The Performance Of Integrated Healthcare Center Cadres In The Toddler Early Development Intervention Detection Stimulation Program

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ABSTRACT

Stimulation, Early Detection, and Intervention of Growth and Development (SDIDTK) was an activity to monitor growth and development and deviations or disorders of toddler development. Cadres' primary task is to monitor toddlers' growth and development. SDIDTK coverage in the working areas of Public Health Centre Langsat and Sidomulyo is still below the target, namely 65.0% and 65.4%, respectively. The research aimed to analyze the factors related to performing cadres: knowledge, ability, attitude, motivation, infrastructure, and supervision. The research used quantitative analytics with a cross-sectional study approach. Sampling was taken from all active cadres in the Langsat and Sidomulyo Puskesmas working areas, totaling 230 cadres. Data analyses used the chi-square test and multiple logistic regressions. The results showed that the number of performing cadres was less in SDIDTK by 48.7%. The variables that were significantly related to performing cadres were attitude (p-value = 0.006 POR = 1.342), motivation (p-value = 0.00 POR = 9.05), and supervision (p-value = 0,000 POR = 37.66). This study concludes that the dominant factor related to cadres' performance in the SDIDTK program is supervision. For this reason, advocacy, atmosphere building, empowerment of community movements, and partnerships are needed to improve cadres' performance in the SDIDTK program for toddlers.

Keywords : cadres,development, early detection, performance,stimulation

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INTRODUCTION

Stimulation Detection and Early Intervention of Growth and Development (SDIDTK) is an activity to monitor growth and development and deviations or disorders of growth and development of children under five years old.[1] The implementation of SDIDTK is regulated in the Minister of Health Regulation No 25 of 2014 concerning child health efforts[2] and strengthened in Permenkes No 66 of 2014, which states that monitoring growth and development through SDIDTK is part of health services for infants, toddlers, and preschool children aimed at improving the continuity and quality of life of children.[3] SDIDTK activities can be carried out in public and private health and non-health facilities such as community health centers, independent midwife practices, clinics, maternal and child hospitals, pre-schools, daycare centers, kindergartens, and community-based health effort networks such as Integrated Health Centers (HIC). SDIDTK implementation is carried out by health and non-health workers who have received SDIDTK training, such as kindergarten teachers, early childhood educators, and HIC cadres.[1]

HIC cadres are community members who are selected from, for, and by the community, willing and able to cooperate in various community activities on a voluntary basis, especially in the health sector.[4] SDIDTK activities by HIC cadres, namely conducting growth monitoring consisting of measuring Body Weight, Height, Length, and Head Circumference and development monitoring activities consisting of observing abilities in gross motor, fine motor, speech, language, emotions, and socialization.[1]Growth and development disorders of toddlers can be known early by cadres by recording in the Maternal and Child Health (MCH) book. However, several studies have shown that cadres' knowledge of monitoring the growth and development of children under five through the use of the MCH book still needs to be higher.[5–8]

Based on data from the Pekanbaru City Health Office in 2019, it was found that the number of toddlers in the Pekanbaru City Health Office Working Area was 111,583 toddlers, the number of toddlers with very thin nutritional status was 205 toddlers, nutritional status was less than 807 toddlers, nutritional status was very short as many as 651 toddlers, developmental disorders in the gross motor as many as 22 toddlers, fine motor as many as 23 toddlers, socialization of independence as many as 12 toddlers, hearing loss as many as seven toddlers, follow-up on stimulation as many as 55 toddlers and referred as many as nine toddlers.[9] The existence of growth and development disorders in toddlers can be detected early through SDIDTK.

Growth and development disorders that often occur in children are autism, Attention Deficit Disorder (ADHD), Down Syndrome[10,11] and motor development disorders such as language development disorders and mental retardation.[11]The World Health Organisation (WHO) states that 5-25% of children under five in the world suffer from minor brain dysfunction. The prevalence of developmental delay is 10%, while suspected developmental delay is 26.1%. Prevalence increases from 21 months of age and peaks at 36 months of age.[12]

Early detection and intervention of toddler growth and development is needed to prevent growth and development disorders.[13–15]Early detection activities in the SDIDTK program are carried out at least eight times for growth monitoring and at least two times for development monitoring in one year.[16] Early detection of growth and development disorders in toddlers is carried out through history taking, routine physical examinations, developmental screening, and follow-up examinations.[13]

The 2018 Basic Health Research Report shows that SDIDTK coverage of under-fives in Indonesia was 58.4% in growth monitoring and 45.9% in development monitoring.[17] Riau Province's SDIDTK coverage of under-five growth monitoring was 47.36%, and under-five development monitoring was 40.98%. The Government Performance Accountability Report of the Riau Provincial Health Office of Toddler SDIDTK coverage in 2017 was 62.44%[18], and The 2019 health data communication report of SDIDTK data for toddlers was 41.52%. Based on this data, it can be concluded that SDIDTK coverage has not met the target of 100% .

The low coverage of SDIDTK for toddlers illustrates that the implementation of SDIDTK in HIC has yet to be maximized, as well as the lack of visits by toddlers to HIC to monitor growth and development. The higher the SDIDTK coverage, the more toddlers with growth and development disorders are monitored and corrected so that their growth and development are expected to return to normal according to their age.[6]

Of the 21 Community Health Centers (CHC) in Pekanbaru City, there are 2 CHCs with the lowest SDIDTK coverage for two consecutive years, namely Sidomulyo CHC (65.4%) and Langsat CHC (65.0%).[9] Based on the above problems, the purpose of this study was to analyze the factors associated with the performance of HIC cadres in the Toddler SDIDTK program in the working areas of Sidomulyo and Langsat CHCs in 2020.

METHODS

This type of research is quantitative analytic with a cross-sectional study design. The study was conducted in the working areas of Puskesmas Langsat and Puskesmas Sidomulyo Pekanbaru City in July-September 2020. The population was all active IHC cadres in SDIDTK implementers in the working areas of Puskesmas Langsat (70 active cadres) and Puskesmas Sidomulyo (160 active cadres). Hence, the population amounted to 230 active cadres. All active cadres in the two health centers were sampled.

Data were collected through interviews using a questionnaire. The data collected included dependent variables and independent variables. The dependent variable is the performance of IHC cadres in the SDIDTK program, namely the work achieved by IHC cadres in carrying out their duties in the SDIDTK Toddler program, which includes preparing equipment for the implementation of SDIDTK before the IHC starts, informing or announcing to residents about the day of the IHC, recording the number of all toddlers in the working area of the CHC, measuring height and weight, counseling mothers of toddlers and families about the importance of SDIDTK, monitoring and observing the ability of toddlers according to age by providing a checklist in the MCH book, recording and reporting the results of SDIDTK toddler activities, home visits to toddlers who do not come to the IHC and meetings and discussions with health workers about SDIDTK toddler activities. Knowledge, ability, attitude, motivation, supervision, and infrastructure are independent variables. The cut-off point value used in the research variables is based on the median value.

Knowledge of cadres is everything that cadres know about SDIDTK activities for toddlers, the duties of cadres in SDIDTK activities, the main targets in SDIDTK activities, the function of the MCH book, how to see growth and development disorders of toddlers in the IHC, tools to measure the weight of toddlers in the IHC, detect sick toddlers with growth and development disorders before being referred to the CHC. Cadre ability is the ability of cadres to carry out the SDIDTK program, which includes finding and monitoring underweight children under five, consulting and counseling mothers of children under five, preparing the place and equipment needed, and weighing children under five. The cadre's attitude is the cadre's response to SDIDTK activities, SDIDTK training, SDIDTK recording in the MCH book, and providing information to health workers and mothers of children under five. Cadre motivation encourages cadres to act on the implementation of SDIDTK. Facilities and Infrastructure are seen from the availability of the MCH Book at the Posyandu, weight and height scales in decent condition, educational game tools, Posyandu information systems and recap reporting on SDIDTK activities for toddlers and the existence of reciprocal guidelines for growth and development of toddlers as SDIDTK counseling tools. Supervision is seen from the direction to cadres related to SDIDTK activities at least once a month, providing information on SDIDTK activities for toddlers from midwives/health workers at Puskesmas, meetings and discussions of SDIDTK activities for toddlers, recording and reporting SDIDTK activities and input and information found from the work of cadres about SDIDTK for toddlers.

The validity and reliability of the questionnaire were tested on 25 cadres at Melur Health Centre, Pekanbaru City. The results of the questionnaire validity test (Pearson product-moment correlation test) obtained the value of r count ≥ r table, meaning that the questionnaire questions/statements in this study are valid. The results of the questionnaire reliability test were carried out with the Crombach Alpha test, with Crombach Alpha ≥ 0.6, meaning that the questions/statements on the questionnaire in this study were reliable.

Data collection was carried out by researchers together with three enumerators who had been trained. Data collection was carried out during the COVID-19 pandemic by implementing health protocols. Data processing using a computer (SPSS) involves editing, coding, data entry, and data cleaning. Data were analyzed univariately (frequency distribution), bivariately (chi-square test) to determine the relationship between variables, and multivariately (multiple logistic regression test) to determine the most dominant variable associated with the performance of IHC cadres in the SDIDTK program. Multivariate analysis stages with bivariate selection, confounding, and interaction checks. This research has been carried out through a research ethics review by the Hang Tuah STIKes Research Ethics Commission Pekanbaru, with the issuance of an ethical feasibility letter with no. 433/KEPK/STIKes-HTP/VII/2020.

RESULT

Characteristics of IHC Cadres

Table 1 shows that the respondents are mostly ≥ 25 years old, namely 51.3%, with the most education at the high school or equivalent level, namely 62.6%. The length of time being an IHC cadre is mostly 1-4 years, totaling 38.7%, while those who have received cadre training are 77.8%, and respondents have received SDIDTK training as much as 47.0%

Table 1. Characteristics of IHC cadres in the Langsat and Sidomulyo Health Center Working Areas in 2020

Characteristics of IHC Cadres	Frequency (n=230)	Percentage (%)
Age		
< 25 years	112	48,7
≥ 25 years	118	51.3
Education		
Junior high school	64	27.8
Senior high school	144	62.6
Colleges	22	9.6
Length of time as a cadre		
< 1 year	54	23,5
1 – 4 years	89	38.7
≥ 5 years	87	37.8
Training participants		
Never	51	22.2
Ever	179	77.8
SDIDTK training participants		
Never	122	53.0
Ever	108	47.0

Cadre performance and independent variables

Table 2 shows that out of 230 respondents, respondents with less knowledge (35.2%) of the SDIDTK program, respondents with less ability (43.0%), respondents with negative attitudes (41.3%), respondents with less motivation (45.2%), respondents who stated that the infrastructure was not complete in the IHC where they served as much as (49.1%), respondents who stated that they received less supervision from health center health workers (40.0%) and respondents with less performance (48.7%).

Table 2: Frequency distribution of IHC Cadre Performance in the SDIDTK Program and Independent variables in the Langsat and Sidomulyo CHC Working Areas in 2020.

Variables	Frequency (n=230)	Percentage (%)
Performances		
Not good	112	48,7
Good	118	51,3
Knowledge		
Not good	81	35,2
Good	149	64,8
Ability		
Not good	99	43,0
Good	131	57,0
Attitude		
Negative	95	41,3

Positive	135	58,7
Motivation		
Not good	104	45,2
Good	126	54,8
Infrastructure		
Incomplete	113	49,1
complete	117	50,9
Supervision		
Not Good	92	40,0
Good	136	60,0

Factors associated with the Performance of IHC cadres in the SDIDTK program

Table 3 shows a relationship between knowledge, ability, attitude, motivation, and supervision with the performance of IHC cadres in the Toddler SDIDTK Programme in the working areas of Langsat and Sidomulyo CHC.

Table 3. Factors associated with the performance of IHC cadres in the SDIDTK Programme in the working areas of Langsat and Sidomulyo CHC in 2020

s	Variable	Performance of IHC Cadres			P_ value	POR Crude (95% CI)
		Not Good n(%)	Good n(%)	Total n(%)		
ge	**Knowledge**					
	Not Good	49 (60.5)	32 (39.5)	81(100)	0,012	2.09 (1.20 -3.63)
	Good	63(42.3)	86 (57.7)	149 (100)		
	Ability					
	Not Good	69 (69.7)	30 (30.3)	99 (100)	<0,001	4.71 (2,68 –8,26)
	Good	43 (63.6)	88 (67.2)	131 (100)		
	Attitude					
	Negative	56 (59.6)	38 (40.4)	94 (100)	0,009	2,10 (1,23 – 3,59)
	Positive	56 (41.2)	80 (58.8)	136 (100)		
on	**Motivation**					
	Not Good	81 (78.6)	22 (21.4)	103 (100)	<0,001	11,42 (6,13 -21,22)
	Good	31(24.4)	96(75.6)	127 (100)		
cture	**Infrastructure**					
te	Incomplete	51 (45.1)	62 (54,9)	113 (100)	0,350	0,75 (0,45 -1,268)
	Complete	61 (52.1)	56 (47.9)	117 (100)		
ion	**Supervision**				<0,001	41,25

Not Good	8 4 (91.3)	8 (8.7)	92 (100)		(17,8 9– 95,12)
Good	2 8 (20.3)	1 10 (79.7	138 (100)		

The results of multivariate analysis using multiple logistic regression tests by linking several independent variables with the dependent variable simultaneously. The independent variables included in the multivariate analysis are variables in the bivariate selection with a p-value <0.25, namely knowledge, ability, attitude, motivation, and supervision. The initial multivariate modeling was to include all candidate variables in the multivariate analysis.

Table 4 shows that simultaneously, the variables significantly associated with the performance of IHC cadres are Attitude, Motivation, and Supervision. Cadres with negative attitudes were three times more likely to perform poorly than those with positive attitudes (POR=3.43, 95% CI: 1.43-8.22). Low cadre motivation was nine times more likely to perform poorly than high cadre motivation (POR=9.06, 95% CI: 3.77-21.79). The confounding variable was cadre ability. The most dominant variable associated with the performance of IHC cadres in the SDIDTK Toddler program was supervision, with a POR=37.67 (95% CI: 14.01-101.27). Posyandu cadres who received poor supervision from health workers in the SDIDTK toddler program were 37 times more likely to perform poorly than IHC cadres who received good supervision from health workers. The confounding variable was cadre ability. The Omnibus test value <0.001 means that the multivariate model formed is fit. The Nagelkerke R square value=0.690 means that ability, attitude, motivation, and supervision can explain the performance of IHC cadres in the SDIDTK program by 69.0%. In comparison, 31.0% is explained by other variables not examined in this study.

Table 4. Initial and Final Multivariate Modelling of Factors Associated with Cadre Performance in the SDIDTK Programme in Working areas of Langsat and Sidomulyo in 2020

Variables		Intial Modelling				Final Modelling			
		P value	OR	P	95% CI for POR	P value	OR	P	95% CI for POR
Knowledge	Knowl edge	0 ,143	1 ,91		0,80- 4,55	-			
Ability	Ability	0 ,178	1 ,80		0,77- 4,23	0, 169	1 ,82		0,77- 4,26
Attitude	Attitud e	0 ,004	3 ,65		1,52- 8,88	< 0,001	3 ,43		8,22
Motivation	Motiva tion	< 0,001	8 ,74		3,60- 21,18	< 0,001	9 ,06		3,77- 21,79
Supervision	Superv ision	< 0,001	3 9,88		14,45- 110,14	0, 034	3 7,67		14,0 1-101,27

Omnibus test of model coeffsient = <0.001
Nagelkerke R Square = 0,690

DISCUSSION

The results showed that the performance of IHC cadres in the SDIDTK program for toddlers with poor performance category was 48.7%. Based on the results obtained from the research questionnaire, the performance of cadres who are lacking in terms of measuring the height of toddlers, informing/announcing the day of IHC implementation to toddlers, consulting with officers if toddlers who do not gain weight three times in a row, recapitulating SDTIDTK activities every month, home visits to toddlers who cannot come to the IHC. Rizki's research states that the performance of implementing officers in implementing SDIDTK for toddlers

and preschoolers is low at 44.3%.[20] The activities in the SDIDTK toddler program will be successful if the optimal performance of SDIDTK implementing officers is achieved.[20,21]

The results of the multivariate analysis showed that supervision is the dominant factor associated with the performance of IHC cadres, which is controlled by ability, attitude, and motivation. Several studies have shown that supervision is associated with the performance of IHC cadres in implementing SDIDTK.[22,23] Supervision by health workers at the Community Health Center is limited to the technical implementation of SDIDTK for toddlers, while recording and reporting activities are still not optimal, which impacts the results of SDIDTK coverage for toddlers. These results are reinforced by the research of Syofiah et al., who state that the supervision and control activities of the SDIDTK program through supervision and evaluation are still not optimal.[24]

The attitude of cadres is significantly related to the performance of posyandu cadres in the SDIDTK program for toddlers. Some studies state that there is a relationship between the attitude of posyandu cadres and performance in the implementation of SDIDTK.[25,26] In this study, cadres with negative attitudes were 41.3%. Cadres with negative attitudes were also found in Napitupulu's research at 58.3%.[27] Negative attitudes can arise because cadres do not receive training on the SDIDTK toddler programme. Training can improve the knowledge and attitudes of cadres regarding the SDIDTK program.[28,29] Attitude is a person's assessment of a stimulus or object after knowing the next stimulus will assess or behave towards the stimulus. Efforts to improve the performance of IHC cadres in the SDIDTK toddler program by fostering an atmosphere with group discussions and establishing good and routine communication so that IHC cadres get information and skills related to the SDIDTK toddler program are expected to increase the coverage of SDIDTK toddlers.

Another variable significantly associated with cadre performance is motivation. Other researchers have also shown a significant relationship between motivation and the performance of SDIDTK implementing officers.[20,30] Highly motivated cadres are likelier to perform better than those with low motivation.[31] In this study, cadres with less motivation were caused by a lack of encouragement within IHC cadres, such as the desire to establish cooperation with mothers of toddlers and a lack of desire to routinely record and report on the SDIDTK program, which certainly had an impact on cadre performance. For this reason, it is expected that health workers in charge of implementing IHC can encourage cadres by providing opportunities to participate in IHC assessment competitions.

Multivariate analysis showed that the independent variables that were not associated with IHC cadre performance were cadre knowledge and infrastructure. Several studies have shown that cadre knowledge of the SDIDTK program is low, and training has been shown to improve cadre knowledge and performance in the SDIDTK program Infrastructure facilities are not related to cadre performance in the SDIDTK program. Another study also showed the same thing, namely that there was no relationship between infrastructure facilities and cadre performance in the SDIDTK program[32] The incomplete facilities and infrastructure of the IHC are due to a lack of funding from the health center. Although facilities and infrastructure are incomplete, with good motivation towards the SDIDTK program, cadres continue to provide health services to toddlers through SDIDTK activities.

CONCLUSIONS

The performance of IHC cadres in the SDIDTK program for under-fives was 48.7%. Factors significantly associated with cadre performance in the SDIDTK program are attitude, motivation, and supervision. Supervision is the dominant factor affecting cadre performance in the SDIDTK program. To improve cadre performance in the SDIDTK program, the Puskesmas should conduct regular supervision to monitor the implementation of the SDIDTK program by cadres. In addition, the health center can build an atmosphere with IHC cadres through group discussions and training activities to provide understanding and motivation to IHC cadres, which is expected to form a positive attitude among cadres toward implementing the SDIDTK program for toddlers. Puskesmas can facilitate cadres participating in competitions between IHC as encouragement and motivation for implementing the SDIDTK program for children under five.

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