E. & Breiman, R. F. (2011) Nutritional status of under-five children living in an informal urban settlement in Nairobi, Kenya. J Health Popul Nutr, 29(4): 357-63.

Pongou, R., Ezzati, M. & Salomon, J. A. (2006) Household and community socioeconomic and environmental determinants of child nutritional status in Cameroon. BMC Public Health, 698.

Rahim Fitri K. 2014. Faktor Resiko Underweight Balita Umur 7-59 Bulan. Kemas 9(2): 115-121

WHO (2012) Levels and Trends in Child Malnutrition. Available from < http://www.who.int/nutgrowthdb/jme_unicef_who_wb.pdf> [Accessed February 26, 2013].