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Portrait of the Healthy Family in Banyuwangi District, Indonesia: Implementation Evaluation of the Healthy Indonesia Program with Family Approach (PIS-PK)

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Abstract

The Healthy Indonesia Program with Family Approach (PIS-PK) implementation is a way to implement Minimum Service Standards (SPM) in the health sector through family empowerment. The achievement of families visited in Banyuwangi District in 2017-2019 was 42%. Healthy Family Index (IKS) Banyuwangi is 0.08 (unhealthy category). That IKS is the second lowest value in East Java Province in 2019. Six PIS-PK indicators are far from the total coverage. The study purpose is to evaluate the implementation of PIS-PK based on the PIS-PK Regulation of the Minister of Health Republic of Indonesia Number 39 of 2016. The type of research is descriptive exploratory research. The study was conducted in 10 PHC and the Banyuwangi DHO. The informants are the PIS-PK coordinator at the PHC, head of the PHC, and the team of PIS-PK at the Banyuwangi DHO. This study uses primary data and secondary data. Primary data obtained from in-depth interviews and Focus Group Discussions. Analyzing research data descriptively and thematic content approach. The stage of family visits and initial intervention has been carried out by PHC quite well. At the family visit stage, the data collection team has various perceptions of healthy family instruments, there are signal problems in some areas and not yet total coverage. The PIS-PK data analysis stage has not been carried out thoroughly. The stage of further intervention on health problems has not been carried out thoroughly by all PHC because the majority of PHC is still in the family visit stage. The monitoring and evaluation phase is carried out by most of the PHC from the PIS-PK preparation stage to family visits and initial intervention. Several PHC has carried out monitoring and evaluation up to the initial IKS analysis stage and advanced intervention. The implementation of PIS-PK in Banyuwangi is not fully following the guidelines for implementing the PIS-PK Regulation of the Minister of Health Republic Indonesia Number 39 of 2016.

Keywords
healthy family index; PIS-PK; program evaluation

I. Introduction

The implementation of PIS-PK is carried out by the Primary Health Care (PHC) to strengthen the function of the PHC in organizing Community Health Efforts (UKM) and Individual Health Efforts (UKP) 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 (Kementerian Kesehatan Republik Indonesia 2017b) (Afrianti and Pujiyanto 2020). The coverage must be "total coverage" in accordance with the objectives written in the MSS in the health sector (Mujiati, Sulistiowati, and Nurhasanah 2020). The

achievement of families visited in Banyuwangi 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 Banyuwangi District IKS was 0.08 (unhealthy category) (Pusat Data dan Informasi Kementerian Kesehatan Republik Indonesia 2019). The IKS value of Banyuwangi District is the second lowest value at the East Java level. The lowest IKS score in East Java District/City is 0.07.

The coverage of 12 PIS-PK indicators in Banyuwangi District has not yet reached total coverage. There are 6 indicators that are still far from total coverage, namely the indicator that the family is already a member of JKN (21.83%), hypertension sufferers receive standard treatment (23.13%), pulmonary tuberculosis sufferers receive treatment according to standards (27.64%), people with mental disorders receive treatment and do not receive treatment. neglected (34.75%), no family member smokes (43.31%), and the family participates in the family planning program (49.73%). The same thing also happened at the Kuwut PHC, Brebes District, namely IKS until 2018 had not reached the target expected by the Government, namely 100%. There are 6 main problem indicators, including pulmonary tuberculosis, smoking habits, not yet a member of JKN, breastfeeding, and people with mental disorders (Lestari 2021). 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 Banyuwangi 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.

II. Research Method

This type of research is descriptive exploratory research. The study was conducted in 10 PHC and the Banyuwangi DHO. The informants are the coordinator at the PHC, head of the PHC, and the team of PIS-PK at the Banyuwangi 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 10 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 10 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 8 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.

III. Results and Discussion

3.1 PIS-PK Family Visits

PHC conducts family visits to collect comprehensive family data through twelve indicators on three types of forms. The highest achievement for family visits was obtained by PHC by sub-district, namely Rogojampi Sub-district (126%) and the lowest was in Gambiran Sub-district (37%). the achievements of family visits in the details of Banyuwangi District as of August 22, 2019 are presented in Figure 1 below.

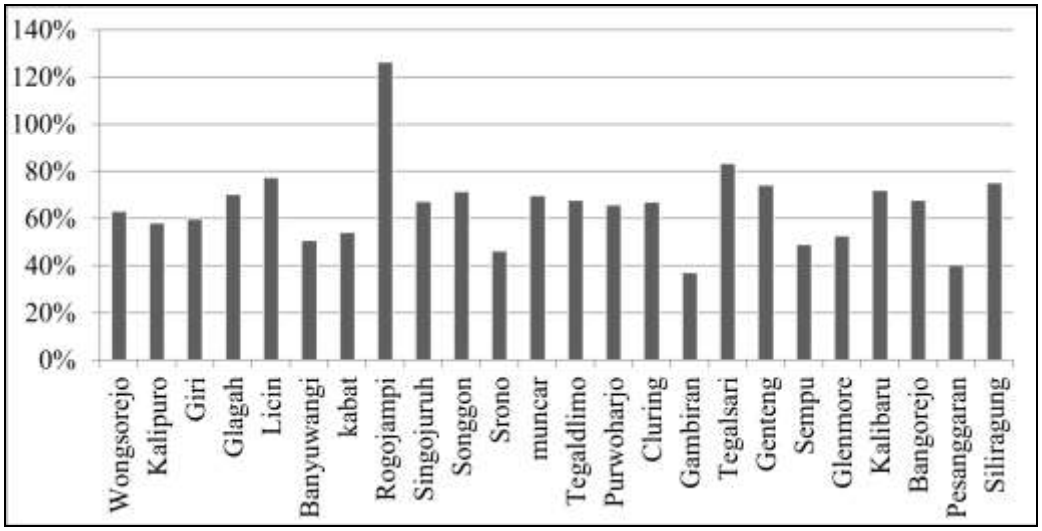

Figure 1. *Home Visit Coverage*

The visit was carried out by a data collection team from PHC consisting of doctors, paramedics and other health workers (department of environmental health, nutrition, family planning, maternal and child health, non-communicable diseases, health promotion). Generally, in a team there are 3 people who have different roles. Doctors and paramedics will conduct medical tests, such as measuring blood pressure and recording related illnesses, and other health workers (environmental health, nutrition, family planning, maternal and child health, non-communicable diseases, health promotion) will make observations related to environmental health and documentation.

The process of carrying out family visits includes socialization related to health promotion, then if there are family members who have complaints of illness, the officers will also provide referrals at the same time. In the initial intervention, officers will detect health problems found in family members, then given interventions according to the problem. Then, to contact family, there is also a communication forum, there is also a URC (Quick Response Unit) car for quick handling. If there is a change in family data, an update will be carried out if there are no problems with the healthy family application system.

PHC staff conducted data collection as well as intervention in the form of giving leaflets from PINKESGA. This gives PHC an advantage in terms of more efficient financing. The officer first explained the purpose of the interview and observation before collecting data because data collection was carried out by interviewing and observing the

home environment. Visits are carried out by PHC staff at 07.00 - 12.00. The visit is carried out by the implementing team which has been divided by the program holder according to the schedule. The team on duty will ask for permission to the RW and RT of the place to be visited.

Data collection is carried out once, but if the family data is incomplete, a repeat visit can be made. According to interviews with informants,

"If the healthy one is once, the unhealthy one is twice and three times, but in that case, there is a visit whose father is working" (A201).

The problem is the lack of human resources because the holders of the PIS-PK program are also responsible for other programs so that they have a dual role and are not focused on the implementation of PIS-PK.

"At that time, my friends and I collided with time, one person was holding the double double program, so what's crowded? Finally, here, we appointed a team for data entry" (A207).

Human Resources (HR) is the most important component in a company or organization to run the business it does. Organization must have a goal to be achieved by the organizational members (Niati et al., 2021). Development is a change towards improvement. Changes towards improvement require the mobilization of all human resources and reason to realize what is aspired (Shah et al, 2020). The development of human resources is a process of changing the human resources who belong to an organization, from one situation to another, which is better to prepare a future responsibility in achieving organizational goals (Werdhiastutie et al, 2020).

This is also in line with the results of research (Fauzan, Chotimah, and Hidana 2019) (Sulistiowati et al. 2020) showing that the availability of human resources in the implementation of PIS-PK at PHC Mulyaharja, Bogor is inadequate, so that the workload becomes more. In addition, the large area, geographical location, and large population make data collection officers feel overwhelmed to meet the target of family visits. This is the reason PHC has not yet achieved the total coverage that should have been anticipated from the start based on the staff at PHC, number of families, work area area, and geographical conditions of the work area. The comparison of the achievement of family visits with the number of Heads of Families (KK) in Banyuwangi Regency is shown in Figure 2 below.

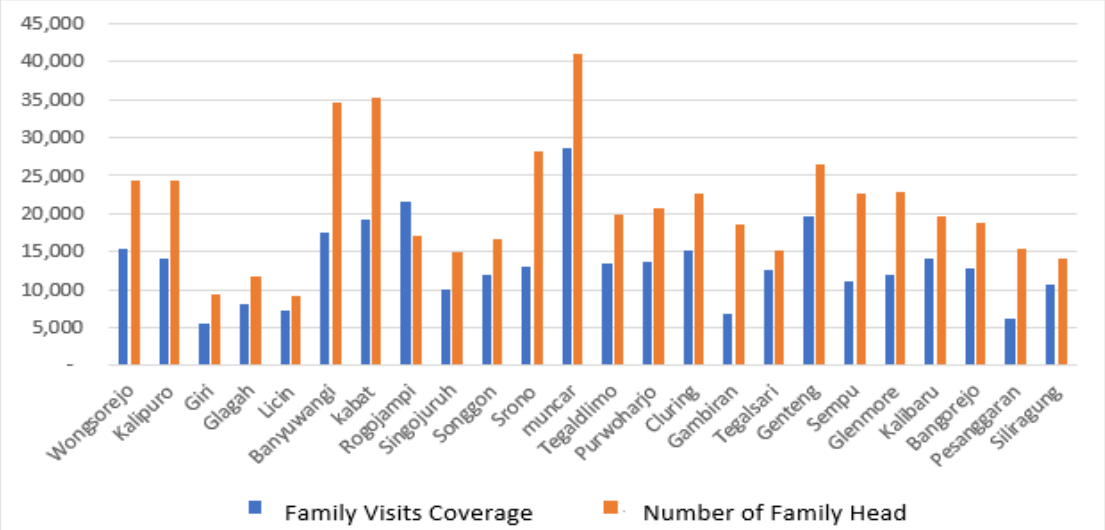

Figure 2. *Comparison of Coverage of Family Visits with Number of Heads of Families in Banyuwangi District*

Muncar Sub-district occupies the area with the highest number of family heads, namely 40,966 households. Meanwhile, the sub-districts that have the least number of family heads are Giri (9,427 families) and Licin (9,249 families). The difference in the number of heads of families in each region varies, it is possible that the achievement of family visits obtained by PHC is not yet total coverage. And can be a benchmark for PHC to recruit surveyors (health workers and non-health workers) as research at Kulon Progo District (Agustina, Trisnantoro, and Handono 2019).

3.2 PIS-PK Data Analysis

The results of the family visits were analyzed by the PIS-PK coordinator. The analysis process is carried out by looking at the analysis and priority of health problems from various results obtained with a faster probability to be overcome. The follow-up plan from the analysis of family visits also looks at the priority results from the results of the analysis obtained. From the results of the PIS-PK data analysis, its use is for example in terms of cross-sectoral, in the village, then these results can provide an overview of the problems that exist in the village, so that plans can then be made. The integration of PIS-PK results with other data sources is by holding a meeting between the PIS-PK team and program holders who have the relevant data source, and then seeing what results can cover the needs between the two.

The guidelines used by PHC in processing family data are the twelve indicators in the PROKESGA form including:

a. Families participate in the Family Planning Program
b. Mother gives birth in a health facility
c. Babies get complete basic immunizations
d. Babies get exclusive breast milk
e. Toddlers get growth monitoring
f. Patients with pulmonary tuberculosis receive treatment according to standards
g. Hypertensive patients take regular treatment
h. People with mental disorders receive treatment and are not neglected
i. No family members smoke
j. The family is already a member of the National Health Insurance (JKN)
k. Families have access to clean water
l. Families have access to or use healthy latrines (Kementerian Kesehatan Republik Indonesia 2017a) (Primadina, Basori, and Perdanakusuma 2019).

The recapitulation of the twelve indicators will be calculated for the Healthy Family Index, when using the application it will appear automatically. The Healthy Family Index is calculated at the family level, Village level, and sub-district level. The results of the recapitulation show the coverage of each healthy family indicator which will later be used to identify problems and determine priorities for health problems. The following is a snippet of the informant's statement:

"So far, I've been like this, Ms., yes, that's all the data that has been entered from online, we copy it too offline. The offline version is like this, we make it into the Excel program, after that we copy it according to the instructions from the Department of how the formulation can bring up IKS, so later after it is entered into the Excel program there is a formulation after that we already know the IKS how much later can appear. If there are 3 PIS PK indicators later, then less than 5 is unhealthy, 5-8 is pre-healthy, more than 8 is healthy". (A208)

Data on family visits were analyzed by the head of the PHC and the PIS-PK coordinator. Then the data is used to determine health problems and as material for village

planning. Based on the existing health problems, interventions were then carried out according to the 12 easiest and priority PIS-PK indicators.

"From the head of each PHC and the coordinator from PIS-PK. There is also a PHC where the IT officer will sort the data. The analysis process is to look at the twelve IKS, on which indicators are most likely to be given intervention first. Like when it comes to smoking, JKN is rather difficult, so it is usually ruled out" (I102)

"As before, judging from the indicators that are priorities and it is easier to give intervention first" (I102)

Family visit data is integrated with other data sources through communication between officers and program holder meetings. In addition, it is also integrated with cross-sectoral and village problem analysis, but there are PHCs that do not integrate PIS-PK data with other data. Based on the results of in-depth interviews with informants above, the stages of data analysis of PIS-PK vary because each PHC has a different strategy in implementing PIS-PK. The success of a program must be supported by cooperation between PHC personnel, so that the data obtained can be used optimally.

3.3 PIS-PK Health Problem Intervention

Intervention of health problems in PIS-PK, consists of initial intervention and follow-up intervention. Based on the results of in-depth interviews with the PIS-PK coordinator at PHC, PHC officers who conduct family data collection themselves without involving external parties, such as cadres and others can directly intervene early. The initial intervention was carried out by providing Pinkesga, as well as providing counseling or counseling to families who had inappropriate behavior based on questions related to the 12 Healthy Family indicators contained in the PROKESGA form. The following is a snippet of the informant's statement:

"...and if you don't, from the question knowing that it's not healthy, we immediately get counseling, that for families who smoke, we immediately get counseling that cigarettes are like this, this, so that the family can stop or not smoke in the house." (A204)

This is in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 39 of 2016 concerning Guidelines for the Implementation of PIS-PK, namely PHC personnel who collect data can directly intervene, at least in the form of providing health information sheets (Pinkesga) and health counseling in accordance with the health problems found. in that family. Before PHC officers conducting data collection go to the field for family visits, they first coordinate with program holders related to the 12 PIS-PK indicators. This is done so that the initial intervention is carried out as it should be. The following is a snippet of the informant's statement:

".....Before we go into the field, we must first coordinate with the programmer holder. For example, TB, what do we want to do in that area, what do we want to convey to patients with TB, who knows the programmer." (A206)

In addition to providing Pinkesga and counseling, in this initial intervention, PHC officers also provided a referral letter for treatment at PHC. The following is a snippet of the informant's statement:

"...Is there, is there a history of hypertension, no... no, have you ever checked, never, we have tension rongatus, sis, naaah,, that means it's an intervention, right, the point is T, right? , we intervene, we give what it's called, a referral to PHC is ordered to control the same as advice, lifestyle advice." (A202)

Another important step carried out by PHC before carrying out further interventions, namely PHC needs to plan. The planning is stated in the preparation of the Proposed Activity Plan (RUK), which then becomes the Activity Implementation Plan (RPK). PHC

management can be strengthened with a family approach, both in the Planning (P1), Implementation (P2), and Monitoring-Control-Assessment (P3) stages (Mujiati, Sulistiowati, and Nurhasanah 2020). Phase P1 is the stage of preparing the Proposed Activity Plan (RUK) and Activity Implementation Plan (RPK) based on facts and data. With the PIS-PK, data on all families in the PHC working area from Prokesga will increase. Then in the P2 stage, which means the stage of implementing the things that have been listed in the RPK and encouraging their achievement through regular mini workshops. This stage will be strengthened by PIS-PK because PHC can provide services that are truly in accordance with the health problems faced by families (community). Mini-workshops can be used to mobilize more effective and efficient activities, as well as improve cross-program coordination and cross-sectoral collaboration. However, according to the PIS-PK Coordinator, not all of the programs intended for this follow-up intervention have received a budget for their implementation. This is also an obstacle.

3.4 PIS-PK Monitoring and Evaluation

The implementation of PIS-PK monitoring and evaluation by PHC is carried out from the preparation stage to the analysis of IKS changes. However, the implementation of PIS-PK in Banyuwangi itself is still at the advanced intervention stage, it is still being carried out recently, there are even some PHCs that are still in the stage of family visits and initial intervention. So, it can be estimated that the implementation of PIS-PK monitoring and evaluation in all PHC Banyuwangi that has been carried out is at the PIS-PK preparation stage until further intervention. The discussion of PIS-PK in the Lokmin is in accordance with the Regulation of the Minister of Health of the Republic of Indonesia Number 39 of 2016 concerning Guidelines for the Implementation of PIS-PK. The Minister of Health explains that the Monitoring-Control-Assessment (P3) stage which is based on a family approach makes Mini Workshops also used for Monitoring-Controlling and Assessment, in addition to Movement-Implementation. The P3 stage in PHC Management is the stage of monitoring the progress of achievements, making corrections to the implementation of activities, and assessing the achievements of activities in the middle and end of the year.

Based on the Regulation of the Minister of Health of the Republic of Indonesia Number 39 of 2016 concerning Guidelines for the Implementation of PIS-PK, PHC supervision itself is divided into two, namely internal and external supervision. Internal supervision is supervision carried out by PHC itself, both by the Head of PHC, the internal audit team and each person in charge and program manager/implementer. External supervision is carried out by agencies from outside the PHC, including the Regency/City Health Office, other institutions other than the Regency/City Health Office, and/or the community. Cross-program monitoring and control through monthly lokmin are basically intended to:

a. Reviewing the process of activities that have been running as well as the results of activities in identifying obstacles and deviations from those that have been planned, namely those relating to home visits, such as: family acceptance, family awareness, and family PHBS
b. Determine corrective actions to be taken, if there are obstacles/difficulties and deviations, in order to ensure the running of activities and the achievement of targets as planned.

In addition to monthly lokmin, cross-sectoral monitoring and control is also carried out through tri-monthly lokmin, which are intended to:

1. Reviewing the ongoing cross-sectoral collaboration process to identify the presence/absence of obstacles and deviations from what has been agreed.
2. Renew and/or strengthen commitments for cross-sectoral cooperation, in order to ensure the implementation of cross-sectoral support for each indicator of a healthy family.

If the monitoring of the implementation of PIS-PK is carried out at monthly and quarterly lokmin, then an assessment of the success of the implementation of the RPK, including activities related to the family approach, is carried out twice a year. The first assessment is carried out in the middle of the year in the form of a midterm review. This mid-year review should simultaneously include cross-sectoral collaboration and be carried out in the 6th month lokmin. The mid-year review aims to:

a) Assess how much achievement has been achieved so far (in this case the orientation is IKS, i.e. IKS for each family, IKS at the RT/RW/kelurahan/village level, and IKS at the sub-district level). How close is the achievement to the target set in the RPK.
b) Identify existing opportunities, threats, weaknesses, and strengths (both internal PHC and cross-sector), in order to achieve the targets, set in the RPK.
c) Establish steps to seize opportunities, face threats, overcome weaknesses, and maximize the use of strengths.

The second assessment is carried out at the end of the year, using the 12th month lokmin. The year-end assessment aims to:

1) Knowing whether the Sub-District IKS that has been determined in the planning can be achieved.
2) Knowing which families, RT, RW, kelurahan/village have achieved the IKS target as planned and set targets to be achieved in the following year or steps to maintain the achievement of these targets.
3) Knowing which families, RT, RW, kelurahan/village have not reached the IKS target as planned, the problems that become obstacles, and set targets that must be achieved in the following year along with steps to overcome existing obstacles.

PHC in Banyuwangi Regency itself has not done much further intervention. This means that the RPK which contains activities with a family approach has not been carried out so that the 6th and 12th month lokmin as described above have not been carried out. This is also the reason why the IKS of Banyuwangi Regency is still stagnant below 0.1, which is 0.08.

IV. Conclusion

The stage of family visits and initial intervention has been carried out by PHC quite well. The PIS-PK data analysis stage has not been carried out thoroughly. Some PHCs have conducted analysis through the PHC management process. The implementation of the intervention is carried out based on the easiest and priority indicators. The advanced intervention stage for health problems has not been carried out thoroughly by all PHCs because the majority of PHCs are still in the family visit stage. The monitoring and evaluation phase is carried out by the majority of PHCs from the PIS-PK preparation stage to family visits and initial intervention. Several PHCs have carried out monitoring and evaluation up to the initial IKS analysis stage and advanced intervention.The monitoring and evaluation phase of PIS-PK in all PHCs has been carried out on the implementation of healthy family training in supporting PIS-PK and the implementation of PIS-PK preparations; has been partially implemented in the implementation of family visits and PIS-PK initial interventions, implementation of IKS analysis, and PIS-PK follow-up interventions; and has not been implemented in the implementation of the IKS change

analysis. The implementation of PIS-PK in Banyuwangi Regency is not fully in accordance with the guidelines for implementing PIS-PK in the Regulation of the Minister of Health of the Republic of Indonesia Number 39 of 2016.

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