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Nurses and Midwives involvement in Health Promoting Education to Parents in Yogyakarta, Indonesia
To prevent ill-health among children

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Abstract

Background: Indonesia is a republic in Southeast Asia, consisting of approximately 13,600 islands and is the home for 239 million inhabitants. The country was governed by a dictator but has since 1998 had democratic elections. The majority of the population, 88 percentages, are Muslims which makes the country the largest Muslim nation in the world. The structure of the health system in Indonesia is built on districts with sub-districts which are supported by sub-centres. Problem: The health care is improving and more women are attended by professional health care workers when giving birth, despite this child birth still is a common problem. Yet there is a lack of human resources which contributes to the problem. Since the children are the future of Indonesia it is important that the health development policy is adequate and that it has a great compliance in order for the children to stay healthy. Aim: The aim of the study was to describe nurses/midwives work with health promoting education to parents to prevent ill-health among children in the district of Yogyakarta, Indonesia. Method: The method that has been used for the seven interviews is a qualitative content analysis. The interviews were carried out in the Dr. Sardjito Central General Hospital in Yogyakarta and in Puskesmas NGAWEN, Gungng Kidul district, Yogyakarta Province and Puskesmas Mlati II, Sleman district which are placed in the rural areas of Yogyakarta. Result: The result shows that there is a constant work with increasing the knowledge level among nurses and health workers on grassroots level in the district of Yogyakarta, to prevent ill-health among the children. Regarding the health promoting education a crucial finding was made that revealed the most common reason why parents did not apply the health implications that they received, was related to culture and tradition. Positively, there is a great will among health workers and nurses to learn more and increase the health level among the children. Nurses and midwives in the hospital had to rely on their experience when educating the parents while the nurses and midwives working in the puskesmas used the Mother and Child health handbook as a guideline. Discussion: To increase the chance of implementation among the families the health promoting education has to include culture and socioeconomic factors.

Keywords: Health promotion, education, nurses, midwives, parents, children, ill-health
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INTRODUCTION

All around the world people live lives in poverty suffers from diseases and obtain little or no education at all. The majority of these people have little influence on these matter and struggle everyday to survive. This is a problem that needs to be brought up by us in the developed parts of the world who possesses the resources to make a change. Imagine if you actually could change this and make the world a healthier place. We got the chance to at least shed light on an issue that is important for us when we received a scholarship which made a journey abroad possible. The Minor Field Study (MFS) is founded by SIDA which is the Swedish International Development Cooperation Agency and the scholarship is supposed to bring development and knowledge in international cooperation work. Since we both are interested in health-promoting education the topic of this paper was given and since we find children to be particularly vulnerable in the developing world the aim of the result would be how the society are working with enhancing the children’s health. Since the University of Borås already have a connection to the Gadjah Mada University in Yogyakarta, Indonesia the selection of place to execute the field study was easy. For two months, when the field study took place we experienced a lot of good will among nurses and volunteers to make the children healthier and also a thirst for knowledge which leaves us with hope for a better and healthier Indonesia.

BACKGROUND

Facts about Indonesia

Indonesia is a republic in Southeast Asia with Jakarta as the capital city which is located on Java. The country consists of approximately 13 600 islands and is the home for no less than 239 million inhabitants. This makes Indonesia the fourth most populated country in the world. The majority of the population is resident on the five largest islands Sumatra, Sulawesi, Java, Papua New Guinea and Kalimantan (Borneo) (Nationalencyklopedin 2009).

After being a Dutch colony Indonesia was declared independent in 1949 and for many years the country was governed by a dictator but has since 1998 there has been democratic elections. The current president is Susilo Bambang Yudhoyono who has been in charge since 2004. The president’s term of office is five years and in 2009 there will be a new election (Nationalencyklopedin 2009).

Language and religion

In Indonesia there are about 300 different ethnic groups and almost as many different languages. The official language is Bahasa Indonesian but Javanese is the most frequent language and is spoken by approximately 85 million inhabitants. Javanese is most common on Java which is the most populated island. The Indonesian diversity of culture is also reflected on the religious practice. As much as 88 percents of the population are Muslims, which makes Indonesia the largest Muslim nation in the word (Nationalencyklopedin 2009).
**Human resources and development**

Although poverty is a great problem and the proportion of poor population in Indonesia is 17 percent in 2004 (according to the international criteria of $1 per day) the growth rate and development of other resources than oil and natural resources, like tourism, agriculture and home industries, are strong and contributes to economic growth for the whole country. The government has also made up a strategy for the poverty and that resulted in a higher standard of living (World Health Organization 1 (WHO), 2009).

Indonesia has developed a lot the last decades both in stabilizing the economy and increasing the per capita income and has made major improvements in the education so that the number of children actually attending school has increased rapidly. Since 1992 the health sector activities are based on the Health law No. 23 that has stated “goals of the health programmes to increase awareness, willingness and ability of everyone to live a healthy life” (WHO 1, 2009). With this law the responsibility lays on a local level which is necessary for a successful development. The infrastructure for health has also improved as well and the number of health facilities such as hospitals, public health centres and public health sub-centres.

**Structure of the Health System**

The provinces in Indonesia are divided into districts and every district is in its turn divided into sub-districts. Every sub-district is after the decentralizing an administrative unit and has at least one health centre (puskesmas) that is supported by a sub-centres (posyandu). Doctors are practicing at the health centres and the sub-centres are often manned by nurses. The majority of the health centres also provides assistance to the population in the rural areas of the country either by going there by (motor) boat or four-wheel drive vehicles. In the villages the Family Health Post, which are managed by the community (kader) and assisted by the health centre staff, provides the habitants with preventive and promoting services. Midwives are also employed in the villages to improve the child and maternal health (WHO 2, 2009).

**Figure 1.** Structure of the Indonesian Health System (WHO 3, 2009)
Child Health

The percentage of women giving birth attended by a professional health worker or midwife has increased steadily from 40.7% in 1992 to 72% in 2004. Despite this development the infant mortality was and still is a problem and the most common causes are diarrhoea, acute respiratory infection or complications during birth. These conditions together are equal to 75% of the infant deaths. Malnutrition is also a problem among children in Indonesia and although the number has decreased it is hard to reach the most disadvantaged groups in the rural areas. Through policies Indonesia wants to ensure the availability of food with adequate nutritional quality for a price that everyone can pay (WHO 1, 2009). In 2005 were the death-rate among infants 46 ‰ and women’s risk of maternity death 6, 5% (NE, 2009).

Nurses and midwives

Even though the health care system is established, accessibility is still a problem mainly in obstetric and maternity care. In order to decrease risks for women the Ministry of Health has decided to give doctors, nurses and midwives two types of training in reproductive health service. The pre-service training that has its focus on maternal and neonatal health, family planning and sexually transmitted infections (STI), and the in-service training is intended for those with working experience that needs more particular training. The formal nursing education is three years and in order to get the midwifery diploma it’s another two to two and a half years (WHO 2, 2009).

In order to reduce maternal death the government is trying to increase the number of midwives at village level. Most of the midwives are trained to provide service on normal deliveries and to a certain degree manage complicated situations. The in-service training for midwives includes such as essential obstetric and neonatal clinical care, life saving skills, clinical postpartum care, post-partum haemorrhage and inter-personal communications and counselling skills (WHO 2, 2009).

Integrated Management of Childhood Illness

In many low-income countries the recourses of the health facilities are very limited or might not even exist, therefore WHO in collaboration with UNICEF has developed a strategy called Integrated Management of Childhood Illness (IMCI). The IMCI is a programme intended to promote growth and development and to reduce illness, death and disability among children less than five years of age in developing countries. The training programme which is divided into three parts is used in both preventive and curative approaches. The IMCI programme promotes accurate identification of childhood illness and ensures appropriate treatment of all major illnesses and at the same time it promotes a care seeking behaviour for parents. The programme also focuses on the need of improved nutrition and the importance of preventive care (WHO 4, 2009).

In Yogyakarta nurses from the Province Health Department visit puskesmas to introduce the IMCI program for the staff there. The program is a training-cd that consists of four components. At first the health worker read about the disease and common symptoms. Then there is a visual part where shorter films and pictures are shown of the condition. After that there is a practice part where questions are asked and the participant can exercise to improve their skills. The fourth part is the examination where the participants are being tested on their new knowledge, personal communication with Fitri Haryanti (RN), (2009-04-17).
International Council of Nurses

According to the International Council of Nurses, ICN a nurse has four fundamental areas of responsibility and these are to promote health, prevent illness, restore health and to ease suffering. The nurse should offer care to the individual, the family and the public with respect and dignity regardless of age, culture, religious views or social status (International Council of Nurses, 2005).

Health promotion

This declaration of health promotion was established as early as 1986 in Ottawa and for improvement in health to be possible some fundamental conditions and resources were also stated. These conditions and resources are; peace, shelter, food, education, income, sustainable resources, social justice and equity and a stable eco-system.

Health promotion is the process of enabling people to increase control over, and to improve, their health... Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-style to well-being, (WHO 5, 2009. Milestones in Health promotion, 2005).

According to the Ottawa Charter for Health Promotion the action aims to reduce the differences in the existing health status and to guarantee equal resources and opportunities to enable all people to reach their fullest health potential. Unless people are not able to take control of these things that determine their health they cannot achieve their fullest health potential. Therefore they have to have access to information, life skills and opportunities in a supportive environment and a secure foundation for making healthy choices. The strategies that are used should be modified to the local needs and possibilities to include the different social, cultural and economic systems. And for the health promotion to be successful the responsibility in health services must be shared among individuals, community, groups, health professionals, health service institutions and governments (WHO 5, 2009).

Concepts of health science

Life world

Life world is the reality that we constantly live in, our everyday life, it is something we are unaware of and take for granted. The life world is a very nuanced and complex reality which composes our experiences and actions, (Bengtsson, 1998). According to Dahlberg, Segesten, Nyström, Suserud & Fagerberg (2003) it is in our life world we seek a meaning and a context to our living. For health workers this means that a greater understanding for the patient’s life world is necessary to ease the suffering and to see it in a bigger perspective.

Health

According to Wiklund (2003) the human is a multidimensional unit and with such a view also health is something multidimensional. This means that it is difficult to draw a line for what is health and what is not. The meaning of the word health differs from individuals and also
between times in a person’s life. Health is something that depends on how an individual sees oneself in different contexts and how well he interacts with his surroundings. The biological heritage is also of importance for the experience of health.

**Suffering**

Suffering according to Wiklund (2003) is something that is linked to health and it is not just symptoms of a disease it can also be an inner process and in every case there is a threat or a loss of a person’s “self” or a loss of control. In many cases it is hard for the individual that suffers to talk about it with someone and the individual who is suffering often feels left outside and distant to other people. Health workers are sometimes also unable to talk about a patients suffering and in these cases the health worker focuses on the concrete things like medicine and symptoms. When a patient is suffering from a disease there are symptoms and the patient is often feeling unable to do things because of the disease. If the health workers are not able to cure the patient or if the healthcare is not good enough the patient experiences another kind of suffering. The author also mention another kind of suffering that is called life suffering. This is linked to activity and performance and on another level it is connected to who you are and what you hope to become. This suffering can take form as existential questions such as “what have I done to deserve this”.

**Wellbeing**

According to Dahlberg et al. (2003) wellbeing is something as important to aim for as suffering is to avoid. Suffering and wellbeing can coexist but for the wellbeing to be possible the human has to admit to the suffering and dare to be suffering. Both suffering and wellbeing can be explained and pointed out through different perspectives but the most important one is the life-world perspective where the only one who is experiences the suffering or the wellbeing can explain it. Also Wiklund (2003) strengthen this life-world perspective and points out that it is an inner experience and is therefore personal and unique. Dahlberg et al. (2003) points out that wellbeing can be created with simple means for example for the patient to be addressed with his or hers first name makes them feel that someone cares that they are where they are right now.

**Resources**

Available resources are according to Wiklund (2003) everything that a human has to use to handle suffering and ill-health to promote once own health. The resources can be of inner character for example how a person can verbalize and put words on his experience of ill-health and be able to reflect over once own thoughts and feelings. The resources can also be of external conditions like a well structured existence and support from friends and family.
FORMULATION OF THE ISSUE

The health levels of the people in developing countries are increasing. In Indonesia there is a constant work with health development and in many ways it has been successful but common health problems such as diarrhoea and acute respiratory infection among children still exists. The human resources, such as nurses, doctors and health workers are still not enough compared to the population.

Ill-health and infections among people living in Indonesia is a problem due to the lack of health knowledge and sometimes poor standard of living. The lack of human resources could also contribute to the problem. The most vulnerable group are the children because their immune system is not fully developed and because they are depending of their parent’s knowledge about health and hygiene and its relation to prevent ill-health and infections.

Health workers like nurses and midwives play a major part in spreading the word about a healthy lifestyle. Prevention of ill-health and infections is an important issue not only in Indonesia but in the whole world. Since the children are the future of Indonesia it is important that the existing health development policy is adequate and that it has a great compliance in order for the children to stay healthy. In the health promoting education nurses and midwives play a major part and to following their work and development is an interesting issue to look closer in to.

AIM

The aim of the study is to describe nurses and midwives experience of working with health promoting education to parents to prevent ill-health among children in the district of Yogyakarta, Indonesia.

METHOD

Preparations

Before we went to Indonesia we sent our request to the Gadjah Mada University, asking for participants to our study. Our request was for nurses who were active in rural areas of Yogyakarta and also active in the health promoting education. We also sent our aim and purpose of the study so that the University would know what our expectations were. This was a help for the University to clear some things out for us since we were not familiar with the context. We also asked for an interpreter who could help us carry out the interviews. Once the University had selected the participants an information letter were sent out telling them what the study was about, that the participation is voluntary and that the information would be handled discretely (Information letter, Appendix I). At this point the University help us with a local research permission that made this study possible.

The interviews

The interview method were structured and consisted of 18 questions. We were interested in nurses and midwives work with health promoting education and what the education consists of. We were also interested in how nurses and midwives educate the parents, their view of the
parents and how they can keep updated with new scientific research. Present at every interview were the two authors, the respondent and the interpreter. While carrying out with the interviews one of the authors read the question in English and then the interpreter translated it in to Indonesian. The respondent answered in Indonesian and the interpreter translated the answer into English. This also made it possible for the authors to ask follow up questions. The interviews were recorded with a minidisk and transcribed as soon as they were completed. The interview questions are presented in Appendix II.

**Place of data collection and the participants**

Data were collected in four different settings. Interviews were carried out in the maternity ward at the Dr. Sardjito Central General Hospital in Yogyakarta, Puskesmas NGAWEN, Gungng Kidul district, Yogyakarta Province and Puskesmas Mlati II, Sleman district. The hospital is located in the centre of Yogyakarta and the puskesmas are located in more rural areas of the district around Yogyakarta. The authors also got the opportunity to visit a posyandu for observation. A total of seven interviews were made and the respondents had between two to thirty-two years of experience and the numbers of respondents were fourteen. Six of the interviews were conducted with only one respondent but one of the interviews was a group interview consisting of nurses, midwives and doctors. The group interview were handled the same way as the individual interviews.

**Qualitative content analysis**

The data were analysed by a qualitative content analysis illustrated by Granskär (2003) to describe nurses and midwives work with health promoting education to parents to prevent ill-health among children in the district of Yogyakarta, Indonesia. To be able to get as adequate data as possible the method of a focused interview were chosen. This model is according to Bell (2000) easier to structure and it could be compared with a questionnaire but it is the interviewer that fills in the answers and not the respondents. Bell (2000) also points out that the respondents in every question will be given the opportunity to talk free about things that concern the issue which is of importance because new questions and thoughts can be brought up.

**The analysis**

From the transcribed data meaning bearing sentences where picked out and written on a post-it with the number of the interview written in a corner. This was made so that the meaning bearing sentence easily could be tracked down to its original transcribed interview in case of quotation. The meaning bearing units were then placed on a large wall and as the analysis proceeded the wall got more and more post-its. The post-its were placed on the wall one by one and if two post-its had similar content they were placed together. When all the post-its were placed on the wall several groups concerning the same issue was made and themes and sub-themes was created. These themes and sub-themes was a condensation of the meaning bearing unit which means that themes were crated out of the foundation of the interviews. When the themes and sub-themes were selected the work with converting the meaning bearing sentences into a result started. At first a Power Point presentation was made which worked as a summary of the result though the result was not yet compiled into text. This presentation was introduced for a group of lectures and students from the Gadjah Mada University. The Power Point presentation worked as a foundation when writing the result.
Scientific articles are used in the discussion. The articles were found by searching through databases such as Cinahl, Pub Med and Blackwell Synergy. Keywords were used for the search and those were: Nurse*, health promotion, education, children, parents, developing country. Other literature for the study was found by manual research.

Ethical consideration

The Gadjah Mada University chose the participants and place of data collection, we had little or non influence in the selection. This may have affected the outcome of the result by them providing us with representative context.

RESULT

Introduction to the result

According to our respondents the education is provided by nurses, midwives, doctors, kaders and sometimes also students. The education takes place at the hospital, the puskesmas or posyandu and even sometimes in the families’ homes. The posyandu is a temporary health centre in the village, which is open once a month and where mothers are introduced to the Mother and Child health handbook and they can bring the children for weighing. But it is also available for elder who can get their blood pressure measured by a nurse and receive necessary medication from a pharmacist. Everyone who visits the posyandu gets a free meal.

The staff that works at the posyandu are called kader and is a person that voluntarily helps out in the posyandu with education and information to the mothers about how to take care of their child. The kader has no formal education but the nurse or midwife from the puskesmas teaches the kader what to teach the parents about and if they can not handle the problem they should go to the puskesmas or the hospital. Without the kaders the health care would not be possible in many places and they are a good support to the staff in the puskesmas when it comes to checkups and nutrition status controls.

In general the education in both the hospital and at the puskesmas focused on giving the parents the appropriate tools to take care of the baby at home to prevent ill-health and manage illness. The education for women in the posyandu is provided by midwives and based on The Mother and Child health handbook which is further explained in Appendix III. While the education in the posyandu was carried out in groups based on the Mother and Child health handbook the education in the hospital was given to the mothers one by one and based on personal experiences of the nurses there.

The analysis disclosed three main themes regarding the health promoting education. The result is based on a description of:

- The foundation and content of the health promoting education
- The respondents view on the parents
- Obstacles for the health promotion education to be implemented
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<th>Sub-themes</th>
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<td><em>Guidelines</em></td>
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<td>The foundation and content of the health promoting education</td>
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<td><em>Mother and child health handbook</em></td>
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<td><em>How to take care of the baby</em></td>
<td>The content</td>
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<td><em>Further education for the nurses and midwives</em></td>
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<td>Ways for the respondents to keep up to date with new scientific research</td>
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<td><em>The parents</em></td>
<td>Who receives the health promoting education and do they need it?</td>
<td>The respondents view on the parents</td>
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<td>Expectations</td>
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<td><em>Low education and poor socioeconomic standards</em></td>
<td>Compliance</td>
<td>Obstacles for the health promoting education to be implemented</td>
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<td><em>Home situation</em></td>
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**The foundation and content of the health promoting education**

**The foundation**

The result of the interviews showed that the respondents at the hospital did not have any guidelines educated the parents. The guideline that they used where The Mother and Child health but they performed health promoting education based on their knowledge and experience. The respondents at the puskesmas did have guidelines that they used when they handbook and all the respondents where very pleased with it. Since the guideline includes the different stages of the pregnancy, dangerous signs and child development, the respondents found it useful for nurses, midwives and parents. All the respondents work with health promoting education is trying to strengthen the parents’ ability to take care of their children at home.

**The content**

The respondents are involved in the education about how to bath the baby, take care of the umbilical cord, the importance of frequent breastfeeding and immunization. All the education is health promoting and make the parents aware of dangerous signs and how to take care of the baby at home and when its time to seek professional help.

The most common problem among newborn babies and children over one year of age according to the respondents are fever, diarrhoea and influenza. For these afflictions the respondents recommend good hygiene, good and balanced nutrition and enough breastfeeding. It is also important to regularly control the baby’s development status at the puskesmas and posyandu. If the baby get diarrhoea it is important to prevent dehydration witch means enough breastfeeding, extra fluid, sometimes ORALIT (salt solution), keep a clean and healthy environment and good hand hygiene.

Many respondents mentioned icterus as a common problem among new born babies but also and for this problem the parents get the advice to expose the baby to the early morning sun and give enough breastfeeding. For this or other conditions that the parents can not over come at home or at the puskesmas they should go to the hospital. The respondents that gave the icterus advice did not inform the parents and did not know why the sun was important for the baby they only referred to the doctor and that it was his or hers task to give that information.

The majority of the respondents answered that most of the education takes place after the baby contract an illness but everyone agree that it is better to educate before in order to prevent ill-health. Many times the education depends on the situation for example if many babies in a community get diarrhoea the education in the puskesmas or posyandu will be about diarrhoea.

**Changes in the education**

The respondents do not express any specific changes since the implementation of health programs from the governments but many mentioned changes in breastfeeding. For example the time that the mother should give the baby breastfeeding have change from four moths till six months and that it should be frequent whenever the baby wants and not every two hour, the baby also gets additional immunization.
Ways for the respondents to keep up to date with new scientific research

All of the respondents stated that the health education is prioritized in their district and that they have enough competent staff to perform the education. The most common way for the respondents to keep up with new scientific research is through seminars and training. No one of the respondents has this seminar or training frequently and many respondents mentioned that they would like to have these activities more often. It is common that one or two nurses/midwives get the opportunity to go to a seminar or training and then they have to share their new knowledge with the rest of the staff. Further it is common that the doctor’s keeps updated frequently and then share the knowledge with the nurses and midwifes. The respondents said that they seldom read scientific articles or use the internet. More common is to read health magazines that are provided from the health department.

The respondents view on the parents

Who receives the health promoting education and do they need it?

The respondents expressed that the mothers most of the time where the only one who got the health promoting education. The respondents described the absence of the father as the one having to work or that the education was specific to the mother like in the posyandu. Some of the respondents also said that it was an active choice of the father not to attend and even if the education took place in the families home it was rare that the father participated.

The majority of the respondents were convinced that the parents need the education. The respondents believed that the parents need the education because of poor standards of living, low education and strong cultural and traditional believes. The parents with high educating level do not seem to need the education as much as the parents with low education level since they tend to read or seek information on their own. Requests from communities and parents for health education from health providers show that they need and want the education. The respondents are also convinced that the education they provide give positive effects. Although the respondents from the hospital never get to see the effects of the education since the children come to a different ward for follow up controls. The respondents believed that the education is very important to prevent the mother and child from ill-health and to increase their quality of life.

Expectations

Most of the respondents expressed that the parents have rather high expectations of the health providers. The parents assume that the health providers know everything about all different conditions and they have a lot of questions. Many of the respondents also experience that the parents want to have own time with the health provider to learn more but since the health providers are not enough this is not possible.
Obstacles for the health promotion education to be implemented

Compliance

Why the parents did not comply with the advices the respondents revealed were depending on low education level, poor socioeconomic standard or that the parents did not understand the education. Some of the respondents mentioned that some of the parents did not even care or that they were lazy. The home situation is also a determining factor to if the parents are able to follow the advice. If they don’t have the support from home it is harder for them to comply or if their family or relatives have strong traditions or cultural believes it could be hard for the parents to implement the new way to take care of the baby.

If the parents comply with the education the respondents believe it is because that they are satisfied with the education and have hopes for a healthy baby. It could also depend on the parent’s high education level, good socioeconomic standard and good support from home.

Cultural problems

Traditions and culture is very strong and sometimes it creates problems according to the respondents. For example if the mother can get education from the provider but the family tells her to act different and therefore she follows their advice instead. Many respondents expressed that the mother only had a traditional way of thinking before she got the education and that it is the providers roll to clarify what is right and wrong. One example a traditional way of thinking is when the mother give breastfeeding she should not, according to tradition eat meat, chicken or fish only vegetables or fruit, which is wrong according to the respondents. Many respondents stated that the expose to the media makes it easier to implement the education among the young generation since they many times are more open and less bound to the tradition than the older generation.

Other source of information

The respondents stated that TV, newspaper, family, neighbours and friends are common sources of education besides the puskesmas or posyandu. Most of the time media provides good information although the information sometimes needs to be updated. For example the commercial about how to take care of the umbilical cord says that the parents should use 70% alcohol or “Betadine” but that is not right since now the health workers use only clean water and keep the umbilical cord in the open air.
DISCUSSION

Method discussion

The study took place in a different setting then we are used to, in a developing country. That means that religion, culture and language totally differs from our own and we faced a huge challenge. We accepted the assignment with great spirit and were looking forward to what the outcome would be.

Finally there

When we arrived at the University in Yogyakarta participants to our study where already chosen for us and it was both nurses and midwives from one hospital and two puskesmas. Since the participants already were chosen and appointments already were made we had little or none influence on the selection of participants. The University motivated the selection by telling us that we would get a broader perspective on the health promoting education. Our aim was to interview nurses but also midwives were included since they are mostly responsible for the health promoting education, especially in the hospital. We chose to follow the recommendation from the university and interview both nurses and midwives.

The interview questions

The numbers of questions were motivated by our method which is a focused interview Bell (2000). The number of questions could seem like too many but we wanted as much facts as possible concerning our issue, without the answers depending too much on the respondent’s willingness to expound on one’s views. The structured interview questions kept the respondents answers short.

The interviews

An opportunity appeared to carry out a group interview, which was not planned from the beginning. After the interview we had to think how to use the data. Our experiences from the interview were that the result strengthened our result from the individual interviews and confirmed already known facts. It felt like the respondents where more eager to answer the questions and where inspired and motivated by each other to answer as detailed as possible. Our assumption is also that if any of the respondents would answer a question incorrectly or that the answer wouldn’t correspond with the truth some of the other respondents would protest against the answer.

Language barrier

None of us working with the study are native English speakers which we found out was the largest challenge with this Minor Field Study (MFS). When the spoken word was not enough the body language played a major part in the understanding of the respondents answers. This may have caused some loss of information or personal opinions from the answers. While carrying out with the interviews we asked the interpreter to translate as exact as possible and to put personal views aside. Kapborg & Berterö (2002) describes threats to validity when using interpreter in qualitative approach. Different problems during the interview process can arise, the first one is when the researcher is not doing the interview in his or hers mother
tongue but in English. The second one attest when the interpreter translates the questions to the respondents and the last threat is when the interpreter is translating back, then it is hard for the researcher to know if the interpreter modify or sum up the response. Further more the authors mean that these threats can be reduced through using an interpreter that has a good linguistic knowledge and have experience of research.

When doing research in a different culture there are some aspects to consider. Birks, Chapman & Francis (2007) are discussing this problem and says that in order to get a deeper understanding about the respondents the researcher have to increase the knowledge concerning the culture and the current context. While interviewing examples and rephrasing of statements could be necessary in order to minimize misunderstandings. Further more the authors are discussing the fact that the respondent may have a strong desire to please, and give the researcher the right answers. Then it is important to clarify the respondents roll and to make them understand what is expected. This was something we had in mind while carrying out with the interviews. We asked the respondents to describe their work with health promoting education on the basis of their own experience.

Birks et al. (2007) assert consideration of the environment where the interviews take place; it needs to be a quite and calm place for the respondents to feel secure. Time is also an aspect to consider, the respondents should not feel stressed because they need to be elsewhere.

**Limitations of the study**

Seven interviews including one group interview may seem like a small number but every interview confirmed the outcome of the other interviews. The result appears to be rather accordance to the reality in the district but it might be hard to generalize and apply the result to whole of Indonesia. Java and especially Yogyakarta appeared to be a rather developed part of Indonesia and the outcome of the study may have been different if it had been conducted in a less developed part of the country.

**Result discussion**

The result of the interviews showed that none or little consideration of the parent’s life world was taken and the health promoting education was more of a one way communication than a dialog. The health workers could encourage the parents to ask questions and perhaps the parents would feel more involved. If the education would have been more individualized maybe the parents would have had a better acceptance for the education and the compliance and understanding might have increased. When working with health promotion the parent’s life world need to be considered.

**Costume made education and networking**

Most of the respondents were sure that the parents need the education and factors that indicates that the parents need the education is poor standards of living, low education and strong cultural and traditional beliefs. In the article by Burkhart (2008) different aspects of how to educate patients in home care is described and the author declare that there are barriers that can affect the patient’s ability to learn such as age, culture, motivation, emotion and cognition and therefore it is important for the nurse to adjust to every patients situation. If the
education is individualized the patient can obtain information and use it. The words that are used and how they are applied has a crucial importance in the patients learning process. To teach frequently and focus on the patients goals has a significant impact. Further more the author describes that confirming and ascertain what patients wants to know will motivate and engage them to meet personal goals. In order to increase the effectiveness of the teaching it is important that the patient understands the purpose of the education. The authors view of personal and easy education could be applied on our view of the Mother and Child health handbook which we found had an uncomplicated design and where easy to understand and to use for the nurses in their teaching roll. The book consists of pictures combined with short texts which also make it easy for the mother to use. Reynolds, Wong & Tucker (2006) brings up an interesting aspect of education and health service and says that it should be more costume made to match the unique needs for the woman and that the interventions should target them in their own communities which in our understanding could be to have a better life-world perspective. What we saw in our field study was that the mothers and the nurses gathered in the posyandu and this is one way to get closer to the mothers so they do not have to travel far to attend the education. The education is for all women both for the ones who will give birth for the first time and for the women who have given birth before. This is not only a social gathering but also a chance for the women to exchange experiences and knowledge. The importance of networking is brought up in an article by Andrzejewski, Reed & White (2008) who indicate that it benefits both the highly and the lower educated parents. The individuals who are literate may share their knowledge and health information with others in their social network, both literate and illiterate. The result in our study showed that the respondents mentioned that low education level is one factor that indicates that the parents need the education and this is confirmed by Andrzejewski et al. (2008) who also mention the exposure of information in mass media to have an significantly and positive effect on those who where literate and strengthen the importance of health developing interventions through mass media. Our conclusion is that this information also will reach the illiterate once through the positive effect of the network. Mass media as another source of information was only mentioned briefly in the interviews but the respondents believed that if the information is correct it could be a good source of information.

Education close to home

Intervention that is provided closer to the babies´ homes and in cooperation with the local grass-root health workers would result in better follow-up rates according to de Souza, Sardessai, Joshi & Hughes (2005). Our interpretation of the grass-root health worker is that it could be compared with the kader in the Indonesian society. This person is someone who is close to the families, helping them with health related issues. The kader is working voluntarily and we believe that without this engagement the heath system in Indonesia would fail in many places. The kader is primarily working at the posyandu which is the health centre in the villages not far away from the families. Our assumption is that if the posyandu would not offer it services it would be less likely that the parents would travel to the puskesmas for preventive care. de Souza et al. (2005) discusses some possible causes why the compliance was so low and mentions that the unwillingness of parents to travel a long distance to a centre that provides only preventive and rehabilitation services may depend on the factor that the woman’s work is never done. Since the majority of the babies are brought in by their mothers it could be hard for them travelling to a health centre and at the same time cope with the housework. It could also be hard for them if they do not have the support from home. The authors therefore suggest that instead of the mothers coming to the program, the program
must go to the families. We believe that this theory might be accurate since our visit to the posyandu revealed that all the visitors this day where woman, which all appreciated the activities at the posyandu. Our conclusion is that this is one way to come closer to the families and actually pursue preventive care. We assume that there is a small chance that these woman would bring there children for preventive care at a different health centre located further away from home. Although we believe the majority would bring there children to the puskesmas if they experience severe ill-health.

**Level of education among the parents**

The level of education is of importance to parent’s willingness to comply, according to de Souza et al. (2005). Mothers who had a college education were over three times more likely to comply with the intervention program. The level of education in the fathers was not statistically significant. The respondents express that women who had a low education level had a lower frequency of compliance while the highly educated women had a deeper understanding of the education they received and therefore had a higher frequency of compliance. All the respondents in our interviews strongly believed that the parents need the education and primarily the parents with low education level who might not get accurate information from elsewhere.

de Souza et al. (2005) declare that even if the health care interventions are free and administrated by highly trained professionals, parents with high-risk babies may not attend the intervention program and the poor compliance may be caused of the low level of education of the parents and the distance to the centre.

**The meaning of culture and tradition**

According to the respondents culture and traditions were very strong and constitute a dilemma for parents when choosing what treatment to use when their babies experienced ill-health. The respondents reviled that in many cases the parents did not get any support from their family and relatives to follow the health workers advice and therefore they followed the family tradition instead. Since this appears to be a huge problem that influences the compliance among the parents we where surprised that none of the health workers brought up culture or traditions as an aspect in the education. It seems like most of the respondents where aware of this problem but no one addressed the issue. We found this part of the result the most interesting and if we would have known this before the study, we probably would have focused more on this issue. Pitts, McMaster, Heartmann & Mausezahl (1996) have addressed the aspect of cultural beliefs and the problems it could cause. The study was made in Zimbabwe where two health care systems coexist, the modern western and the local traditional. The authors (Pitts et al., 1996) explain the traditional health care to be holistic in its approach and are affected mainly by two factors, the physical environment of the individual and the philosophy of life and religion. Western medicine may be the leading practice concerning physical aspect of health but in many cases it neglects the spiritual aspects. It is crucial that interventions for health combine both traditional elements and western beliefs to accomplish effective education for the mothers regarding treatment.
A skilled attendant

Every minute of every day somewhere in the world one woman dies during pregnancy or child birth and eight newborns die, which is a great loss to families and to societies... One of the most important interventions proven to promote safe or healthy pregnancy for women and their newborns is the availability of skilled care... Yet skilled care is missing for nearly half of the world’s women, (Thompson, p 472, 2005).

A skilled attendant, according to Thompson (2005) is defined as a nurse, midwife or doctor who has education and been trained to expertise in those skills that is needed to manage relevant health issues. Whet this formulation of a skilled attendant the shortage of professional care is obvious above all in the rural areas of Yogyakarta where the volunteer (kader) plays a major part in the health care and health promoting education. Our experience of the kader was not negative, if anything the other way around. And if you have to choose between having no health worker at all or have the kader present, the kader might be the better option since she is at least informally educated. In our visit to the posyandu we saw a major effort from the kaders and a fighting spirit of making the population healthier and avoid infections and ill-health. Since the kader is taught by a nurse her skills would at least be that good that she would know when it is time to seek help from a puskesmas or at the hospital. We also experienced the kaders to be taken serious by the women in the village and that is another condition that has to be achieved for their work to matter.

Thompson (2005) also point out that the countries need to establish and implement strategies to educate skilled attendants and that they also have to make sure that their health system is effective for the ones using it. Furthermore the countries should estimate how different barriers like class, culture and literacy may have an effect on the availability of skilled care for the women in their district. The IMCI program is one way for Indonesia to increase the knowledge among health-workers. It is a programme that reaches a lot of health-workers at the same time with probably a low cost and hopefully a positive result in increasing their knowledge level. The risk of misunderstandings and second or third hand information decreases along with the use of this training programme which also is available when there is no shortage of time. Therefore the patient work is never suffering and every staff member of the puskesmas can be educated without the organization suffering. The further education does not only benefit the professional health-workers but also the kaders and therefore in the long run also the parents and their babies in rural areas, even if they do not have the possibility to visit a puskesmas. About the economic aspect of this issue we assume that the cost of using this training program ought to be below the cost of sending the same amount of health-workers to further education. Another statement by Thompson (2005) is that it is important to strengthening the primary care worker’s resource base of skills which will ensure the optimal use of manpower available at the grassroots. At this writing moment the Health Department of Yogyakarta is educating health workers around the region in order to strengthen their knowledge with support of the IMCI program (World Health Organization 2009). This effort makes it possible for more people to take part of the knowledge and spread the information to those who actually need it. There is a thirst for knowledge among the health workers and a strong will to make it available for everyone.
Healthy women lead to healthy children and promote healthy families, and healthy families lead to healthy nations, (Thompson, p 476, 2005).

This could be a health promoting educational goal set up by a nation that has a vision of how their country could be. But for this vision to come true the right amount of health-workers with the right knowledge and the will to make a difference has to be adequate and meet the needs of the population. Our observation made it clear that there is a will among health-workers and even if the basic conditions might not be the best they are trying to do the best out of every day. But for the health promoting education to be effective it takes that it includes different factors like socioeconomics and culture, otherwise there is a risk that the education only goes one way and never gets implemented in the families and the villages. The health-workers has to understand why the parents do not follow their advices and what they can do to change that, and the parents has to understand why it is important that they act differently than their family and relatives tell them to do. The health workers also have to be aware of that they themselves can be a carrier of tradition and culture. We heard about highly educated nurses that, even if they knew better, still acted as their elderly told them to do concerning actions for health.

To improve health among children in Indonesia, parents have to be given the right tools for a healthy behaviour and be strengthened in their resources, both social and personal. By understanding factors that might contribute to non-compliance the chance of enabling people to increase control over and improve their health should be seen as a successful process of the health promoting education.
CONCLUSION

While working with this study three main findings were made. First of all there is a constant ongoing work increasing the knowledge level among nurses and health-workers in the district, in how to detect, treat and educate parents in different ill-health conditions concerning the children. Slow but surely the work is proceeding and there is an enormous will among nurses to learn more and to make a change which was another main finding. The further education of the nurses is necessary since new science is developed every day and many of the nurses are founding their teaching on personal experiences. Regarding the health promoting education for parents a crucial finding regarding the meaning of culture and tradition where made and in our understanding this stood for the majority of the non-compliance cases among parents who received health promoting education. For the health promoting education to be successful the meaning of culture and tradition should therefore be implemented in the education much more than today.

IMPLICATIONS FOR NURSES AND MIDWIVES

It became clear to us when working with the study that the health promoting education is needed and that different factors contribute to what the education is about. All respondents agreed that the education should be held with a preventive approach but in many cases the education took place after a disease or outbreak of infections in a village. This seems to be a resource based issue that might be hard to rapidly do something about. But for the existing health promoting education to be effective it is of crucial importance for the nurses and the midwives to have a good knowledge of the people in the village or in the district where she is teaching. What are the main problems and how do they react to different ways of treating ill-health than their elderly? The level of literacy may also be an aspect worth considering for the provider of health promoting education. Groups that gathers and discusses health related issues seems to be the best way of education since the group members can learn from each other and the nurse can teach about issues that is brought up by many participants instead of teaching them one by one. This is also a chance to talk about former health education that might be wrong today. However, for the health promoting education to be effective is has to be individualized and held out of every participant’s different base of resources.
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Personal Communication and help with translation and explanation of the Mother and Child handbook, Fitri Haryanti, RN Masters, Paediatrics Nursing Department, School of Nursing and also a teacher at the Gadjah Mada University

Personal Communication with Rizki Puji – nursing student from Indonesia


Gadjah Mada University
Appendix I

To whom it may concern,

We are two nursing students from the Faculty of Health Science at the University of Borås, Sweden, and we are writing our Bachelor thesis in the subject of health promoting education. The purpose of this study is to describe nurses/midwives work with health promoting education to mothers who has given birth for the first time, to prevent infections among children in rural areas if Indonesia.

To get this information we will interview nurses/midwives and it is absolutely voluntary to take part in the study. The interviews will be strictly anonymous and confidentially treated. An interpreter will help us to carry out with the interviews that will be in your mother tongue. For us to get the most truthful information in the subject, we would appreciate if you answered the questions as honest and correct as you can.

Yours sincerely,
Emma Heleander and Susanne Nygren
Appendix II

Interview

1. Do you have any guidelines regarding health promoting education for parents to prevent ill-health among their children?
2. Do you experience the guideline to be useful?
3. What do you believe is important to educate about?
4. What do you believe is the three most common problems among newly born children in your district?
5. Do you educate the parents in how to prevent, how they get the disease, how to take care of and treat these diseases at home? If you do, how do you educate the parents?
6. What do you believe is the three most common problems among children over one year of age in your district?
7. Do you educate the parents in how to prevent, how they get the disease, how to take care of and treat these diseases at home? If you do, how do you educate the parents?
8. Who educates the parents?
9. When do you educate, before or when the parents seek help for their sick child?
10. Have you experienced any changes the last years (since the introduction of the health programs, Healthy Indonesia 2010)?
11. What expectations do you believe that the parents have on you and the education?
12. What is your opinion on parents’ compliance to health promoting education, why/why not compliance do you think?
13. If compliance among parents, do you see effects on the health status of the children?
14. Do you believe that the parents need the education?
15. Do you experience that the parents get education from elsewhere like media, friends or relatives?
16. Resources
   - Is this education prioritized in your district?
   - Do you have enough competent nurses who can provide the education?
   - Do you use any brochures or something concrete to show on/with/ or give the parents?
17. How, or do the nurses get education on how to educate the parents?
18. How can you keep up with new scientific research in this matter?
Appendix III

Mother and Child health handbook

This is a book that every pregnant woman gets when the pregnancy is confirmed. The book follows the mother and child until its five years old. If the mother seeks healthcare in a different ward she should bring the book that is used as a personal journal. The book contains the parent’s identity, address, phone number, religion and occupation. Later on also the baby’s identity, birth weight and measurement is documented.

Information to the pregnant woman

When the woman visits her provider for the first time she will be weighed and her vitals will be checked, she will also be given the vitamin folic acid to prevent anaemia. The provider will also give the woman advice about nutrition and hygiene and if she needs any vaccinations. The pregnant woman should rest a lot and should not be afraid to have intercourse; this is important information because in the past the pregnant woman was told not to have intercourse since there was a strong belief that the sperm would make the baby filthy. The pregnant woman should not drink alcohol or smoke. The woman should seek her provider if she gets high fever, bleedings from the vagina, oedema, if the baby does not move frequently or if the water breaks.

Planning the delivery

The preparations for giving birth to the child begin with the parents deciding who they want to attend the delivery and the father pays for it. Then the time will be estimated for the pregnancy and an approximately delivery date will be set. Arrangements with extra blood for the mother will be conducted in case of an severe bleeding during the delivery. Since the blood banks resources are limited the relatives will be asked for a contribution. The parents will also be asked to arrange transportation to the delivery ward. If the parents decide to make the delivery at home preparations with lights, towels, linen, clean water, soap and clothes for the baby has to be done. The parent knows that the baby is on its way when the water breaks or if the woman experiences contractions.

The actual delivery

Before its time to deliver the baby the mother should eat and drink properly, use the bathroom, walk around and breath correctly then its time to listen to the provider when its time to push. Dangerous sign before delivery is if the amniotic fluid is discoloured and dark, not clear as it should be. Symptoms to observe during the delivery are when the woman has been in labour for more than twelve hours, bleeding, having a seizure, or if the woman is not strong enough to push. Other things to be noted are if the woman experienced serious abdominal pain or suffer from disorientation. It is also dangerous for the mother if the placenta does not come out. If the mother is giving birth at home these are signs that indicates that the mother needs immediate health care.
After delivery

When the baby is born it is important to breastfeed the baby within thirty minutes after delivery and then breastfeed regularly until the baby is six months old. It is possible to keep breast milk in bottles in room temperature for six hours and in a refrigerator for twenty four hours. After the delivery the woman also gets advice about how to take care of herself with plenty of rest, good food and vitamin A. The woman should take good care of her hygiene and change her sanitary towel regularly. The parents also get the advice to not get pregnant to soon again. The health status of the woman is carefully documented in the Mother and Child health handbook. There is also documentation about what kind of health promoting education the mother has received. A follow-up will be conducted two times during the three first days and then on the seventh day and after two weeks.

The baby

After the delivery the baby’s weight, length and head measure will be documented. The mother gets information about how a healthy child up to one month should act. The baby should cry, be active, find the breast and satisfy its need for nutrition. A healthy child should weigh from 2500 gram and up and have a healthy skin colour.

The woman should breast feed her child within thirty minutes after delivery and she should absolutely give the baby the first breast milk, since it contains a lot of healthy substances. This is important information because in the past there was a strong belief that the first breast milk was filthy and was not good for the baby. The child should be kept warm and dry close to the mother. Six hours after delivery the baby should be bathed and dressed with dry clothes.

To avoid infections the umbilical cord should be washed with water and then be kept clean and dry. The parents should absolutely not use anything else than water since the risk of an infection increases. This is important information because in some Indonesian cultures a herbal salve is being used for the umbilical cord. The baby also gets standard A-antibiotic and hepatitis B vaccination within seven days.

Signs of ill-health of the baby

The parents should pay attention to signs that indicates that the child experience ill-health. This could be signs such as lack of apatite, seizure, bad circulation in the extremities, signs of icterus, odour, wet umbilical cord or lack of activity from the baby. If the parents notice any of these symptoms they should go to their provider.

1 month – 5 years

The baby should get weighed and measured once a month and the mother get educated in how to keep the weight and measure curve. If the baby follows the normal curve there is no need for the parents to worry but if the child occurred below the normal growth curve they should seek their provider. Two times a year they pay a visit to their puskesmas or posyandu to get their vitamin A and if necessary vaccinations.
How to take care of an ill child at home

The parents get educated in how to take care of their child at home in case of illness. First of all it is important to give the child breast milk or fluid frequently and if necessary salt-solution. If the baby suffers from diarrhoea it is important to maintain good hand hygiene. If the baby has a fever the parents are told not to expose the baby to large temperature differences, medicate with paracetamol and use mosquito net in malaria regions. If the baby gets unconscious or have a seizure the parents need to go to the hospital or puskesmas. High fever with petechiae, abdominal pain and bleeding from nose or gums, could be dengue fever and indicates that the child needs immediate care. Cough and high frequent breathing could be symptoms of pneumonia and should be treated by a professional health worker. Diarrhoea with bleeding could also be a serious condition and need to be treated.