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IMPLEMENTATION OF THE HEALTHY INDONESIA PROGRAM WITH A FAMILY APPROACH (PIS-PK) AT COMMUNITY HEALTH CENTERS IN BINTAN DISTRICT, KEPULAUAN RIAU PROVINCE

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ABSTRACT

One of the policies to strengthen quality essential health efforts is through the Healthy Indonesia Program with a Family Approach (PIS-PK), monitoring and evaluating policies to measure whether policy implementation is going according to the expected goals. This study's purpose was to implement the Healthy Indonesia Program with a Family Approach (PIS-PK) at the Bintan District Health Center. This study uses a qualitative design, determining informants by purposive sampling technique where the primary informants are five people, and triangulation informants are six. Data analysis uses content analysis. The results of the PIS-PK implementation research could have been more optimal. The factors that support implementation are the communication factors that have gone well with the internal and external socialization and the attitude factor of the implementer committing enough to support the program's implementation well. While the inhibiting factors in terms of resources are limited resources, program infrastructure, and delays in budget disbursement. From the bureaucratic structure factor, there needs to be tiered coordination between the health office and the puskesmas. The district health office can immediately create a program organizational structure to facilitate coordination, facilitate the budget disbursement process and provide program support infrastructure. There needs to be cross-sectoral collaboration in supporting the implementation of PIS-PK at the Bintan District Health Center

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1. INTRODUCTION

Health development is the effort of all components of the Indonesian nation, which aims to increase awareness, willingness, and ability to live healthily for everyone to realize the highest degree of public health. One of the leading programs in current health development is the Healthy Indonesia Program with a Family Approach (PIS-PK) [1]–[3]. According to the Minister of Health of the Republic of Indonesia (2016), PIS-PK is one of the fifth Nawa Cita agenda programs, namely improving Indonesian people's quality of life. In the context of implementing PIS-PK, it has 12 main indicators to mark the health status of a family. The Community Health Center is the spearhead in implementing the policies that are formed, including the Healthy Indonesia Program with a Family Approach. Therefore, puskesmas need to carry out more optimal strengthening to properly implement a program [4], [5].

The Healthy Indonesia Program with a Family Approach started in 2016 in 9 Provinces, 64 Regencies/Cities, 470 puskesmas, then PIS-PK was implemented in 34 provinces, 514 Cities, with the stages of 2,926 puskesmas in 2017,

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5,852 puskesmas in 2018 and 2019 implemented in all health centers. The provinces with the lowest percentage of registered families in 2017 were Maluku (0.00%), Papua (0.01%), and the Special Region of Yogyakarta (0.02%). The coverage of PIS-PK in 2018 was 26.8%, with 17,651,605 families out of a total of 65,588,400 families [3]. The implementation of PIS-PK is carried out by the Primary Health Care to strengthen the function of the PHC in organizing Community Health Efforts and Individual Health Efforts at the first level in their working areas. PIS-PK is a way to implement Minimum Service Standards (SPM) in the health sector through family empowerment. The coverage must be "total coverage" in accordance with the objectives written in the MSS in the health sector.

The achievement of families visited in Bintan District in 2017-2019 (as of March 20, 2019) was 42%. This means that there are still 58% of families who have not been visited to achieve total coverage. Indonesia's IKS up to 9 May 2019 was 0.17 (unhealthy category), while East Java's IKS was 0.18 (unhealthy category), and Bintan District IKS was 0.08 (unhealthy category) (Pusat Data dan Informasi Kementerian Kesehatan Republik Indonesia 2019). The IKS value of Bintan District is the second lowest value at the East Java level. The lowest IKS score in East Java District is 0.07.

These problems must be addressed immediately because of the importance of implementing PIS-PK which has a purpose in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 36 of 2016. The purpose of this study is to evaluate the implementation of PIS-PK in Bintan District. The implementation of PIS-PK is useful for increasing the access of families and their members to comprehensive health services, supporting the achievement of district/city minimum service standards, supporting the implementation of national health insurance by increasing public awareness to become participants of the National Health Insurance, and supporting the achievement of the objectives of the Healthy Indonesia Program.

2. RESEARCH METHOD

This type of research is descriptive exploratory research. The study was conducted in 10 PHC and the Bintan DHO. The informants are the coordinator at the PHC, head of the PHC, and the team of PIS-PK at the Bintan DHO. This study uses primary data and secondary data. Primary data obtained from in-depth interviews and Focus Group Discussions. In-depth interviews and focus group discussions were conducted to implement triangulation. Secondary data is obtained from the Health Service Report and the Ministry of Health dashboard application.

Stage 1. In-depth Interview In-depth interviews were conducted to 5 person PIS-PK coordinators at the Puskesmas. The topic that was asked was about the implementation of PIS-PK based on a systems approach. Stage 2. Focus Group Discussion The participant of Phase 1 Focus Group Discussion is 5 persons the head of the PHC. The topic that was asked was the implementation of PIS-PK based on a systems approach at the Puskesmas level. The participants of the Phase 2 Focus Group Discussion are 4 persons the PIS-PK team at DHO consisting of teams in the field of health services, health resources and financing, disease prevention, public health, and program planning and evaluation sub-sections. The topic that was asked was the implementation of PIS-PK based on a systems approach at the district level. The data collection instruments were interview guides and FGD guidelines. Analyzing research data descriptively and thematic content.

3. RESULTS AND ANALYSIS

The following shows the Healthy Family Index for Bintan District-Kepulauan Riau Province in 2020

Table 1. Healthy Family Index for Bintan District-Kepulauan Riau Province in 2020

No	Indicator	Percentase
1	Family joins family planning program	52,86%
2	Maternal delivery in health care facilities	93,37%
3	Babies get complete basic immunization	96,60%
4	Babies get exclusive breastfeeding	81,08%
5	Toddler growth monitored	89,94%
6	Pulmonary TB patients are treated according to the standard	37,59%
7	Hypertensive patients receive regular treatment	42,11%
8	Patients with severe mental disorders, treated and not neglected	25,11%
9	No family member smokes	42,58%
10	Family is already a member of JKN	68,04%
11	Families have access/use clean water facilities	93,15%
12	Family has access/uses family latrine	90,66%
Healthy Family Index (IKS)		0,273

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Rank	3

Focus Group Discussion of PIS-PK Community Health Centers at the Bintan District Health Office
Factors Inhibiting the Implementation of the PIS-PK program
a. Public

- Large area and population
- At the time of the visit, the community or family was not at home
- Geographical location, not a few locations of community houses are difficult to reach.
- The involvement of the Local Government (District, Kelurahan, RW, and RT) has not fully supported PIS-PK activities
- There are still people who have not been open and accepted the presence of health workers

b. Health center staff

- The number of health workers still needs to be increased due to multiple activities and health services.
- The officer did not complete the data at the Prokesga and did not report the results of the Prokesga data collection to the data input team on time.
- Time management (Officers, Society)
- Lack of budget (facilities and infrastructure)
- Updates are still slow, related to slow changes in the application
- Management of Community Health Centers that still need to run.
- Support and assistance from the District Health Office.

Driving Factors for the Implementation of the PIS-PK program
a. Public

Involvement of health cadres in data collection and PIS-PK intervention

b. Health center staff

- Budget available (BOK)
- Sarpras available
- Shared commitment to the Implementation of PIS-PK
- Distribution of Regional Responsibilities

Understanding of the Puskesmas as the implementer of the PIS-PK program by looking at the follow-up of data collection on healthy families. The Community Health Center can then carry out evidence-based further intervention planning that is more targeted so that the impact through improving health status, primarily by increasing the IKS score per family.
Priority of problems and steps that become stages of solution related to the PIS-PK program.
In general, the recommendations are:

1. Local government regulations are needed to support the implementation of PIS-PK
2. Involve the PIS-PK program in every implementation of cross-sector and cross-program activities.
3. Equalize the perception of each program that PIS-PK is a joint program
4. Remind the public about the importance of the PIS-PK program

4. DISCUSSION

They also followed Article 32 of the Minister of Health of the Republic of Indonesia No. 75 of 2014, which states that the puskesmas is a technical implementation unit of the district/city Health Office. The role of the district/city Health Office is to make serious efforts so that the puskesmas conform to the Permenkes. In the context of implementing the family approach by the puskesmas, the provincial and district/city Health Offices have three leading roles: resource development, coordination, and guidance, and monitoring and control. District/City Health Offices can coordinate with provincial Health Offices to organize training/debriefing for puskesmas staff following directions from the Ministry of Health if provisioning/training is needed. Success in implementing PIS-PK in puskesmas must be in line with the role of the district/city and provincial health offices.

Program implementation can run smoothly before the delivery of various policy outputs to the target group needs to be preceded by the delivery of information; in this case, based on the results of research in the field, the program's policy communication transmission has gone well in the form of program socialization carried out

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externally and internally, starting from provincial level up to the puskesmas either in the form of cross-sector meeting methods with lectures, as well as in the form of instructions or letters (Ikhwan et al., 2016).

The activity of conveying information in the implementation of this policy is commonly referred to as socialization activities, namely directly and indirectly, to provide information so that the target group understands the policies that will be implemented so that they will not only be able to accept various programs initiated by the government but also participate actively. To achieve policy goals [7]. The PIS-PK program still needs more socialization to increase understanding for every staff in the puskesmas and the community who receives benefits from this PIS-PK activity. Suphanchaimat's study found operational program challenges where inadequate communication factors and unclear service guidelines contributed to ineffectiveness in budget spending and service provision [8]–[10].

The utilization of information systems can improve apparatus performance. Information and communication technology is helpful for various purposes, including information processing in government organizations [11], [12]. Follow-up data collection results with cross-program collaboration to obtain optimal results in achieving the program. The findings of this study indicate that the training provided for PIS-PK data collectors is still minimal, so 1 (one) Community Health Center only sends 3-5 Health Center staff to receive PIS-PK training, while the data collection staff are in total sampling and period. Specific times can reach tens of people. Efforts on the job training (OJT) of other health center personnel who will help collect PIS-PK data also do not necessarily provide quality knowledge transfer. Evident from the fact that there are still errors in collecting PIS-PK data. Preferably, OJT for PIS-PK data collectors who have never received training under the supervision of the City District Health Office [1], [13]

Managing an organization means managing the resources that exist within the organization. Resources include the resources of an organization: man, money, material, machine, and methods; information resources are no less critical [14]. Puskesmas that have carried out PIS-PK data collection must prepare these resources so that activities run according to guidelines. Research [15] found that the obstacle in implementing PIS-PK data collection at the puskesmas was that there was no increase in knowledge, especially regarding IT and data analysis; the unavailability of IT devices (gadgets, program entry, which is still uncertain) supporting equipment such as IT to support health services, in the era of digitalization the use of the internet as a means of communication between health services is unavoidable, the speed of information so that planning and decision making is fast, so that provision These resources are an essential part of program implementation. Before implementing this system, there should be planning and utilizing the resources owned so that the activity program can be well sustainable [16].

The commitment of the PIS-PK program implementers is very good; this can be seen from their intense desire and enthusiasm to carry out this program from the policymakers to the implementers of the activities. Due to limited facilities and infrastructure, PIS-PK data collection continues due to high commitment from the head of the puskesmas and other officers. The exemplary commitment is because the puskesmas has implemented a sound work system. The practice of the high-performance work system that applies in an organization will affect performance by increasing the knowledge, skills, abilities, and commitment of employees by providing them with the information and wisdom needed to utilize their skills and commitment in completing their work [17]. According to [18], the disposition or attitude of the implementers is an essential factor in the approach to implementation. The quality or characteristics of implementing actors will affect the quality of a policy, the best of which can be an example for the system [19].

Regarding the statement regarding the bureaucratic structure, in this case, tiered coordination, it has not gone well because there is no standardized structure at the health office level regarding program coordination structure with the puskesmas (Ikhwan et al., 2020). Coordination is one of the obstacles that hinder program implementation because the problems encountered cannot get a response immediately by those with higher authority, in this case, the district health office and from the puskesmas regarding their duties and functions in the PIS-PK team, which are still limited to verbal statements from the head puskesmas, no physical form was found in the form of a decree.

Delegation of authority or responsibility from superiors to subordinates is necessary for organizations to function more efficiently and effectively [21], [22]. Delegation allows subordinates to grow and develop. The main steps in delegating authority or responsibility are explaining assignments, specifying the discretion of subordinates, providing opportunities for subordinates to participate, and establishing feedback controls. The success or failure of this implementation will significantly depend on the extent to which the quality of planning is a strong and quality foundation for the implementation phase [23], [24]. In carrying out a policy implementation, there is a network that must in order to realize policy objectives through agency activities that involve various interested parties [25]–[27]

5. CONCLUSION

Implementing the Healthy Indonesia Program with a Family Approach has been running in all District Health Centers but has yet to run optimally. The factors that support the implementation of the policy are the communication

factor, where socialization has out both internally and externally, and the attitude factor of the officers who have received the program well and have carried out family data collection activities to support the success of PIS-PK. In contrast, the inhibiting factors are the resource factors, where limitations and delays in budget disbursement and lack of program infrastructure mean the program is not running optimally. In contrast, from the Bureaucratic Structure Factor, tiered coordination between the health office and the puskesmas could have improved. The district health office should immediately create a program organizational structure to make coordination easier, facilitating the budget disbursement process and providing program support infrastructure. Equalizing the perception of each program that PIS-PK is a joint program. They are reminding the public about the importance of the PIS-PK program. Optimization of the KS application system is more operational to implement. Improved performance, especially in hypertension, ODGJ, smoking, and tuberculosis programs.

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