Caring for Children Who Suffer from Malnutrition
Nurses’ experiences in the highlands of Papua

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Abstract
This study was carried out during the spring of 2009 in the highlands of Papua, Indonesia on a Minor Field Study (MFS) scholarship funded by the Swedish International Development Cooperation Agency (SIDA). Indonesia is a developing country with Papua as a province in the most eastern part of the country. Mountains and jungles cover Papua, which makes health care hard for people to reach. Half of the child deaths in the world are connected to malnutrition and most of the suffering children live in developing countries. The authors had been informed about the high rate of malnutrition and child diseases among Papuans in the highlands and that the nurses who work in the highlands were faced with challenges when working to improve the health among children who suffer from malnutrition and their families. The aim of the study is to describe nurses’ experience of working with children who suffer from malnutrition.

A qualitative approach was chosen for the study and by using an open-ended interviewing method seven interviews were collected. Seven nurses were asked about their experience working with children who suffer from malnutrition. The interviews were collected at one specific hospital in the highlands of Papua and the respondents were of both gender. The interviews were transcribed and analyzed according to the qualitative content analysis. The result was presented in themes and sub-themes, where these three main areas were found: “Hindrance of health”, “Improving health”, and “Challenges”. The result shows that Papuans belief in spirits and traditional treatment and also lack of trust in the western medicine is a major problem for nurses who give care to the children suffering from malnutrition. The result is discussed in relation to background where relevant literature is referred to.

Keywords: nurse, child, malnutrition, the highlands of Papua, health, caring
# Table of contents

**Introduction** ................................................................. 3

**Background** .................................................................. 4

The republic of Indonesia ....................................................... 4
  History and Politics ........................................................... 5
  Religion ........................................................................ 6

Papua .............................................................................. 9
  Geography .................................................................... 9
  The language .................................................................. 9
  The people ...................................................................... 9

Central concepts in nursing science ........................................ 10
  Caring relationship ............................................................. 10
  Suffering ........................................................................ 10
  Health ............................................................................. 10

Malnutrition ...................................................................... 11

**Formulation of issue** ......................................................... 12

**Aim of the study** ............................................................... 12

**Method** .......................................................................... 12

  Literature research ............................................................ 12
  Interviewing .................................................................... 12
  Selection of participants ....................................................... 13
  To use an interpreter ........................................................... 14
  Qualitative content analysis ................................................ 14
  The data collection .............................................................. 15
  Analysis of the collected data ................................................ 15

**Result** .............................................................................. 16

  Hindrance of health ............................................................. 17
    Lack of compliance ............................................................ 17
    Experiencing parents not caring for their children .......... 19
    Experiencing feelings of frustration ..................................... 20

  Health Improvement .............................................................. 21
    Educating and involving the family ................................... 21
    Positive feelings as a motivation ....................................... 22
    Working through relationships .......................................... 23

  Challenges ......................................................................... 24
    Understanding the highland culture .................................. 24
    Communication ................................................................. 27

**Discussion** ..................................................................... 29

  Discussion of method ........................................................ 30
    Data Collection ................................................................ 30
    Data analysis ................................................................... 32
  Discussion of result ............................................................ 32
Introduction

The authors of this paper are studying nursing in Sweden and had the privilege to visit Indonesia and Papua to convey a research on how nurses experience working with children who suffer from malnutrition. The authors spent three weeks getting familiar with the diverse culture of the Indonesian province Papua before they began the data collection and interviewing. None of the authors had ever been in the role of a researcher before and therefore the task was taken up in great reverence and with a feeling of curiosity on what laid ahead.

Malnutrition in children leads to suffering and is also the cause to why half of children die too young, especially in the developing countries. People in our part of the world have a higher standard of living compared to the Papuan. Geographically Papua is one of the world’s most isolated areas where people still are living un-affected by the western world. The way of life there is very simple and it is not un-common to find people living in huts, drinking the rainwater, eating what the nature brings them and having to walk for days to reach civilization. Papua is very little influenced by the modern world and struggle with major health problems such as malnutrition among children. Nutrition is one of the nurse’s main responsibilities in the care of the children in the developing countries. With this responsibility also comes a challenge for the nurse to use all his or her skills to do whatever he or she can to prevent malnutrition in children and care for the children who are already suffering from it. With the following research the authors hope to shed some light on how nurses can experience to work with children who suffer from malnutrition in the Highlands of Papua.

The Swedish International Development Agency’s (SIDA) scholarship, Minor Field Studies (MFS) aims to increase the knowledge and the understanding of the developing countries. The University of Borås granted the authors of this study a scholarship and as a part of this, the authors of this paper went to Indonesia and Papua for eight weeks to study how nurses in the highlands experience taking care of children who suffer from malnutrition and what follows is the result of that study.

Background

Since the political situation and the history of Indonesia have had and have a major impact on the health care system and the relationship between the government and the Papuan province the authors have chosen to describe history and politics more thoroughly.

The republic of Indonesia

The republic of Indonesia is a country situated in the Southeast Asia north of Australia. It is the regions largest country with 240 million people (CIA, 2009). The country covers a large area with it’s about 18000 islands. The capital Jakarta is located on the island of Java, which also is considered the centre of the country (Landguiden, 2009).
History and Politics

Mainly three large traditions; the Indian, the Islamic and the European have influenced the Indonesian history. These three cultures have been integrated in the Malaijan culture through centuries and have affected religion, art and language. The Indian culture came mostly from the long distance trading over the Pacific Ocean where Indonesia had a central place in the middle of the travel routes. During a thousand years efforts were made trying to unite the smaller island kingdoms to bigger states. Some kingdoms were quite successful during this time period (Nationalencyklopedin 1, 2009) Arabic salesmen brought Islam to Indonesia in the 13th century (Landguiden, 2009). Islam did not conquer the older beliefs of the region but more mixed in with the already established beliefs (Nationalencyklopedin 1, 2009). After the Islamic influence the Europeans reached the islands. The Portuguese were first but were soon forced away by the Dutch and could only keep East Timor. The Dutch managed to get Indonesia for itself by playing out other smaller kingdoms ad local competitors against each other. When the Dutch trading company had grown strong in the country the Dutch government took over the rule and claimed Indonesia as a Dutch colony. Except for a short period of British rule in the years 1811-1826 the Dutch governed the country and fought to put down any effort from the local people trying to gain rule.

The Dutch used the Indonesian soil for growing sugar, coffee, tea and indigo and it gave great income. During this time the infrastructure was improved. The improvement gained the already rich people but the poor people who owned no land were negatively affected. Along with the growing Dutch influence different anti colonial groups came together and tried to gain power and political influence (Nationalencyklopedin 1, 2009). The Japanese occupied the country in 1942 during the Second World War and were met by Indonesians tired of the Dutch rule and somewhat positive to the new occupational force. Their positive reaction was soon changed when the Japanese treated the local people ruthlessly and forced them to join the army (Landguiden, 2009).

This further encouraged the Indonesians to come together and when Japan capitulated in 1945 Sukarno the Indonesian national leader claimed independency for Indonesia on the 17th of August, which also is the Indonesian day of independence. During this time Bahasa Indonesia became the national language. The Independency was not totally established until 1949 when peace was reached with help from the UN, this after years of military and political fighting with the Dutch. The Dutch only managed to keep the rule over Irian Jaya (todays Papua). Sukarno ruled Indonesia politically together with the communist party PKI (Partai Komunis Indonesia) and the army. Sukarno remained in power by working with these two other political forces, sometimes supporting them and sometimes playing them out against each other. Sukarno was also active in foreign politics and in 1963 Irian Jaya (Papua), which was under the control of the UN since 1962, was turned over to Indonesian rule with the promise that an election on Papua’s future as a nation was to be held in 1969. This election, which was manipulated by Indonesian government ended in Papua being an Indonesian province without its own rule. Indonesia has kept its rule in Papua until today by military presence and economical investments (Nationalencyklopedin 1, 2009).

In 1965 the disagreements between the communist party and the army ended in a bloody massacre where as many as 500 000 people were killed. Sukarno lost his power
more and more during this crisis and General Suharto stepped into the political scene supported by the military, the bureaucrats and parts of the Islamic establishment. This new regime with General Suharto built up a political stability in Indonesia during 1970-1990. President Suharto held a more capitalistic view in the development, which led to an increase in the industrialization, Indonesia being self sufficient on rise and that the class gaps increased. The economical development in the country had a prize in form of a more authoritarian rule, with hardly any political opposition and increased corruption. When Asia was struck by the economical crisis in 1997 the opposition against the authoritarian rule gained ground and Suharto was forced to leave his Presidential post and was replaced by Vice-President Habibie whose government worked for more democracy (Landguiden, 2009).

The first free elections for the parliament were held in June 1999 and resulted in a new president, Wahid. Indonesia and the rest of the world had high expectations on the new president and his plans for more democracy. The hopes were soon scattered when Wahid was accused of corruption, which of course meant people could not trust him anymore. Vice-President Megawati Sukarnoputri was chosen to be president from 2001 until the new elections were to be held in 2004 (Nationalencyklopedin 1, 2009). In 2004 the Indonesian people for the first time could vote for a President in a direct election and it resulted in former general Susilo Bambang Yudhoyono being elected President. The government since then prioritizes solving the problem with terrorism and the regional conflicts going on in Aceh and Papua. The fight against corruption and to get more people into work is also highly prioritized but the government under President Yudhoyono (Landguiden, 2009).

In 2001 the Indonesian government granted Papua with a special autonomy. With this act a Papuan representative council was established (Papuan People’s Council). This was done in an attempt to give the indigenous Papuans more power to protect their basic rights, to have power over their own affairs as well as being able to improve the standards of health, education and economy in Papua (Rees, Van de Pas, Silove & Kareth, 2008).

Religion

According to a law founded in 1965 the four religions Islam, Protestantism, Catholicism and Hindu-Buddhism were given freedom of religion. In the year of 1973 a new law stated that the so-called “new religions” were to be included in this freedom of religion too. The tribal animistic religions have never been granted this freedom whereas people who profess to these beliefs are considered not being a part of any religion. Islam is the largest religion in Indonesia and approximately 85% of the population claims to be Muslim. About 50% of the Indonesian Muslims profess themselves to the stricter Islam; the other 35% profess themselves to the “new religion”, the Indonesian Islam that is mixed up with Hinduism, Buddhism and other Indigenous religions. In the most western parts of Indonesia, Papua, people still practice indigenous religions and so called cargo religions. About 12% of the Indonesian population has Christianity as religion (Nationalencyklopedin 1, 2009).
The Indonesian health and health care

Up until the Asian economics crisis the Indonesian health statistics improved alongside the improving Indonesian economy. Average life expectancy at birth increased and the child mortality rate fell. At the same time a successful family planning programme reduced the birth rate in the already crowded country. After the crisis many people lost their jobs families could not afford enough food and the price on rise, which is the staple food in Indonesia doubled and the price on cooking oil tripled. Malnutrition among mothers increased as well as child anemia. With the increasing prices on child formula malnutrition among children increased very fast. In Indonesia as in many other developing countries mothers cannot breast-feed due to the fact that they have to work to support their families. Their children are often taken care of by relatives where upon child formulas are important for the survival of the children (Shields & Hartani, 2003). Along with this Indonesia has suffered an increase of serious endemic diseases such as typhoid, cholera, tuberculosis, dengue hemorrhagic fever and malaria. In 2001 a decentralization of all government departments took place giving autonomous provinces and districts increased influence but also the responsibility to raise a third of their income which used to be governmentally funded (Hennessy, Hicks, Hilan & Kawonal, 2006a). All 33 provinces are divided into districts and each district is divided into sub-districts. A doctor heads the health centers in the sub-districts and under the health center nurses run sub-centers as a support. Preventive and promotional services are provided at village level by Family health posts, which are managed by the community with help from health personnel (World Health Organization, 2007).

There are two forms of health care in Indonesia public and private. Hospitals and primary health care clinics are funded by the state. Companies, individuals or religious organization runs the private forms of health care, which can be hospitals or clinics. About 34% of the over 1000 Indonesian hospitals are private. To give the poorest a chance to get health care without having to pay the International Monetary Fund and the World Bank have supported Indonesia financially. Hospitals and Community health facilities provide the poorest with free medical, nursing and hospital care and supplies needed for treatment under a scheme known as Jarang Pengamang Sosial Bidang Kesehatan (JPSBK). Ministries of health or local authorities on city or provincial level administer the public hospitals. All hospitals charge the users an admission except the ones who provide free health care through JSPBK. The admission covers a bed, nursing care, food and sometimes medical care. All equipment drugs, dressings, intravenous fluids and such have to be bought at the hospital pharmacy or chemist shops. The hospitals divide the wards in different classes with daily prices that range from 5000 to 8000 Rupiahs up to 450 000 Rupiahs. As a comparison a meal for a family costs about 8000 Rupiahs. The different classes also reflect the different classes in the Indonesian society. Paying the basic admission will give a poor family a bed in a large ward including some nursing care. If extra nursing care is needed or wanted it costs more and most often families cannot afford this and therefore have to take care of their sick relatives by themselves. If a family pays the highest rate they get a private room with beds for family members, bathroom, refrigerator and a television. Though nursing care standards vary a lot depending on the hospital type, nurses education and the philosophy of the institution (Shields & Hartani, 2003).
Standards of health care in Papua are lower than in other Indonesian regions. The infant mortality rate in the region of Puncak Jaya is about 85-150 per 1000 live births (Rees, Van de Pas, Silove & Kareeth, 2008) compared to 32 per 1000 live births in the rest of Indonesia (WHO, 2007). The figures for those under five years of age are 30-50 per 1000. Common death causes for children are curable diseases such as diarrhea and pneumonia. At the same time maternal mortality are 500-1000 for 100 000 births, which is three times higher than for the rest of Indonesia. Medical centers often lack staff and enough resources. Clinics often suffer from a lack of medications due to under funding. The HIV rate is higher in Papua than in the rest of Indonesia and organizations fear for a growing HIV epidemic in the highlands. This risk is growing with rapid social changes due to populations moving (Rees et al., 2008). In 2000 the Indonesian government recognized the poor health status in Papua whereupon the province received US$ 2.25 billion from the government to improve the health care (Rees & Silove, 2007).

The Indonesian primary health care system is extensive. There is at least one community health care center, Pusat Kesehatan Masyarakat (PUSKESMAS) in each sub-district. The PUSKESMAS are linked to sub-centers called PUSKESMAS pembantu and community-level centers called Pos Pelayan Terpadu (POSYANDU). The staffs at these centers are nurses and midwives and their work consists mainly of providing immunization, information on family planning, maternal and child health care and giving different preventive services. Health services in the more remote parts Indonesia are often disadvantaged and the government has tried to change this by making it obligatory for doctors to work in rural areas before they can go work in areas they choose (Shields & Hartani, 2003).

Nursing in Indonesia

There are 50 nurses per 100 000 people in Indonesia (Shields & Hartani, 2003) and even though there are no official numbers from the Papuan province, health fact numbers seem to be lower (Rees et al., 2008). In Sweden there are 109 nurses and midwives per 10 000 people (WHO 3, 2009). One per cent of the Indonesian nurses are educated at university. The university levels are S1 sarjan satu or bachelor’s degree, S2 sarjana dua or master’s degree and S3 sarjana tiga or doctoral degree. 39 % of the nurses have education to the Diploma level, which can be reached both at governmental and private nursing academies called Akademi Keperawatan (AKPER). Sixty per cent of the nurses have a senior high school nursing education. Specialist nursing and midwifery are taught at the levels eleven and twelve in senior high school, which means that graduates as young as 17 years can care for patients who needs complex care or even deliver babies. No centrally based nursing registration exists in Indonesia, which makes it hard to have any standardization on nurses’ competence and capacity. Nurses with diploma and degrees are needed in nursing education whereupon they are being recruited as teachers right after graduation. The clinical practice they lack leaves them with little integration of clinical practice in their teaching. Even though the nursing status compared with medical practitioners’ status is low and nurses are considered the doctors’ helpers the status on nursing has raised lately and is considered a safe occupation; about 25 per cent of the nurses are men. The government employs nurses and at the age of 55 years retirement is forced to make sure younger Indonesians get employment (Shields & Hartani, 2003)
Papua

Geography

Papua or West Papua is situated in the most western part of Indonesia and north of Australia. Papua is the western part of the world’s next largest island, New Guinea, which has an area of 800,000 square kilometers. The island is placed in between two big landmasses or earth plates that have moved towards each other during a long time period. This movement of landmasses have made New Guinea into what it is today, an island which is one of the most complex geological areas in the world. The central mountain range reaches from east to west with its 2400 kilometers. The mountain crest is 3000 meters with a few peaks reaching up to 4500 meters. The highest peak Puncak Jaya has the islands only glacier and its height of 4884 meters makes it the highest elevation between The Himalayas and the Andes (Muller, 2008).

The language

The official language in Papua as in the rest of Indonesia is Bahasa Indonesia, but most of the people living in Papua speak Papuan languages (Landsguiden, 2009). Furthermore the languages of Papua are so many that linguistics for long has struggled to try and organize and understand them. Because many languages are so different from each other they have even been hard to group in some sort of related units (Muller, 2008).

The people

The indigenous people living in Papua today originates mostly from old Papuan tribes. The tribal culture is very different compared to the Indonesian culture from Java. The Indonesian government ordered an immigration policy with a goal to move 20 million Javanese people to Papua and this of course threatens the Papuan culture (Nationalencyklopedin 2, 2009). Most of the two million indigenous Papuans live in small villages remotely placed in the mountains and the forests (Rees & Silove, 2007). The highland is a cold environment where it’s often raining at night and the areas are surrounded by mountains of jungles. People usually walk everywhere and sometimes it can take week to get to the destination. Papuans are still living in their huts, inside the huts they do have only one rum and middle of the hut they do make fire to keep them warm. It is known that smoke from the fires in the huts make many of the Papuans sick in different lung diseases (Personal communication, 2009).

For the highland Papuans hunting and gathering used to be the main life-sustaining activity. But that has changed during the years. The highland Papuans today practices agriculture since the elevation, climate and soil type are good for planting and growing. This type of life-sustaining activity means that the Papuans in the highlands have to put a lot of time and effort in trying to keep their land so that the crops grow and give them the much needed food for their family’s survival. The main staple food is the sweet potato. The keeping of the land is a task mostly being done by the women while the men take care of the clearing and fencing that takes place when preparing the land (Muller, 2008)
The sweet potato was introduced to the Papuans 300 years ago and with its introduction in the highlands the people could survive on a much higher altitude and therefore the highland population increased seemingly. With sweet potato being the main staple food there is another very important thing for the highland Papuans, the pig. Since having been introduced to the Papuans about 4000 years ago, the pigs still have a most important roll in the highland culture. As a Papuans have expressed it, ‘babi, masyarakat punya dompet’ (pigs of the people’s wallets). Being a source of income as well as the bride’s wealth the pig also remains the largest source of proteins when over-hunting have reduced other animal resources. The domestic pig in the highlands represents the traditional source of wealth and power. In many areas pigs are an important part of the bride-price and are used in cultural feasts or rituals where many pigs are killed and the meat is given away as a gift to re-establish good relationships and alliances between different tribes and groups. Fish was recently introduced in the highlands and before this the highland Papuans only had crayfish as a natural resource from streams and lakes (Muller, 2008).

Central concepts in nursing science

Caring relationship

Wiklund (2003) says that caring presupposes that human beings meet and the context springing from this is the caring relationship. A caring relationship is created when a nurse or a caretaker really wants to ease another person’s suffering and therefore enters into a caring relationship with this person. In this caring relationship suffering can be eased and strength and purpose can be found.

Suffering

According to Wiklund (2003) suffering is not only a physiological feeling but also an on going process. Suffering is experienced in different ways and is described in three parts suffering of illness, suffering from caring and life suffering. Suffering from illness is connected to the symptoms from the illness and the consequences from it. Suffering from caring is the form of suffering that comes from the care giving or the treatment or when these two are not carried out properly. This form of suffering can be prevented if the caregiver recognizes it. But only recognition is not enough, the caregiver also needs to reflect on the care as such and over the roll as a caretaker to find if anything can be changed in this to prevent suffering from caring. Life suffering includes all of human life, the reality around a human being as well as the self-image. This form of suffering can be present in different extent when a human being experience health but when illness is present this form of suffering is often actualized. Therefore life suffering involves the human being’s whole existence.

Health

In caring science the human being is considered multidimensional and consists of body, soul and spirit. In relation to this health is also a multidimensional concept. Two people can experience health in different ways and therefore health is considered being a relative concept. Health is a condition that includes experiencing soundness, freshness and wellbeing. Health can be experienced without absence of illness. Experiencing soundness means being oriented in time, room and in person and in practice means that a person can act soundly and understand the consequences of an action and chose to act
in a health gaining way. *Freshness* is more related to a person’s physical abilities and that the bodily organs work as they should. This part of the health concept is described as absence of illness. *Wellbeing* is a relative concept since it describes a person’s feeling. Wellbeing describes a person’s inner experiences and is therefore subjective (Wiklund, 2003).

**Malnutrition**

To reduce child diseases should be a number one priority in every country.

*We are guilty of many errors and many faults, but our worst crime is abandoning the children, neglecting the foundation of life. Many of the things we need can wait. The child cannot. Right now is the time his bones are being formed, his blood is being made and his senses are being developed. To him we cannot answer "Tomorrow". His name is "Today".* (WHO, 2009. Gabriela Mistral, 1948).

Child malnutrition is a major global problem and a very complex one since it involves many factors. Half of the child deaths in the world are associated with malnutrition and still it is one of the most neglected worldwide problems. Child malnutrition affects hundreds of million of children around the world and most of the health burden is in the developing countries, particularly southern Asia (Muller 2005).

More than 17 percent of all children born in the developing countries are under weight, a weight, which is less than 2,500 grams. An even bigger problem is that more than 74 percent of the infants are not at all weight measured in South Asia. Deficiencies of important vitamins and minerals as iron, vitamin A and iodine cause malnutrition. Only half of the households in south Asia consume iodized salt. The determinate to child malnutrition can be classified in three levels: The most proximate level; Intake of energy, protein, fat and health status. The second one is to have proper health environment with access to health services, access to food and good care for mother and children. Finally it is of importance how wealthy the country is and what resources are available for the needed (Khan, 2006).

Child malnutrition is the cause for more than half of the child deaths in the world and it needs immediate action to reduce or even solve the problem. Many children are suffering and it requires great efforts from civil society, national government and international organizations. During the year 2000 the United Nations and 147 head of states made an agreement on eight goals with the hope to reduce the malnutrition in developing countries. One of the goals are to reduce hunger and poverty by 2015 and other goals are about; primary education, empowerment of women, improved maternal health, decreased child mortality, prevention and management of HIV/AIDS, malaria and other diseases, environmental protection and global partnership for development (Muller, 2005).
Formulation of issue

It is a fact that many of the world’s children suffer from malnutrition and it is a major global problem of today. More than half of the child mortality rate in the world is related to malnutrition. Indonesia as most developing countries is facing problems with malnutrition in children. As a part of “Healthy Indonesia 2010” (WHO, 2007) the country works for decentralization of the health care, which leaves the different regions with greater responsibilities to work towards a better health care and a better health status for the people. In the highlands of Papua organized health care is hard to reach for different reasons.

The treatment of children who suffer from malnutrition and underlying causes demands a long hospitalization and the health organization is dependant on the fact that the parents or other family members stay with the children in the hospital (Personal communication, 2009). This long hospitalization makes the relationship between the nurse and the patient and the nurse and the patient’s relatives very important. In Papua the cultural gaps can be large between the nurse and the patient and their relatives. Building caring relationships is a challenge for every nurse and doing it under the pressure from working in another culture and with a lot of suffering surrounding makes it even harder. There is no study made on how nurses experience working with children who suffer from malnutrition in the highlands of Papua whereas a study about this could give better understanding about how it is.

Aim of the study

This study aims to describe how nurses in the highlands of Papua experience caring for children who suffer from malnutrition.

Method

This study is a field study of empirical character and the result is therefore based on material from the interviews conducted. Scientific articles are used in the background and in the discussion.

Literature research

The scientific articles were found by searching through databases such as Cinahl, Pub Med and Blackwell Synergy. Certain keywords were used for the search and those were: Nurse*, care, malnutrition, children, Indonesia, Papua, highlands, rural area, health. Other literature for the study was found in reference literature lists and by manual research. The scientific literature was reviewed and it was hard finding scientific literature that had relevance for the study.

Interviewing

The qualitative research can be conducted using different methods. A qualitative research method used when the aim is to understand peoples experience is the qualitative interview. According to Widerberg (2002) interviewing means that the researcher uses the form of communication to better understand another human’s experiences or stories. An interview should also be focusing on the meeting between
two or more people (Fägerborg, 1999). Further describing the interview, Lantz (2007) explains the difference between an interview and a regular conversation. In an interview the interviewer wants to get information and has an aim and a purpose with the questioning while in the regular conversation the questioning does not need to have a purpose or an aim and what to talk about is formed by the partakers of the conversation as the conversation goes on. In an interview the responsibility for the conversation lays on the interviewer whom also has the responsibility to guide and control the conversation so it stays in the beforehand fixed direction.

If the aim is to describe how people experience their world the qualitative approach is a method to prefer. The aim of the qualitative research method is to gain insight rather than to gain statistical facts (Bell, 2000). Widerberg (2002) further explains the aim of using a qualitative research method as trying to elucidate the characteristics of a phenomenon. Therefore the qualitative approach is chosen for this study.

The interviewing methods can be of different character; structured, semi-structured or non-structured questioning forms can be used. The aim and the purpose of the study have to be in mind when choosing interview form. When not being familiar with the phenomena or area of interest a more non-structured form is recommended but also demands a lot from the interviewers (Bell, 2000). Therefore the non-structured form with one prepared question is chosen for this study.

The interviews have to be registered in some form so that the material can be remembered and analyzed. The most common way to do that is to use a tape recorder. Using a tape recorder gives the interviewer freedom to focus on the subject and the dynamics of the interview (Kvale & Brinkmann, 2009). However using a tape-recorder can also influence the interview situation in a negative way. According to Thomsson (2002) the use of a tape-recorder can make the respondent uncomfortable during the interview. Just the knowing that what is told during the interview can be listened to repeatedly afterwards puts a pressure on the respondent to answer correctly. It is therefore important that the interviewer takes this serious and informs the respondent on why the use of a tape-recorder is important and that confidentiality and anonymity will be protected.

**Selection of participants**

Inclusion criteria for the selection of the participants were as following; the participants had to be nurses and they had to be or have been working with children who suffer from malnutrition at one specific clinic in the highlands of Papua.

The selection of the participants was conducted at the hospital in the children’s ward. The authors established contact with the head nurse at the ward and the seven respondents were selected after the authors had been introduced to the nurses working with children who suffer from malnutrition. Five women and two men were selected for the interviews. The respondents were chosen to get a variety in gender, working experience and cultural origin. The amount of years working with children who suffer from malnutrition ranged from 3 months up to 19 years. Only one of the respondents was of traditional Papuan origin. The other participants were born in Papua or had moved there and were of other cultural background. The participants’ knowledge in the
English language varied and none of the participants felt comfortable communicating in the English language.

**To use an interpreter**

To use an interpreter affects the whole interview situation and a lot of things has to be taken into consideration when doing it. Not only has the authors to be aware of their own pre-conceived understandings but also be aware of the interpreter’s as well.

**Qualitative content analysis**

Kvale (1997) describes the purpose of the qualitative content analysis as being a way to describe and interpret the themes that the respondents express in his or hers life world. Lundman and Hällgren Granheim (2008) further describe the qualitative content analysis as putting the focus on interpreting the text. They also say that the method is useful in an area such as nursing science. The inductive approach means that the researcher analyzes the text without any preconceived thoughts and this is used when the respondents experience is in focus. This also means that the approach the qualitative researcher takes is the one that “truth is to be found in the eye of the observer”. This approach is a guideline in qualitative research. When analyzing a text the author should also see the context surrounding the text and the respondent, which means that the respondents personal history, life world and culture has to be made aware. This further leads to that a text can have many possible interpretations and all can be reliable. With a qualitative approach to a study the researcher change from being close to keeping distance to the studied object. With a narrative interview the respondent is free to tell about the phenomenon the researcher wants to study. To keep the interview flowing the researcher stimulates it by asking follow-up questions. This makes the researcher an active part in the creating of the text.

The researcher’s involvement in the text is hard to avoid in the qualitative data collecting process. To give the study credibility, reflection and discussion between the individuals of the research team is an important aim towards unanimity in the analysis. The authors use some terms to describe the analysis process and these are analysis unit, content area, meaning unit, condensation, abstraction, code, sub-category and categories. An analysis unit can be whole interviews. Content areas are parts of the text including a special area and can be different phases of the phenomena studied. A meaning unit is a part of the text, which carries a special meaning; these meaning units are the basis of the analysis. The next step in the process is condensation, abstraction and coding the meaning units. This is done by making the text shorter, lifting it to a higher level and then making codes that describe the content of the meaning units. During this part of the analysis it is of great importance that the substance of the meaning units is not lost. Sub-categories are made by putting codes with similar content together in groups. All data that answers the aim of the study has to be put in a sub-category and no data is allowed to fit in more than one sub-category. Further the authors explains that this can be hard when the study is about peoples experience for they are often woven in together and hard to separate from each other. Finally at a more interpretive level categories are being made by finding a meaning that flows through sub-category after sub-category (Lundman & Hällgren Granheim, 2008)
The data collection

The authors prepared the opening question, “How do you experience working with children who suffer from malnutrition” beforehand. Since none of them had any deeper knowledge or experience of the Papuan culture the question was read by several people with cultural insight so that misunderstandings could be avoided. One of the interviews was held at the hospital ward, three were held outside in the open air and three in a separate room in another part of the hospital complex. The interviews lasted as long as the respondents had anything they wanted to say, which in fact meant the length of the interviews ranged from 20 to 60 minutes. Both authors participated in all seven interviews. A tape recorder was used for all the interviews and the respondents were asked for permission to use it before the interviews started. All interviews started with the authors introducing themselves and the study and the respondents introduced themselves as well. One of the authors led the questioning and the other started the tape recorder and kept a record of the respondent’s body language and acted as a support in the questioning. The two authors took turns interviewing and supporting. The interviews were held in the English language since none of the authors spoke Indonesian. An interpreter familiar with English and Indonesian was used during all the interviews and he was informed about the aim and the purpose of the study and informed about the importance to translate the questions and the answers correct and not add any personal thoughts or opinions to the translation. The interpreter was repeatedly informed about this before every interview was being held. In the beginning of the interviews the authors informed the respondents about themselves and about the aim of the study. The respondents were also informed of the purpose of the study and that there were no right or wrong answers but that their subjective experiences were valuable. The authors informed the respondents that their participation was voluntarily and that they could stop the interview if they felt uncomfortable or simply did not want to answer a question. Follow-up questions were asked to expound the Respondents’ answers continually during the interviews. The respondents were informed that the recorded interviews would be transcribed and that all the material would be confidentially handled. The data was collected over a time period of seven days and were transcribed after each interview.

Analysis of the collected data

The data was analyzed according to the qualitative content analysis as described earlier. The collected data, the interviews, were transcribed and then read through several times as soon as the interviews where conducted so the authors had a chance to contact the respondents if any questions concerning understanding appeared. This also assured the authors that the collected material was enough for the study as well as it was valuable concerning the aim of the study.

The two authors separately took out meaning units from each analysis unit with focus on the purpose of the study. The findings were then discussed and compared until unity and agreement was reached on which meaning units were of importance for the study. The meaning units were different as some consisted of larger parts of the text where as some consisted of a meaning or only one word. The meaning units were then condensed, abstracted and coded one by one. The coded meaning units that had similar content were put together in sub-categories and no meaning units were left out just because they could not fit in any sub-category. During this last part of the analysis the
authors could see a read thread going through some of the sub-categories and these were put together and formed the categories. The headlines were formed after three large areas that were found when reading through the interviews.

**Result**

The result is presented in the table below and further described in categories and sub-categories in the following pages.

<table>
<thead>
<tr>
<th>Headlines</th>
<th>Categories</th>
<th>Sub-categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hindrance of health</strong></td>
<td>Lack of compliance</td>
<td>Experiencing problems with patient and family not following treatment or refusing treatment Experiencing lack of cooperation</td>
</tr>
<tr>
<td></td>
<td>Experiencing parents not caring for their children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experiencing feelings of frustration</td>
<td></td>
</tr>
<tr>
<td><strong>Health improvement</strong></td>
<td>Educating and involving the family</td>
<td>Ways to increase trust</td>
</tr>
<tr>
<td></td>
<td>Positive feelings as a motivation</td>
<td>Building caring relationships</td>
</tr>
<tr>
<td></td>
<td>Working through relationships</td>
<td>Experiencing patience as important</td>
</tr>
<tr>
<td><strong>Challenges</strong></td>
<td>Understanding the highland culture</td>
<td>Belief in traditional medicine</td>
</tr>
<tr>
<td></td>
<td>Communication</td>
<td>Belief in spiritual beings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experiencing distrust</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experiencing a different lifestyle</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experiencing different values</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experiencing language problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experiencing lack of knowledge and understanding</td>
</tr>
</tbody>
</table>
Hindrance of health

The respondents experienced many things hindering the children’s health, lack of compliance and the parents not caring for their children enough were things that hindered the child from getting healthy. The respondents expressed not only having to deal with outward things that hindered the health process but also having to deal with feelings of frustration and hopelessness within themselves.

Lack of compliance

Compliance was by most respondents mentioned as being an important part in the health gaining process. Lacks of compliance was mentioned when patients did not follow a medical treatment or were they refused the treatment or any care that was offered. The respondents talked about the parents as being a cause to if there was compliance in the treatment and in the care of their children.

Experiencing problems with patient and family not following treatment or refusing treatment

All the respondents expressed difficulties and problems having to do with refusals of treatments that were due to the fact that many of the children needed to get injections of Antibiotics on a regular schedule, which also meant getting injections during the night. Several respondents expressed difficulties with parents refusing those nightly injections being given. One respondent said that during the last five months about 90 percent of the patients did not receive medication at night and that they were used to getting more refusals to the treatment than acceptances. The same respondent also said that the status of the child could tell whether the parents had refused treatments or not (Interview no 7). Another respondent said that if the patient had never been to hospital before they were more likely to refuse the treatment (Interview no 2). Most of the respondents related this problem with refusing treatments during the night to the patient and their family’s traditional beliefs. Not only did the respondents express problems having to do with refusal of medical technical things like injections and nasogastric-tubes but also with more basic care related things like giving milk and regular food.

The difficulty is the tradition of the people they often don’t receive the treatment we want to give well.”...“Like with the injections, when we have scheduled the injections for the morning afternoon and the night. The night injection they (the parents) often refuse. That has something to do with their traditional beliefs. (Interview no 4)

The respondents further explained this refusal having to do with their beliefs in spiritual beings.

They don’t want to get an injection because they think that the injection is being done by an invisible or spiritual being that comes in the form of a nurse. (Interview no 3)

We experience a lot of problems with the parents, for example the ngt (nasogastric-tube) is sometimes refused by the parents, even drink milk they rarely want. There we face problems with families that give difficulties. (Interview no 5)
The respondents’ reacted differently to the refusals. Some of them got emotional and got into an argument with the parents. Another respondent who was more experienced said that she did not gain anything by arguing or pushing it only meant that the parents would take their child and go home. So she said she gained more by having a sensitive approach and by respecting the parents. Another respondent also took it as a personal let down and she felt said about her good intentions not being recognized by the parents.

Sometimes we get into an oral fight, like we start fighting. Not fighting but uhm...arguing with the parents, why do you refuse the treatment? (Interview no 3)

If we push too much they go home. It’s very hard to give understanding but also to have respect. Because they go home and they don’t get anything anymore. (Interview no 1)

We feel very sad because we do these things to heal the patient and then the parents refuse the treatment and we feel very sad. (Interview no 4)

Experiencing lack of cooperation

The respondents were used to working together with the parents and talked about the importance of involving parents in the care of their children. Sometimes the respondents experienced lack of cooperation, which they said affected the healing process of the children. All respondents wanted the parents to be involved in the care of the children but often found this being complicated. The respondents experienced the parents not cooperating as a hindrance in the care.

Of thirty kids there are only one or two mothers who are really helpful, it’s very difficult. (Interview no 1)

The parents were not really enthusiastic about the treatment not really supporting like in the healing process and sometimes that hindered us in the care we gave. (Interview no 3)

Some respondents experienced a problem with children having too many people staying with them at the hospital, even though the nurses had told them to only come with a few relatives. At the same time the respondents expressed difficulties concerning feeding the child since other family members needed food too.

We used to tell them not to come with many people but they don’t listen to us. ... Normally they come with five family members although we would like them to be with two family members only they come with more. They also bring their healthy children here. They often don’t bring food themselves so they share the food for the patient with the other children. (Interview no 5)

Some of the respondents expressed a need of controlling the parents since they felt they could not trust that the parents did what was best for there sick children. The respondents felt needed to control the parents concerning the food or administering
intravenous fluids. The respondents expressed problems with the parents eating the child’s food and they said it was due to the fact the parents also were hungry and did not have any food.

*We normally ask help from the parents.*” She also said: “If they refuse the sond (the nasogastric-tube) we will keep standing there till the parents have given the whole glass of milk with a spoon through the mouth. (Interview no 5)

... when the food comes out of the kitchen and they (the cooks) just put it next to the child and there are no nurses or nurses are busy or something. The parents don’t understand and the parents don’t feed the child and after a few hours the child is still hungry and the parents have eaten and they say the food is finished...We weigh the kids every morning and we ask the mother if he (the patient) finished the food and they say - Yeah! But it’s not possible because the child doesn’t gain any weight... If we put an IV line in and count how many drops an hour and stuff like that they just open it because they think that half an hour is very good if it’s finished and then they know they just get a new one anyway. They get very mad if you put it really slow because they don’t understand. Really mad, more mad and fight. (Interview no 1)

Experiencing parents not caring for their children

Many respondents meant that parents’ lack of care also was an issue that hindered the children’s health. The respondents experienced that the children often got sick again after coming home from the hospital, they also experienced that the parents did not realize in time that their child was getting worse and take the child back to the hospital.

*We say to the mother: Why is this child sick again? Maybe you didn’t take care of it? Because parents are still stupid with their children, they don’t want to learn because normally when the parents come their child is already terrible sick.* (Interview no 3)

*It’s not even the parents idea often to come here because the parents don’t see it, they don’t understand at all that the children is getting skinnier and that it’s not normal. They don’t see at all.* (Interview no 1)

Some respondents said that if the parents had cared more about their children in the beginning when their children were born healthy it would have prevented the children from getting diseases. The respondents also said that the parents should have taken more responsibility in what kind of environment their children grew up in and also in their hygiene.

*I tell especially about the people here. The children get runny noses because of the rain. From the childhood they get big children, but they don’t give good regulated care, they don’t give the food they need and finally they get diseases.* (Interview no 2)
Often the malnutrition comes from the parents, the personal hygiene as well as the environment they are staying in is not clean. (Interview no 5)

One respondent also said that the parents lack of care were one of the main causes to child malnutrition, children did not get good food from their parents. In the respondents eyes the parents looked healthy while their children looked skinny.

The parent’s body is healthy and big but the child has malnutrition like they don’t give food, only the sweet potatoes, sometimes they don’t even eat rice. (Interview no 3)

Parents can also be a hindrance for their child getting healthy in the hospital when they care more about their own hunger than their sick child. Many respondents experienced the situation very difficult to handle.

... if we don’t wait by the patient’s bed the parents tend to eat their child’s food and they excuse it with that the patient didn’t eat. But in fact they are hungry themselves. (Interview no 5)

It can make me sad and sometimes also angry when I see that the parents eat the food and the child doesn’t get healed. (Interview no 3)

The respondents explained that some parents did not care if their sick child did not eat or did not want to eat. The respondents meant that the nurses had to be close to the bed and watch so that the sick child ate the food.

They say that the kids don’t want to eat and they (the parents) don’t care, this is one of the difficulties... and I also learned that a nurse has to be there and sit with the child, otherwise the parents will eat the food so they can say it’s finished. (Interview no 1)

... we sometimes say: “mama let the child eat the food, not you” and we start feeding the child in the late afternoon and the parents eats it again. (Interview no 3)

Experiencing feelings of frustration

Most of the respondents expressed feelings of frustration when caring for children with malnutrition problems. One of the feelings they experienced was hopelessness since they could not do anything about people’s religious beliefs, which hindered the child from recovering. Some respondents experienced sadness with the condition of the patient they had treated because they had not been able to give the help the patients needed to stay healthy. The respondents expressed feeling sad and even angry when the parents ate the children’s food.

I feel very disappointed, why they don't listen and do what is good for the patient. (Interview no 7)
It can make me sad and sometimes also angry when I see that the parents eat the food and the child doesn’t heal. (Interview no 3)

Many respondents felt sad when a child died and also because they could not do more to help. They also had to deal with why parents did not do the best for their children, refused a treatment or stopped a treatment and instead took the child to a traditional doctor. Many times the respondents did not know what happened to the children when they had left the hospital and the chance was big that they would never see the child again, as many of them probably died.

... so they promise to come back with the child after they have received this traditional healing practice, often they don’t come back and we think that maybe the child has already died. (Interview no 3)

One of the female respondents related her frustration and anger to some of the other nurses at the hospital who she experienced did not have the patient’s best in mind. They complained about the patients and just wanted to get their payment.

I get frustrated and also angry, even on the nurses, because I am head of the nurses. Sometimes I say to a nurse to take one hour and feed a child but she sleeps, a specially the local people. If I say anything about it they say: I have done that already! It frustrates me... it’s very difficult because now the older nurses are like that, because some just come for the big salary here but they don’t like the people they say they smell and stuff like that. (Interview no 1)

The respondents also meant that the doctors expected them to follow out the medical ordination, which they themselves experienced hard to do since the patient did not cooperate.

... in the morning the doctors come and they get angry at us “why didn’t you give this shot” and I answer “we tried to explain to the patient and then he doesn’t want. (Interview no 1)

Health Improvement

The respondents worked to improve the children’s health and important ways to do that were educating and involving the family, having caring relationships between the nurse and the patient and the nurse and the patient’s relatives. The respondents experienced a tough working environment and therefore positive feelings in themselves were held up as a motivation in the work towards improving the children’s health.

Educating and involving the family

The respondents’ purpose with educating and giving information to the parents were different. One part of the information was about how to give medical treatments to the patient and basic care. That kind of information was given to explain what the nurses were about to do and to get the family to accept the treatment. Examples were given that
had to do with intravenous antibiotic treatments, the children getting a nasogastric-tube as well as the children being fed.

*If they refuse the injection so we immediately put the medical stuff in another room. Then we explain that it’s good for the patient and how it works. If we explain well they may take the medicine.* (Interview no 2)

The respondents sometimes informed the patient and their family from a health improving and illness preventing perspective. That kind of information and education was about personal hygiene, birth control and diseases. Some of the information and education that the respondents gave were concerning the parent’s own health. They meant by this that improving the parent’s health also meant improving the child’s health.

*We also teach that health goes for all because if you are sick you cannot work... That way I can teach the parents a lot and maybe their child doesn’t have to get sick again. Because normally when the child is healed it becomes sick again.* (Interview no 3)

Another respondent added further to this by saying that people who get more education from the nurses can take care of their children in a better way, if they do not get a disease which they could not cure without medical help. The communication had to be ongoing during the hospital stay according to some respondents, so that the information would stay with the parents and give result. Such information could for example be on what food is important and why it is important and the importance of food hygiene.

*We also share with family about how to give food and the hygiene so they can independently go on with the good treatment.* (Interview no 2)

Positive feelings as a motivation

Half of the respondents said that positive feelings encouraged them to keep working and gave meaningfulness in their work. The positive feelings the respondents talked about were joy and hope. Most of the positive experiences were related to children getting healthier and that it gave the respondents joy.

*I liked when it once happened that the nurse fed the patient through the nasogastric-tube and the parents also tried to do that besides the nurses and that child healed very well and I liked that... I like it when the family understands the treatment and like their knowledge increase like we learned in school. That I can also give (something) to the parents when they see that there child heals.* (Interview no 3)

Though most of the respondents related positive feelings to when the children got healthier one female respondent with a long working experience expressed her belief in god as being a crucial reason for her to keep working.
I know that God gave me this responsibility and I have to do it, which is why I have kept going for 19 years. Just because I know that God gave me this responsibility so I do it for him (God). (Interview no 1)

Working through relationships

All the respondents talked about the nurse-patient/family relationship as being important. All the work being done depended on a good relationship. Building trust in the health care system, staff and in the relationship was considered important. The respondents also experienced that it was important to have patience and understanding in the caring relationship.

Ways to increase trust

It was obvious for the respondents that trust in the caregiver and in the health care was important if health was to be improved in the children. Most of the respondents found it hard to win the patient and the family’s trust and ones it was lost it was hard to win again. Trust could either be rising due to positive experiences or ruined by bad experience from the health care. The respondents expressed a cultural reason as to why or why not trust was gained. The respondents were of non-Papuan origin and did not speak the local languages which they said was problematic and the respondents solved this by using local people in the care even though they did not have the education required. The respondents expressed that this way the confidence in the healthcare staff as a whole could be gained.

... it’s important that we use the local people because the trust is way bigger and of course also the language. So that’s why we need to have the combination of staff.” She also said: and then we get more patients so they bring the sick people because their trust is rising. (Interview no 1)

Building caring relationships

The respondents had different ways of expressing to the patients that they cared for them. Even though the ways were different they expressed the importance of showing that you care for the patient. When the patients or their family reacted positively to an action being done by the nurses the respondents could take this action and implement it on all patients like with prayer for the patients. A program had been made were they prayed for the patients and their families every Sunday. The respondents’ experience was that touch could be used as a way to show the patients that they cared for them.

They are very sensitive every morning even though I don’t do anything special (medical) I just say good morning to them...the very important thing is to have a very personal and open relationship with the patient because they like that. They very much like personal attention. They love it when we pray for them so every Sunday we have a program. (Interview no 1)

Experiencing patience as important

The respondents faced language difficulties, cultural differences and misunderstandings in the caring situations. Being nurses with more knowledge on caretaking the respondents expressed a responsibility to have patience and not get mad at the patient or
the family when hard situations occurred. Having patience was related to both practical caring situations as well as in the educating situation.

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\text{We have to control very much and every meal we have to see how much the child is eating and how much went in and that child doesn’t like the food because it’s different and it’s very difficult so we have to pay a lot of attention to it... you have to be very patient and explain again and try not to get mad to explain and to know they are low educated they just don’t understand. (Interview no 1)}
\]

Challenges

Challenges in life and in the working environment are common in every society as well as in the highlands of Papua, and that’s what the respondents are experiencing. Even if some of the challenges they faced seemed to be different than what the nurses in western countries are facing. The respondents expressed challenges that were connected to the culture and their traditions, which made it difficult to influence or to deal with some of the biggest issues.

Understanding the highland culture

The respondents did not feel integrated in the highland culture, even if some of them were born and lived in Papua. The culture and the traditions of the highland people were so different that it required a lot from the respondents to understand the people and the culture so they could act trustworthy.

Belief in traditional medicine

One of the issues mentioned was the belief in traditional medicine, which was strongly integrated in the ordinary life of people through thousands of years. The belief in traditional medicine was much stronger than the belief in western medicine because people were neither used to the hospitals nor to be in contact with caregivers such as nurses and doctors.

\[
\text{They also believe in traditional medicine. Before the hospital was built they had that. If the parents think the child won’t get healed they take the child to the traditional medicine man. (Interview no 7)}
\]

One respondent explained the traditional medicine as being a combination of traditional treatment and traditional prayer. The same respondent gave the impression that people’s trust in hospitals was not so strong and that it made them leave the hospital and take their children home to give traditional treatment instead.

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\text{They give up and take the child home also to give traditional treatment and traditional prayer... they use traditional medicine like from leaves, that’s what I know only from my friends. (Interview no 3)}
\]
Belief in spiritual beings
Many of the respondents found it challenging to work with the patients and their families because of the belief they had in spiritual beings. They did not like to get injections at night, because they claimed that invisible beings were in action and wanted to kill the child. It was very difficult for the nurses who got the ordination on nightly medicine from the doctor and could not carry it out during the night.

They don’t want to get an injection after eight at night. Because they think that injection is being done by an invisible or spiritual being that comes in the form of a nurse. (Interview no 3)

The respondents knew about the belief in spiritual beings so-called “swangys” being a part of the Papuan society. The “swangys” were said to be in action at night and wanted to kill the people. If the nurses wanted to give medicine or injections at night the parents thought that the nurse wanted to kill the child. Because they believed that the “swangy” came in the form of a nurse to take their child’s life away.

They also thing that the one who gives treatment at night is not nurses but the Swangys. (Interview no 7)

Quickly the ideas come to parents that the nurse wants to kill the child so often the family to the patient refused to take medicine at night. (Interview no 2)

Experiencing distrust
The nurses who work at the hospital and the patients lived different lives in many ways. For example the beliefs, the values of life, education and knowledge about the modern world were different. It was of major importance for the patient that the nurses had a trustful relationship with the patient and their family to be able to give good care. Many respondents experienced distrust from the patient and their family and they related this to the fact that the respondents were immigrants or even because they were more educated.

They are afraid that the nurses will do something bad at night like immigrants or people who are educated. (Interview no 2)

The respondents also experienced that the patient’s family misunderstood them even if they did things with a good intention. Therefore the nurses felt a need to clearly explain to the family what they were doing and also to get the parents involved before giving basic care, such as giving food. This was done to preserve a trustworthy relationship so that the children would get the best possible care.

... No! I know how he is treating me. It’s too bad because a lot of sick people just go home because of that so they don’t get better first and then they go home, but I can’t do anything about it. (Interview no 1)

Experiencing a different lifestyle
Some of the respondents said there was a big difference in the lifestyle people have in the highlands compared to the respondents’ lifestyle. They even said that the lifestyle could be one of the reasons to child malnutrition.

*One of the main causes for malnutrition is also that they have too many children to take good care of them.* (Interview no 1)

The respondents experienced a different lifestyle in the meeting with the patients. The fathers were used to hunting and fighting so the mothers had to be home and do all the rest so that life could move on. That was why the mothers had to take care of all the children at home and at the same time take care of the garden so that they had food for the whole family. When a child was admitted to the hospital it often came together with a relative because the mother could not stay in the hospital too long because she also had the responsibility of the other children at home.

*Sometimes it’s the older brother or sister that has to take care of the child because the parents have to provide for the rest of the family and the mother cannot stay here because she can have another ten kids at home and the father have to work and try to get money for the rest of the family... so the mother has to go and take care of the children and take care of the food and the garden and they cannot just stay so long.* (Interview no 1)

One respondent said that the food the Papuans ate and the water they drank had a major negative impact on problems connected to malnutrition in the highlands. The children used to get diarrhea due to the fact they did not boil the water.

*... a lot of diarrhea as well because they don’t boil the water before they drink it so they just drink the water like that and it makes them skinnier and skinnier and they just have diarrhea the whole time.* (Interview no 1)

The respondents also said that most food the mother got from the garden was sweet potato and also that it was the only food the children were used to eating. This kind of food was known not to be rich in vitamins. If the nurses then gave the patients new kinds of food like fish or other vitamin rich food the children did not like it because it was a totally new taste for them.

*They need the fish and stuff like that but if the children are not used to it they spit it out. They don’t like the fish and that kind of food because it’s new to them... so they have a lack of vitamins because of only one sort of food.* (Interview no 1)

One of the respondents explained that the families were living in huts in the highlands and that it is cold they have to make a fire inside, which in turn causes problems for the family because the smoke from the fire affect their lungs in a bad way. She also thought that was the reason why many children were in a bad state when they arrived to the hospital.
Most kids that we get here is with diarrhea and that’s you know one of the malnutrition (causes) and also with their lungs because they sleep in the huts and they make fires in the huts and all the smoke so the children’s lungs are very bad. (Interview no 1)

Some respondents said that the hygiene also was a contributing cause to malnutrition. Children were not used to taking showers or cleaning themselves with soap. They often walked several days through a tough and dirty environment to get to the hospital. This put them in a worse state than they were in at the beginning of the journey when they set out to get help.

And the patient came very dirty so we take care of the personal hygiene. The patient came in dirty for three days and then it dies. We gave food at a regular time but the patient dies anyway, because the patient came in a very bad state. (Interview no 7)

They take showers once a week and they don’t even wash themselves with soap or anything so that’s very difficult. (Interview no 1)

The respondents explained that the lifestyle had a major impact on the children who lives in the highlands. They are poor and even if they get money it does not make things easier. The culture they are used to goes back long in history.

One of the reasons is the economical situation that they are so poor and also because of they are pregnant so often. (Interview no 1)

Some came from very far and some couldn’t be helped anymore. (Interview no 7)

Experiencing different values
One respondent explained the challenge in dealing with the values of the people from the highlands. The respondent experienced that the human life was not valuable and that it was lower than a pig’s. She further experienced that when the people did not have any hope for the future their lives were centered on a few things.

... their garden and their kids and their pigs that is what it’s all about. Their values are different so life is not so valuable... they don’t care about human life, the value of life is so low it’s like a chicken. (Interview no 1)

Communication
The result shows most respondents considered communication problematic. Some of the problems were related to the language differences, though using local people for translation sometimes solved the problem. Explaining things was hard because the local people’s level of knowledge was low according to some respondents. The reason for this was thought to be that the people were isolated from the rest of the world and therefore could not learn new things. The respondents experience was also that conflicts
were created when the parents did not understand what was being said or done by the nurses.

Experiencing language problems
Some respondents explained the challenge to work with children who were admitted to the hospital with their relatives or parent’s who could not speak the language the respondents speak. It became a big problem when you could not explain what you were doing to the children or to involve the parents in the caretaking.

Because we are immigrants it’s difficult to communicate with the family, they often don’t understand what we say. (Interview no 3)

To solve the language problems the hospital had hired local people from the highlands who could speak and understand the local languages. This meant the nurses had to communicate through the local people to reach the parents or the child.

It’s very difficult because the parents often don’t understand the language so we use the local nurses to translate and to try to explain to the parents so that they understand what we are doing to the child. (Interview no 1)

We use the local people from here because they don't understand the nurses who often speak Indonesian. (Interview no 1)

Experiencing lack of knowledge and understanding
Many respondents felt that the understanding and knowledge was very narrow in people from the highland, which made the nurses work with the sick children difficult. It became a burden and a big challenge when parents did not understand why the nurses were doing things they did and had to explain everything to the family who did not understand.

When we have problems with the parents we go into the office and we explain why thing have to be done the way they are done. There can be people who understand it and sometimes they don’t. (Interview no 5)

It’s very difficult here because the people are so low educated and stupid in some ways. They don’t understand why we do some things. (Interview no 1)

The respondents said that the people in the highlands live in isolation and do not have much influence on or information from the outside world. Their experience was that people were still living centuries behind compared to how other parts of the world develop. Therefore the experience was that they did not have the understanding.

Because their understanding is still narrow they don’t have any contact with the outside world they sometimes don’t understand what we say or they don’t do as we say. (Interview no 3)

I think that’s the biggest problems that are so cut off the world so they don’t take part in what’s going on in the world. (Interview no 1)
Lack of understanding from the parents could sometimes create conflicts in the hospital; the parents expected the same treatment for every child even if the diagnoses were different. Sometimes the nurses had to put more attention and care in one child who was severely ill and it made other parents envious because they did not understand the priority. All they saw was another child getting more food or drink.

... they (the parents) don’t understand like the malnutrition children, they get food every five minutes, why that child gets way more and my child only gets a little bit and why don’t we get egg, you know. (Interview no 1)

The respondents explained how parents could get angry with the nurses because they wanted to feed the child when it was very ill. The parent’s did not understand why the nurses would try so hard. One respondent said that if the child did not want to eat the parent’s would not care.

Sometimes they (the parents) get angry with us too, they say: How you do feed this child? It’s impossible! (Interview no 3)

It’s very difficult because the parents often don’t understand why the kid is not eating. (Interview no 1)

One respondent explained that they also liked to inform and educate the parents, so that they learnt more about things that could give quality in life. But it did not gain much quality because parents often did not understand much of what the nurses were talking about.

...we can talk about birth control and they (the parents) don’t even understand the word. (Interview no 1)

Discussion

The authors of this study do not claim it to be transferable to the whole Papuan society or to all the societies in the highlands. This study is made in a specific area in the highlands of Papua with seven respondents, at one hospital and is about their subjective experience on working with children who suffer from malnutrition and therefore the result cannot be generalized. On the other hand the result can shine a light on things that needs to be done more studies about. Since the problem in the Papuan health care many times are to recruit healthcare staff and have them stay in one place a longer time this study could gain information to see what problems nurses face and what preparations could be done to prevent them from leaving their posts. We hope the time we spent in Papua in research and the areas we have enlightened in this study will give a taste of the matter and increase the understanding in how the nurses experience working with sick children in Papua.
Discussion of method
Data Collection

The Interviews
Having one on the beforehand prepared question seemed to be a good idea since the authors could not find enough background material to prepare for the field and the study. There seemed to be a lack of scientific literature and any literature at all about Papua and Papuan health care. The authors of this study set out to do about five to ten interviews since this is the amount of interviews recommended in literature (Thomsson, 2002). Not only the number but also the quality on the collected material has to be taken into consideration when deciding how many interviews should be conducted and when enough data is found. We decided after seven interviews that enough material was found.

The first interview was held with the most experienced respondent and that interview turned out to be the longest and the one with most information as all the material was collected. Not only did the length of the interviews vary a lot but also the quality of the interviews. This is seen in the result were a few of the interviews are more frequently cited than others. The authors are well aware of the fact that this could have been avoided if more interviews would have been conducted and mostly if the quality of the interviews would have been higher. Follow-up questions were asked in all the interviews and due to the lack of experience of the interviewers the questions sometimes tended to be leading even though the interviewers tried not to affect the result by asking leading questions.

Even though one open-ended question seemed to be a good interview method the interviewers found it hard to keep the flow in the interviews. The Indonesian culture seemed to affect the interview situations as well; the respondents were shy and not so used to speak out freely. Therefore the interviewers might have gotten more material if more questions had been prepared beforehand so that the respondents could have felt more relaxed. The respondents also expressed worries about not being able to give the right answers. This was found early in the interviewing process and therefore the interviewers made sure to inform the respondents even more clearly about the purpose of the study and that there were no right or wrong answers in the interviews.

The interviews were conducted in three different places. The best seemed to be were the interviews were held in a separate room at the hospital not so close to the ward were the respondents were working. There the respondents still felt at home but the place was also neutral and separated from the other colleagues. Two interviews were held outside and this also seemed to have a relaxing affect on the respondents, which did not have to feel like they had been put in a room for a test but that the freedom outside seemed to create a good interview atmosphere.

The Participants
The authors met no problems getting participants to the study but a larger sample of participants would have been hard to find if the inclusion criteria was to be followed. The variety in gender as well as working experience was not hard to find in the
respondents and the authors soon met other difficulties instead trying to understand the Indonesian health system and the different levels of nursing degrees. Shields and Hartani (2003) talk about this nationwide standardization issue. The time frame of this study did not give us any choice as to leave the difficult task of trying to understand the nursing degrees and instead focusing on the health system which was easier to grasp. One of the respondents was of traditional Papuan background. The interviewers would have wished for more participants of traditional Papuan background so that the concept of trust and distrust in the caring relationship could have been more explored.

The participants were all told that the participation in the study was voluntarily. Though all participants volunteered some pressure to participate could be seen from other colleagues and therefore one respondent felt uninterested in really participating but still went through with the interview. The interviewers could feel this and the answers to the questions seemed to have been prepared beforehand which the authors realized also could affect the result.

Using an interpreter

The authors of this study were from Sweden and the respondents were from Indonesia or Papua, neither the authors nor the respondents had English as their native language and to use an interpreter for this study was therefore necessary. The interpreter was Dutch and did not have much experience in interpretation and no experience of working in a hospital environment. Even though not being of Papuan or Indonesian origin the interpreter after nine years in the country felt at home in the Papuan culture and had deep knowledge and experience of the Papuan culture which Kapborg and Berterö (2002) describes as a good qualification to have besides the language.

The interviewers felt limitations in using an interpreter; it would have been more satisfactory to speak the same language as the respondents and not having to rely on an interpreter for the understanding. The interviewers could not hold a long conversation with any of the respondents because of the language differences. It was challenging for the interviewers to do a research and having to rely on an interpreter for such an important thing as the data collection.

The interviewers put more attention on the respondents’ body language to understand their expressions of feelings and the interviewers also could observe the interest in answering a particular question and thereby notice how short or long the answer was. A difficulty with using an interpreter was that the interviewer did not know when the interpreter summarized or modified the responses. The interviewers experienced that using the same interpreter in too many interviews sometimes had a negative impact on the interpreter’s commitment to translate the response (Kapborg & Berterö, 2002).

Language difficulties

An interpreter had to be used to make the communication between interviewer and respondent a reality. The Interviewers only new a few words in the Indonesian language but they seemed useful when using those few words made the respondents more comfortable and more equal to the authors who otherwise has the most powerful position in the interview situation. The respondents talked freely in Indonesian and the interviewers felt frustration during the interviews due to the fact that they could not
understand directly what the respondents were answering. This frustration could be seen in the respondents as well and it might have affected the result of the study in a negative way.

**Data analysis**

The transcriptions of the interviews were time consuming but also very important and made out to be a good ground for the coming analysis. The authors did half of the transcriptions each and where questions arose concerning what was said they conferred each other.

When the analysis work started the authors not doing it together took out meaning units from all the material. After doing this they compared and discussed the result of this and agreed on what meaning units really answered to the aim and the purpose of the study. Doing this the authors mean the reliability to the analysis is stronger. Putting the pre-understanding aside is hard especially when findings from a study correlate to the knowledge about the culture. The authors, being two, found it good to question each others assertions and assumptions during the analysis process, though they are aware that putting ones pre-understanding aside totally is impossible. Being aware and making each other aware of it is a good way to avoid that the pre-understanding affects the analysis too much.

**Discussion of result**

The result is presented and discussed following the headlines of the result, hindrance of health, health improvement and challenges.

**Hindrance of health**

Many world organizations and countries are working hard to find solutions to reduce child malnutrition around the world. Sometimes the biggest problem related to child malnutrition can be found within the family, the culture of the people or in their traditional beliefs. As the result shows that the nurses experience the family refusing treatments and lack of compliance as a big problem in the Papuan highlands where they have a hospital and medical staff with knowledge to treat and take care of many patients. But the question is how much can nurses by them self do to reduce the child malnutrition in Papua. Nurses meet a lot of conflicts in the situations with parents who do not listen to them or are not helpful in the care of their sick children. The nurses also experience that parents do not care about their children. In many cultures people take for granted that all the parents do care about their children and would die to save their beloved child’s life. Sure there are Papuan parents who would do anything for their children. But the problem nurses experience is also that some parents do not care if one of their children dies, because they may be used to it or because they have more children at home. Sometimes the nurses got frustrated with the parents because they ate the child’s food but on the other hand starving as a parent is not right either.
Health Improvement

The nurse’s works are one of the most important parts to improve health in Papua and to inform and educate parents in health care. To do that the nurses have to come closer to the Papuans heart through building relationship, otherwise it will be difficult to do any improvement in the area of malnutrition. As many nurses says it is of great matter to let the positive feelings be a part of this psychological hard work as to work with the sick children. To feel joy and happiness when a child get healed or to feel hope when it looks dark sometimes is what every human being need to keep on the good fight. Another thing that motivates a nurse to take responsible and do that year after year is that she felt the calling from god.

Through having a combination of staff the nurses laid the foundation to a good relationship with the Papuan people who trust their own more than the nurses with Indonesian background. When two cultures meet it is of major significance to have patience to learn to know each other and understand the different way of approaching life situations and difficulties.

Challenges

To be working as a nurse in the highlands of Papua is a unique feeling and also full of challenges and adventures where the nurses work with one of the world’s most isolated and unexplored people in the world. Still the nurses have the most difficult area to manage working with children who suffer from malnutrition where many of them die. When the question was asked about nurses’ experiences working with the children in Papua, the nurses’ answers were filled by challenges they experience in everyday work. One of the biggest challenges the respondents experienced were how to deal with the culture in the highlands.

Hospitals, doctors and educated nurses are something new in the Papuan society. Papuans are used to thousand years of traditions where the sick people go to traditional doctors who treat them with spiritual rituals or by leaves or in other traditional ways. Naturally it is a lot easier to believe in something people have been using for many thousands of years than in something the immigrants has brought to Papua which Papuans even sometime do not understand at all. Surely it is a challenge for nurses to deal with this when they are caring for the sick children. The worries increases when more children get sick and malnutrition is spread among the people and Papuans still put their trust in their own traditions and beliefs than in the western medicine.

Most nurses were of Indonesian background and had immigrated to Papua or grown up in Indonesian families who lived in Papua. The nurses were Muslims or Christians and they were not in deep understanding of the Pauans peoples’ spiritual beliefs, for example the belief in Swangy’s (spirits). To know why the parents were so suspicious at the nurses and distrusted them during the care giving at night the nurses had to understand more about the peoples’ traditional beliefs. The Swangy is the spirit the Pauans believe comes at night in the form of a nurse whom has the aim to kill their sick child. From the parents view they tried to protect their child from someone who wanted to kill their child. This can create very complicated situations where the nurses are in a situation were they feel the people do not trust them. When in turn they only want to save them and give the best care possible.
Papua is one of the world’s most isolated places especially the Papuans who live in the highlands are cut off from being influenced from rest of the world. The surrounding is all mountains and jungles where the people have to walk long ways to be connected with people from other cities or small villages. There is a possibility to fly from some cities but most of the Papuans are so poor so they do not even have money to go by bus were it is possible to travel by bus. Gibney, Margetts, Kearbey, & Arab (2004) focus on the influence the environment has on child malnutrition. Children’s development are influenced by a multitude of factors such as genetics, health and nutritional status, the environment, the level of stimulation at home, parental education and culture or type of neighborhood. If the family lives in poor home with lack of stimulation or the mother is illiterate it can have a bad affect on a child’s nutritional condition.

The nurses’ experiences were that the lifestyles of the Papuans and the environment they live in have a negative impact on the child malnutrition in the Papuan highlands. Many nurses agreed that the Papuans have too many children and that they are not capable of taking care of them. One of the main reasons as to why they fail doing this is how the responsibility is divided between men and women in the family. The mothers in the family have the responsibility to take care of all the children and take care of the garden where they plant sweet potatoes which is the main food for Papuans. According to the traditions the fathers is used to go hunting or taking part in fights but now the fathers have to adopt to the new ways of being and therefore make money and take responsibility for the family. The fathers are far away from admiring this new responsibility or having to change a long tradition of lifestyle.

When a child is admitted in the hospital it often comes together with the mother or some other relative. Often the mother has to go back home to take care of the other children in the family. The Nurse’s ambition is to educate the parents to a live in a new and a different lifestyle fails when the parents are not available to get the information and the education from the nurses. To give preventive basic care the nurses needs to educate the parents in hygiene, birth control, nutrition and how to protect from negative things in the environment. The difficulty and the challenges the nurses’ face are procuring totally new information to someone who does not understand the content of the information as with birth control. The nurses had good intentions to educate about eating fish or about the importance of taking a shower or to stay clean and use soap to preserve health, but the nurses also knew that it required more to solve help and child malnutrition.

The main underlying cause to malnutrition is poverty, even if there are other affecting factors such as climate, food production, and breast-feeding habits, the level of education, cultural food customs and political and economical situation in the country. Directly or indirectly poverty causes malnutrition through situations as war, natural and civil disorder, low education for women, an unhealthy environment and insufficient child and maternal care, which in turn cause infections and diarrhea (Muller 2005). Nurses in the highlands can do a lot to take care of the children who are admitted in the hospital but may not be able to take the poverty away.

The nurses experience lack of knowledge about the parents and it affects the communication and understanding between the nurses and the family. The nurses have to use a local person to communicate with the patient or the family, which makes it
difficult to build a good relationship between them. When there is deficiency in communication it becomes easier to misunderstand and distrust each other. The nurses have to be patient and have the motivation it takes to understand that the people in the highlands live isolated and maybe nurses are the one of the few influences from the outside world that they meet and it will take time to change peoples’ minds or to gain trust between people.

Conclusion

This study was conducted in one of the world’s most remote places, the highlands of Papua. The interviews about nurses’ experiences from working with children who suffer from malnutrition rendered in more insight on what nurses face working at a hospital in the Papuan highlands. They experienced challenges and hindrance of health when working with the sick children. Never the less they also saw health improving when their work was successful. People’s beliefs, lifestyle and level of knowledge were some of the issues, which had a negative impact on the process of gaining health for children with malnutrition. Even if poverty may be the biggest cause to all the suffering, a financial solution does not seem to be the ultimate answer. Increased understanding of how nurses experience their work with children who suffer from malnutrition and many times also their families can be of value when support for the health personnel is needed.

Clinical Implications

The nurses, though not always aware of it, already worked with empowering the parents. This is a good way to not only give short time solutions for child malnutrition but to actually build long time solutions. To help children you have to help the parents, and to help the parents you need more than short time financial support. Empowering the parents is one of the long time solutions. Among other things the work with changing peoples old but not always good customs requires a lot of patience and much time. Building the trust that is needed for being able to change health related issues for the better demands time, understanding and knowledge. This study implies that there is a lack of knowledge about the Papuan culture and society. Equipping nurses with more knowledge on the Papuan culture and society and how to deal with problems related to these areas would be good in many ways such as helping them to face the challenges and hopefully give them more ways to go about the things hindering health.
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