SUPPORTIVE PEDIATRIC PROGRAMS AT KAMPAI TABU KARAMBIA COMMUNITY HEALTH CENTER TOWARDS MDGS 2015

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ABSTRAK

*Dengan sisa dua tahun untuk mencapai MDGs nomor empat, semua fasilitas perawatan medis di Indonesia harus berkomitmen untuk bekerja keras berfokus pada masalah kesehatan anak. Pusat Kesehatan Masyarakat (Puskesmas) adalah pusat kesehatan tingkat pertama yang juga berpartisipasi dalam meningkatkan tingkat kesehatan anak. Kampai Tabu Karambia (KTK) adalah salah satu dari Puskesmas yang telah melakukan program kesehatan anak menuju 2015. Tujuan dari penelitian ini adalah untuk mengetahui sejauh mana fitur program anak di KTK Puskesmas, Solok, Sumatera Barat memberikan kontribusi terhadap MDGs selama tahun-tahun yang tersisa sampai 2015. Penelitian ini merupakan studi retrospektif dengan analitik observasional yang dilakukan di KTK Puskesmas, Solok, Sumatera Barat. Hal tersebut dilakukan dengan meninjau catatan medis dari Januari sampai November 2012. Data karakteristik yang didokumentasikan termasuk usia, jenis kelamin, status gizi dan sejarah imunisasi. Data tentang DDTK dan implementasi MTBS diambil dari laporan bulanan. Dari 2.045 pasien anak-anak, kunjungan anak laki-laki lebih tinggi dibandingkan anak perempuan. 9,9% pasien diklasifikasikan sebagai kekurangan gizi. Infeksi Saluran Pernafasan Akut Atas sedang persentase tertinggi di antara kasus lain (45,23%). Selama studi 11 bulan, MTBS telah dilaksanakan 100% dan cakupan untuk kontak pertama DDTK jauh lebih baik daripada yang kedua. Hasil untuk menyusui eksklusif dan pemberian vitamin A berhasil mencapai lebih dari target. Terdapat kemajuan yang baik dalam cakupan imunisasi, meskipun belum mencapai target nasional. Kesimpulannya, program standar di KTK Puskesmas hampir memenuhi kebijakan kesehatan anak di Indonesia. Tetapi hasil yang diharapkan masih terlalu jauh. Beberapa hal yang harus ditingkatkan, terutama tentang isu-isu cakupan imunisasi dan status gizi.**(FMI 2013;49:36-41)***

Kata kunci: *MDGs, kesehatan anak, puskesmas, Indonesia*

ABSTRACT

With the remaining two years to achieve MDGs number four, all medical treatment facilities in Indonesia must commit to work hard focusing on child health issues. Community Health Center (CHC) is the first level healthcare center that also participate in improving child health level. Kampai Tabu Karambia (KTK) is one of CHCs that has been performing pediatric programs towards 2015. The objective of this study was to determine how far the features of pediatric programs at KTK CHC, Solok, West Sumatera give contribution to MDGs during the remaining years to 2015. This was a retrospective study with an observasional analytic conducted at KTK CHC, Solok, West Sumatera. It was performed by reviewing medical records from January through November 2012. The characteristic data that were documented including age, gender, nutritional status and history of immunization. Data about DDTK and IMCI implementation were taken from monthly report. Of the 2045 pediatric patients, boys' visit are higher than girls. 9,9% patients were classified as malnourished. Upper Acute Respiratory Infection was being the highest percentage among other cases (45,23%). During 11 months study, IMCI had been implemented 100% and the coverage for first contact of DDTK was much better than the second one. The results for exclusive breastfeeding and administration of vitamin A succesfully reached over the target. Good progress in immunization coverage, though it hasn't reached the national target. In conclusion, the standard programs in KTK CHC almost meet the policy of child health in Indonesia. But the expected results are still way too far. Few more things should be upgraded, especially about the immunization coverage and nutritional status issues. ***(FMI 2013;49:36-41)***

Keywords: *MDGs, child health, community health center, Indonesia*

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INTRODUCTION

Indonesian medical treatment facilities can be classified as regional hospitals or Community Health Center (CHC), depending on their purpose, at the provincial, district and municipal levels (Japan International Cooperation Agency 2003). The function of CHC including the center for health oriented development, center for community empowerment, the first level healthcare center (private or individual health service and public health service). One of the obligatory programs of CHC that is listed focusing on maternal and child health care (Departemen Kesehatan RI 2008).

The success of maternal and child health care is being one of the main indicators in National Long-Term Development Plan (RPJPN) 2005-2025 (Departemen Kesehatan RI 2009). Child mortality rates very considerably among regions and countries, but the most disturbing findings are that in some countries child mortality rates are on the increase (Mukelabai 2012). Therefore, the world has committed to lead its society to reach the welfare together. That commitment was stated on Millenium Development Goals (MDGs) (Ranuh et al 2011). Of the total 8 points of MDGs, the MDGs' achievement number 4 is to reduce child mortality rate, targeting to reduce by two-third the under-five mortality rate between 1990 and 2015. (Ranuh et al 2011,BAPPENAS 2010).

Current policy of child health in Indonesia focuses on core interventions of health services and covers immunization, IMCI, child nutrition program, strengthening the role of family and enhancing access to health facilities, as described in the following: (i) Improving immunization coverage against measles; (ii) Strengthening strategies to address the key IMCI implementation; (iii) Addressing the key nutritional concerns in children to reduce stunting prevalence; (iv) Developing strategies at family level; (v) Strengthening behavior change interventions; (vi) Improving newborn care and maternal health; (vii) Strengthening and improving health facilities; (viii) Improving community participation and mobilization through integrated health service post (*posyandu*) activities; (ix) Enhancing policy advocacy; (x) Integrating cross sectoral strategies to accelerate achievement of targets for child, infant and neonatal mortality.6

KTK is one of four CHCs located in Solok, West Sumatera. Found in 1993, KTK CHC specifically offers healthcare services for outpatient. The health service that has been offered in pediatric clinic covers promotive, preventive, curative and rehabilitative. In supporting child health, KTK CHC performs programs taking part on nutrition improvement and disease prevention, eradication and alleviation. Some programs are supported using the subsidy for operational cost for health service (BOK).

MATERIALS AND METHODS

An analytic observational with retrospective study was performed between January and November 2012 at KTK CHC, Solok, West Sumatera. The data was taken from the medical record of pediatric patients. The collected data include age, gender, history of immunization, nutritional status and the diagnose. The assessment of nutritional status data were calculated using the indicator weight per age based on WHO standart 2005.

RESULTS

During 11 months analyzing period, there were a total of 2045 pediatric patients. Boys (52%) are more likely admitted into pediatric clinic than girls (48%). Children aged > 24 – 60 months were the group of age who mostly admitted into KTK CHC. About 89% of pediatric patients were classified as well-nourished (Table 1). On September 2012, there were about 210 pediatric patients admitted into KTK CHC, contrasted with May 2012, when there were only 158 visits (Figure 1). Table 2 shows that pediatric patients who were diagnosed Upper Acute Respiratory Infection has the highest rate of any other disease (45,23%) while children with febrile convulsion were only 0,19% admitted to KTK CHC.

I found that the health workers at KTK CHC has 100% applied IMCI for every pediatric patient. While about DDTK application, there were lower coverage of the second contact for infant, under-five group and > 60 months. (Table 3). The coverage of exclusive breastfeeding and the administration of vitamin A had successfully reached over the target. (Table 4). The result of immunization coverage on November hasn't been calculated awaiting collected data from *posyandu*. There was always an uplift point for immunization coverage every month but it was still under the national target. (Figure 2-4)

Table 1. Baseline characteristics of the study subjects (n= 2045)

Characteristic	n
Sex	
Male, n (%)	52
Female, n (%)	48
Age	
0 – 24 months, n (%)	16
> 24 – 60 months, n (%)	67
> 60 months, n (%)	17
Nutritional status	
Obese, n (%)	0,1
Well-nourished, n (%)	89,9
Malnourished, n (%)	9,9

DISCUSSION

The Millennium Development Goals (MDGs) are eight international development goals that were officially established following the Millennium Summit of the

United Nations in 2000, following the adoption of the United Nations member states and at least 23 international organizations have agreed to achieve these goals by the year 2015. The goals are: (i) Eradicating extreme poverty and hunger; (ii) Achieving universal primary education; (iii) Promoting gender equality and empowering women; (iv) Reducing child mortality rates; (v) Improving maternal health; (vi) Combating HIV/AIDS, malaria and other diseases; (vii) Ensuring environmental sustainability and (viii) Developing a global partnership for development (Wikipedia 2012).

Table 2. The top 10 disease in pediatric poli at KTK CHC from January through November 2012

Disease	n (%)
Upper Acute Respiratory Infection	45,23
Common cold	14,91
Gastroenteritis	11,69
Fever	6,40
Infectious skin disease	5,57
Allergic skin disease	2,88
Dyspepsia	1,61
Asthma	1,47
Pneumonia	0,83
Febrile convulsion	0,19
Other disease	9,22
Total	2045 (100)

Table 3. The coverage of Integrated Management of Children Illness (MTBS) and Early Detection of Growth and Development (DDTK) application

Activity	n (%)
IMCI	100
First contact of *DDTK*:	
Infant	87,3
Under-five	49,3
> 60 months	98,2
Second contact of *DDTK*:	
Infant	69,7
Under-five	39,7
> 60 months	61,7

Table 4. The coverage of exclusive breastfeeding and the administration of vitamin A

Activity	Target (%)	n (%)
Exclusive breastfeeding	70	84.1
The administration of vitamin A		
6 – 11 months	80	97.2
12 – 59 months	80	93.5

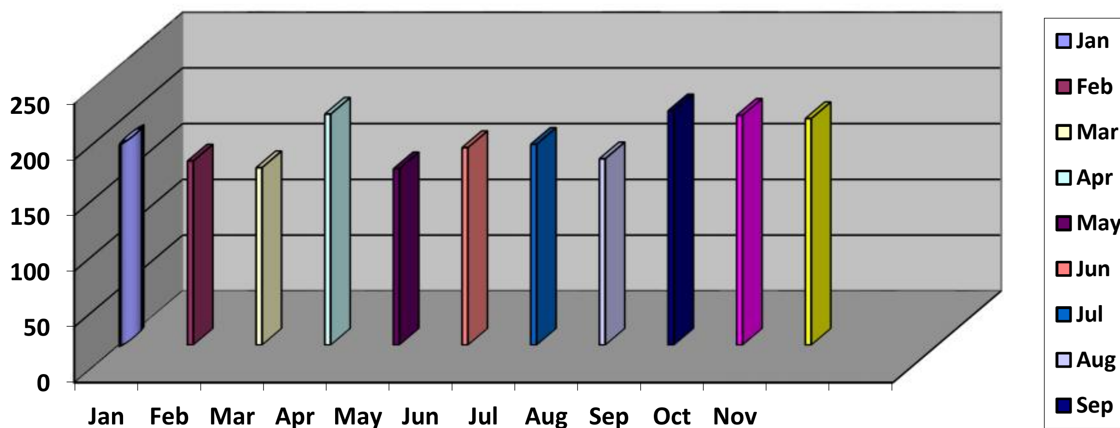

Figure 1. Number of pediatric outpatients by month (January – November 2012)

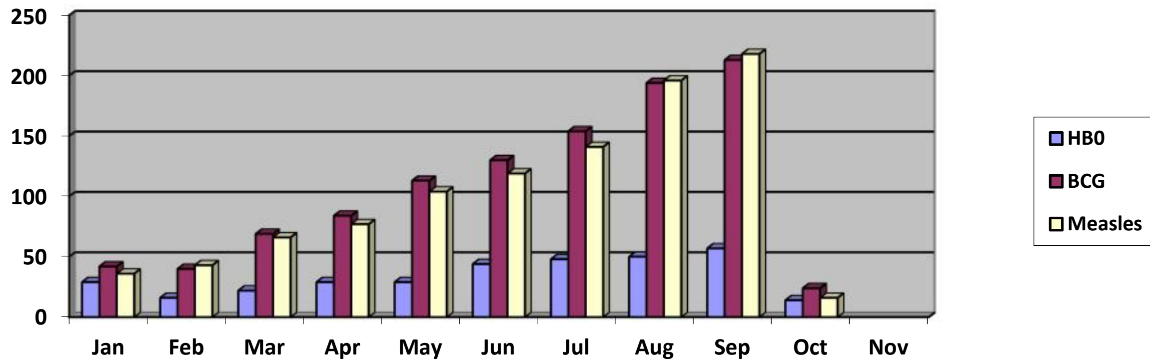

Figure 2. The cumulative of coverage HB0, BCG and Measles immunization by months with a number of target 300 children

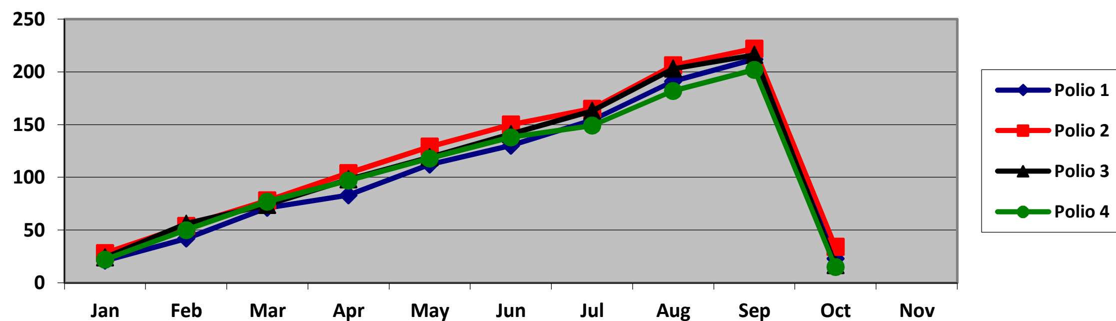

Figure 3. The cumulative of coverage Polio immunization by months with a number of target 300 children

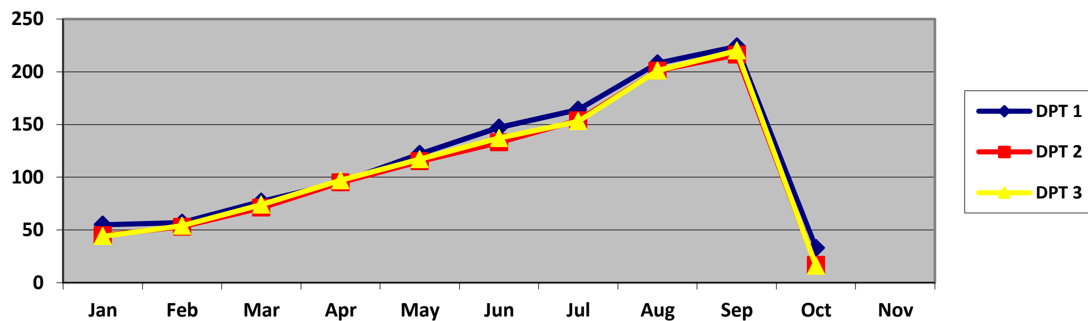

Figure 4. The cumulative of coverage DPT immunization by months with a number of target 300 children

It's written on the report on the achievement of the Millenium Development Goals in Indonesia that there are still six challenges in reducing child mortality rate: (i) Low coverage of immunization; (ii). Ineffective early detection and prompt treatment of sick children (MTBS); (iii). Limited efforts in improving nutrition outcomes for children. More cost-effective, feasible and adaptable nutrition interventions need to be explored; (iv) Low participation of family and community in child health. Only 30% of mothers apply good health practices. IEC programs for behavior change need to be improved; (v) Lack of interventions in controlling for environmental risk factors. Risk factors for infant and child mortality are strongly related to environmental health – clean water, basic sanitation and levels of indoor pollution; (vi) Persistent low access to proper health services. About 20% of births have no access to

proper health services while most babies born in Indonesia are at high risk (BAPPENAS 2010).

Those six challenges are tried to be dismissed by KTK CHC. Concerning to support child health, KTK CHC implements routine activities that are following: giving health service to every neonates, infant, under-five and preschooler; internal and external referral; reporting the number of under-five and preschooler visit; the application of Integrated Management of Children Illness (MTBS) to the ill child. There are also some programs supported by subsidy for operational cost for health facilities (BOK). Those programs are under-five annual health competition every May or June; socializing DDTK for PAUD and kindergarten teacher; organizing DDTK for PAUD and also kindergarten students; the administration of complementary feeding to raise the nutritional status; supporting the establishment of supplementary feeding centers for moderately malnourished children; TFC (Therapeutic Feeding Center) for severely malnourished children; conducting massal weighing on February and August by health cadres; the administration of drugs against soil-transmitted helminth infections to preschooler; organizing home visite to family whose child is undernourished; conducting an exclusive breastfeeding class once a year; the implementation of newborn screening for congenital hypothyroidism; the distribution of vitamin A supplementation; providing basic vaccination based on the national immunization program (BCG, Diphteria Pertussis Tetanus / HB 1-3, Polio 1-5, Measles) and School children immunization program (BIAS).

According to the policies focused on child health section like what had been written on MDGs, all programs have been implemented well by KTK CHC yet the result wasn't satisfying and hasn't met the expectation. The coverage immunization at KTK CHC was still low compared with the national target, particularly in measles immunization that far below the national target (90%). This problem as what has been stated by Loui Thenu, the head of Medecins Sans Frontieres communication for South-East Asia, that there were about 70% children are unreachable by universal child immunization, they are widespread in Indonesia and 5 other countries (Infoimunisasi 2012). Based on the immunization program pointer in West Sumatera province from health agency, some problems that we're still facing here are the negative myth around society that immunization can cause death or disability and about religion doctrine that immunization is forbidden (Dinas Kesehatan Provinsi Sumatera Barat 2012). Teamwork should be raised in effort to socialize to religious organization about how important immunization, back to list the total target of immunization so there will be no child unreachable and giving counselling more to family level about catch-up immunization.

Since 1996, the minister of health Republic of Indonesia has been working together with WHO in developing IMCI in Indonesia in effort to reduce the under-five years of age morbidity and mortality rate caused by diarrhea, pneumonia, measles and malaria, under-nourished or the combination of those above. IMCI is defined as an integrated approach on procedure of infant and under five years of age coming to health service and check on healthy and ill neonatal when it's coming to neonatal visit (Direktorat Bina Kesehatan Anak 2012). KTK CHC has been already applying IMCI daily for pediatric patients, but it still needs to be evaluated and developed. Problems like the availability of the IMCI form and health workers mutation should be prevented from now on. Periodic training is important to strengthen the health workers and cadres' knowledge. Following up of post-training is to ensure the eligible health workers applying IMCI.

What KTK has been done related to child nutrition got almost close to what were stated as the health policies in MDGs. But there are still a few children categorized as malnourished. Eventhough the data of basic health research in year 2010 showed there was a lower malnourished prevalence in under-five years of age at the level 17,9% while in 2007 was 18,4%, but the MDGs targeting in 2015 the prevalence is 15,5% (BAPPENAS 2010). The cause of malnourished in children under-five has been realized. One of the concepts that explain the causes is Unicef concept. This concept tells us if the malnourished issue is literally caused by unmet nutrition and infection disease. Indirectly, these situations are caused by the unavailability food, poor parenting, low socio-economic and inadequate sanitation. The subsidy for operational cost for health service (BOK) is helpful in aiding supplementary feeding center (PMT) for moderately malnourished children. KTK CHC so far regularly distributes 9 or 10 packs of biscuit, 30 eggs, 3 packs of 800 gram powdered milk (the choice can be cow or soya milk) and also 1 kilogram of mung bean. These products actually should have been given every 2 weeks, but since the receiver families have social economic issue for transportation so they take them from CHC once a month (for a month portion). It keeps continued for a period of 3 months. The weight of undernutrition children are being followed up every time they're back to CHC to take supplementary feeding center. Unfortunately, not all children with moderately malnourished can receive it due to limited of subsidy. Meanwhile, the poorest family is being chosen to get that chance.

The participation of family and community are remarkably important to overcome the child health problems. KTK has commited efforts to raise their participation by emphasizing counselling, socialization and home visit to family level. Access to health provider is mainly affected by cost, distance, transportation and difficulty to administer health insurance. Eventhough the chart of route for administering health insurance has been mounted on the wall, but the patients still get confused to follow it. Running the remaining time to 2015, UN member states initiated steps towards advancing the development agenda beyond 2015 and are now leading a process of open, inclusive consultations on the post-2015 agenda. It has been spoken at the September 2010 MDG Summit. Civil society organizations from all all over the world have also begun to engage in the post-2015 process (Wikipedia 2012)

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