

Research Article

Integrated management of childhood illness training needs on cadre for improve family and community capacity in simple handling of respiratory infection, diarrhoea, and less nutrition in children

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ABSTRACT

Background: Public awareness towards health services access required involvement of active community participation in health care neonatal, infant, and toddler through the efforts of Integrated Management of Childhood Illness (IMCI) at community. Cases of respiratory infections, diarrhoea and malnutrition is still a problem which needs to be resolved. The purpose to describe children health of the implementation of IMCI results and the possibility of involving the community through the ability of cadres in the management of sick children.

Methods: The method used is descriptive study, to describe the health of children and overview of the community needs through involvement of cadre in the success of IMCI. Data from the documentation Banyumas district health offices, health workers, and cadres. The sample size of cadre are 605.

Results: Results of the analysis showed that 54% of health centers has not been achieved coverage mortality rate of infants and toddlers. 5 of 10 cases patient who visit came after five days of fever, diarrhoea as endemic case (46.5%), pneumonia (21.4%), malnutrition (7.82%). Active cadre resource support for involvement in the community. Cadre weighing activities every month. IMCI coverage as low as 37%. It takes training a cadre of IMCI in the community as a step involving the community in the achievement of optimal health care, particularly focused on community issues. Furthermore, cadre as a companion of families and communities to resolve the health problems of children.

Conclusions: IMCI training to cadre priority to improve the ability of families and communities in simple handling for respiratory infection, diarrhoea, and malnutrition.

Keywords: Child health, IMCI, Cadre

INTRODUCTION

Parents have an obligation to provide protection to children, especially to the prevention of accidents and ill condition. One illness that is often faced by children is a respiratory disease, experienced by 50 % of children aged under five. Aspects of morbidity in the family are very important to prevent the morbidity of children¹. In addition to respiratory cases such as respiratory infections, diarrhea and malnutrition in children under five years also become a problem.

The achievement of the MDG's (Millennium Development goal's) 2015 in Indonesia is already quite good, but the increase did not reach the expected target. This makes the government decided to continue the program MDG's. Post- MDG's 2015's there was an agreement to develop a program of SDG's (sustainable development goal's), where the new global challenges need to be addressed by the world community.² Based on data from health districts Banyumas (2014), the mortality rate of infants and toddlers in Banyumas has increased in 2013 and decreased in 2014, but 54% of health centers in scope to the target has not been achieved IMR (infant mortality rate) < 8.7 and mortality of children < 9.6.³

Neonatal mortality rate in Indonesia is still considered the highest among ASEAN countries with relatively very slow decline each year. Neonatal mortality rate is 20 per 1,000 live births, which means that every 10 hours of neonatal deaths occur. The condition, caused by a major cause of death that could be prevented with early detection and appropriate treatment.⁴ Nevertheless, the tendency of child mortality, infant and neonatal decrease in line with the government's major efforts through community empowerment and health workers.⁵

The first treatment at the first referral expected to contribute to efforts to achieve the MDG's (millennium development goal's) health sector in 2015.⁶ Indonesia prepares SDG's program after MDG's. Sufficient knowledge of relevant health workers care essential obstetric and neonatal care, community development, planning and management is an important factor.

Public awareness towards access to health services required the active participation of community involvement in health care neonatal, infant, and toddler based standard that is through the implementation of Integrated Management of Childhood Illness at community (IMCI-C).

IMCI-C is the approach to infant and child health services, integrated with community involvement according to the standard IMCI. By the ministry under the supervision of health worker cadres through promotive and preventive approach.⁷

IMCI-C implemented in some countries, one in Pakistan which shows that there is still at least mothers who have children, knowing about nutrition in children and sick children governance. Communities need enough education so as to give strength to care for children, health education is the key to practice how to properly manage a sick child⁸. If IMCI-C can be applied in Indonesia will help the government of the base rate to prevent illness and reduce child mortality. Banyumas has 2508 active integrated health care (IHC), and recorded 99.04% active. IHC is managed by the cadres under the guidance Puskesmas⁹. Increased knowledge of the cadres is one of the important steps to help the community through promotive, preventive, and curative basis.

MCI at the health center services is not optimal, shown by 16 of the 39 health centers IMCI has not achieved its targets. The scarcity of IMCI is also experienced by all health centers, where there are only 1-2 health workers. Some health centers recorded reached yet doubtful considering the scope of IMR, child mortality, neonatal first visit, and exclusive breastfeeding is not reached. Banyumas Regency has a number of active cadres of 11968 people spread across 39 regions public health care.⁹

IMCI service limitations experienced by health centers in Indonesia. Figures IMCI health center coverage in the area is still 71.2% Purbalingga because of knowledge, workload, and training of personnel MTBSM owned. Purbalingga is the nearest town with Banyumas, only 6 of the 22 health centers health centers that have met the target of IMCI 90% coverage by government.¹⁰

The purpose of writing to describe the health of children results from the application of IMCI and the possibility of involving the community through the ability of cadres in the management of sick children in Banyumas.

METHODS

The method used is descriptive study, to describe the health of children and overview of the community needs through involvement of cadre in the success of IMCI. Data from the documentation Banyumas district health offices, health workers, and cadres. The sample size of cadre are 605.

RESULTS

Overview of child health

The following picture of child health as a consideration in determining the need for community involvement. Study on the state of the real society also determine the need for the program to be carried out and the possibility of involving cadres related to the potential number of active cadres available (Table 1).

Cadre training needs

The need to implement training of cadres of simple handling the cases of diarrhea, respiratory infections, and malnutrition consider the results of a preliminary study. Preliminary study results were analyzed by descriptive qualitative to the respondents. Informant obtained through interviews to health workers, cadres and the people in the region with the lowest IMCI coverage (37.87 %). Descriptive analysis of the needs of cadres is presented in Table 2.

DISCUSSION

Infant and child mortality can describe the level of public health issues related to the causes of death, ante-natal care, nutrition, the environment and socio-economic conditions. Despite a decline from 2013 to 2014, but still need a good handling to decrease until it reaches the target of <8.7 / 1000 KH (live births) for IMR and <9.6 / 1000 KH for the death of a child. Of the 39 health centers has not been achieved 54% coverage. In addition to IMR and CMR many cases occur in children in pain related communities.

Table 1: Overview of Child Health in Banyumas Regency.

Variable	n	%
Scope of IMR (39 PHC)		
Reached	20	51
Un Reached	19	49
Scope of Child Mortality (39 PHC)		
Reached	18	46
Un Reached	21	54
Scope of neonatal first visit (39 PHC)		
Reached	28	72
Un Reached	11	28
Neonatal second visit (39 PHC)		
Reached	26	66
Un Reached	13	34
Safe Neonates Complication (39 PHC)		
Reached	13	34
Un Reached	26	66
Scope of IMCI (39 PHC)		
Reached	23	60
Un Reached	16	40
Scope of BBLR (39 PHC)		
Reached	4	10
Un Reached	35	90
Diarrhea (endemic case)	21.55/1000	46.5
Respiratory infection	1999/9551	21.4
Malnutrition	1208	7.82
IHC ($\Sigma=2508$)		
Active	2484	99.04
No active	24	0.96
Cadre ($\Sigma=13024$)		
Active	11968	91.89
No active	1056	0.08

Source: Ministry of Health Banyumas Regency (2013-2014).

Table 2: Description of IMCI cadre training needs for the community.

Informan	Description
Health workers	<p>The number of workers who served in the IMCI too low, so it is not balanced by the number of children treated visitors to the clinic.</p> <p>If public awareness of better health would improve community health status.</p> <p>5 of the 10 cases of pediatric patients coming after 5 days of fever.</p> <p>Required the participation of the community to support the health sector program</p>
Groups of cadres	<p>The cadres said that during these activities are conducted monthly routine weighing and no other activities besides weighing.</p> <p>Supplementary feeding for all children who weighed the form of green bean porridge or egg.</p> <p>The number of active cadres in the region 605, each group consisting of 20 cadres.</p> <p>The cadres said that the expansion of knowledge in the form of extension activities in health centers.</p> <p>The cadres expressed need additional knowledge to help families in need</p> <p>The cadres hardly ever get training.</p> <p>The cadres do not know about IMCI and governance sick children.</p> <p>There are still families with social and economic backgrounds are less preferred to treat themselves traditionally and refusing treatment to the clinic.</p>

Source: primer data

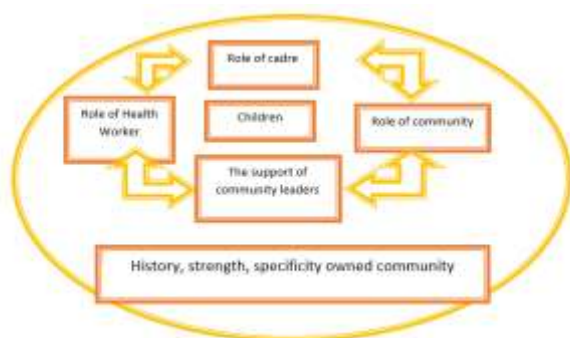


Figure 1: Picture of the strength of the community.

Cases of child morbidity that often occur include diarrhea, respiratory infections, and malnutrition is of particular concern. To handle these cases cannot be separated from the IMCI (integrated management of sick children), which regulates the procedures for handling such cases. While the numbers of IMCI coverage only reached 60% of the lowest even 37.87% of the target of 90% coverage. Based on the preliminary studies required the involvement of the community in this regard through the cadre. Not in the region involving cadres in IMCI in the community.

Regulation of the Minister of Health of the Republic of Indonesia Number 70 of 2013 has set about organizing integrated management of children illness at community-based. In the first article explained, "community-based Integrated Management (IMCI-M) is an approach to community services for infants and toddlers is integrated with community involvement appropriate management standards toddler illness (IMCI)".

IMCI-C aims to improve access to services for sick infants at community level in areas difficult to access health services. Difficulty of access is the lack of human resources including health, social and cultural barriers, as well as geographical constraints, transportation, and season. To achieve these objectives required a strong support system from government, health care, and community. Health care workers are required to have effective communication skills as promotive; increasing the role of the health committee, and innovative engineering approach can help the achievement of the program.¹¹

The basic principle IMCI-C is a partnership between health care facility first level with the communities it serves, increase service availability and access to adequate health information, and integrate promotion of healthy behaviors in the family that are important for the survival and development of the child.

Package intervention in IMCI program-M through health care approach to child survival. Intervention promotive, preventive, and curative include the promotion of healthy behaviors and health-seeking, early initiation of

breastfeeding and exclusive breastfeeding, maintain warmth for all newborns, kangaroo care method for low birth weight infants, umbilical cord care in newborns, without CTPS (hand washing with soap), hand washing without soap, use of mosquito nets, breastfeeding two years with complementary foods, giving an antibiotic ointment for neonatal infections, provision of ORS and zinc for diarrhea toddler, appropriate antibiotic treatment for pneumonia (cotrimoxazole as the first option), and therapy artemisinin-based combinations for malaria.¹²

In Bangladesh IMCI intervention/ IMCI facilitated by trained health workers, 94% had received training. Support health care system in general is very good, but the implementation of the public is very low. People who have been exposed to IMCI, 19% of children sick to come to health services, while only 9% without IMCI.¹³ In Tanzania the impact of IMCI implementation of reduction in child mortality by 13% and the kids get better service.¹⁴

Implementation of IMCI in Haiti affected the economic status of the key factors of society and human resources. IMCI is still difficult to implement because there is a perception among health workers and a practical understanding of families and communities in managing sick children. They still isolate a sick child, so it needs a non-formal approach in order to enter and to approach families and communities.¹⁵

Perceptions of health workers about the IMCI in Lahej Yemen in qualitative analysis on 2007 through in depth interviews. The result obtained is not optimal in the direction of community-based IMCI performance in peripheral health centers better, less supervision function, multi role of one person/ officer, successful primary immunization, less efficient drug supply, their conflict with the participation of the public health committee. After 4 years running, IMCI gives a positive effect, although it should always be monitored ketercapaiannya.¹⁶ IMCI involvement with the community in the district of Banyumas most appropriate is the cadre.

Health workers are volunteers elected by and from the community, as well as in charge of developing the community.¹⁷ Kader is defined also as the local communities that are selected and reviewed by the community, and can work voluntarily managing Posyandu.¹⁸ East Java Health Office (2006) defines cadres, male or female body physically and mentally healthy, and willing to work voluntarily managing IHC.²¹ From the definition, it can be concluded that the cadre force is voluntary, chosen by the community, managing IHC and in charge of developing the community.

Banyumas district health offices efforts in reducing child mortality and morbidity of children through the application of EMAS program (expanding maternal and neonatal survival) recently implemented in two hospitals

and two health centers quite successful, needs to be developed in the territory of the other health centers and through community empowerment in health. Community activities will be monitored by health professionals such as doctors, nurses, and midwives.

The rationale used by Levine's theory of Conservation Model in Nursing Practice. This theory emphasizes human interaction, with three major concepts, namely conservation / conservation (together keep the system alive), adaptation / adaptation (adjustment process with the environment), and wholeness / integrity.²⁰ Consisting of energy conservation, structural integrity, social integrity, and personal integrity. Adaptation includes the responsibility of nurses during the treatment, the success of adaptation to energy advocates a healthy, pain related to how the pattern of adaptation, nursing support during the process of adaptation, as the optimal healthy adaptation purposes. History, advantages, and specificity played a role in supporting the integrity or completeness.²⁰

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