

Obstacles of the Implementation of the Healthy Indonesia Program with Family Approach (PIS-PK)

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Abstract: *The Healthy Indonesia Program with a family approach (PIS-PK) is one of the ways for health center (puskesmas) to improve access of the community to health services by visiting families. This study aimed to describe the obstacles of PIS-PK implementation. The method used was a systematic review. We look for articles to be reviewed using Google Scholar and Indonesia OneSearch (IOS) databases with "Pelaksanaan PIS-PK" as a keyword. We found 186 results, then we apply the PRISMA method to screened the articles. As a result, there are 5 full texts fulfill the eligibility criteria. From several studies, the implementation of PIS-PK is by the guidelines. The obstacles of the PIS-PK implementation are insufficient of PIS-PK officers, inputting data, facilities and infrastructure, disbursement of the fund, and lack of cross-sectoral cooperation. Puskesmas are expected to optimize the existing human resources, conduct intersectoral coordination, increase staff competency through training, and conduct budget planning related to the implementation of PIS-PK.*

Keywords: *Obstacles, Implementation, PIS-PK, health center*

I. INTRODUCTION

Health is an investment to support economic development and has an important role in poverty alleviation efforts. Under Law No. 36 of 2009, Health development must be thought of as an investment to improve the quality of human resources. Health development is an effort that does by all components of the Indonesian nation that aims to increase awareness, willingness, and ability to live healthy for everyone to realize the increasing degree of public health. The success of health development is largely determined by the continuity of sector and program inter-effort, and continuity with efforts that have been done in the previous period.[1]

The implementation of Healthy Indonesia Program with Family approach (PIS-PK) aims at increasing family access to comprehensive health services, promotive and preventive services as well

as basic curative and rehabilitation services; supporting the achievement of minimum district/city service standards; through improving health access and screening; supporting the implementation of the national health insurance program by increasing public awareness to become participants of the national health insurance; and supporting the achievement of the objectives of the Healthy Indonesia Program in the 2015-2019 Ministry of Health strategic plan.[2]

Efforts in reaching health development can be done by utilizing all the potential through the Healthy Indonesia Program. The Healthy Indonesia Program is one of the 5th Nawa Cita programs to improve the quality of life of Indonesian people. The Healthy Indonesia Program upholds 3 main pillars, namely: (1) The adoption of a healthy paradigm, (2) Strengthening health services, and (3) Implementation of National Health Insurance (JKN).[3]

The family approach is one of the ways for Puskesmas to improve targets and bring closer / improve access to health services in areas by visiting families. Puskesmas not only provide health services at the health service center but also provides space for families to be visited at their homes in the scope of work area. Families are the focus on the implementation of the Healthy Indonesia program. According to Friedman (1998), it is related to the Five functions of the family, namely: First, affective function is the main function of the family to teach everything and prepare the member to associate with others. This development is needed for the

development of individual and psycho-social family members. Second, the function of socialization which is the process of development and change of individuals which produce social interactions and learning that involve their social environment. Socialization starts from birth. This function is useful for fostering socialization in children, forming norms of behavior by the level of child development and developing family cultural values. Third, reproductive function is a function to maintain the generation and maintain the continuity of the family. Fourth, the economic function is a function to meet family needs economically. Fifth, Health Care Function is to maintain the health of family members to continue having high productivity. This function was developed into the family task in the health field. [1]

Puskesmas is a health service center that organizes public health and first-level individual health service effort, with more priority to promotive and preventive efforts, to achieve the highest level of public health in the work area.[4] Puskesmas is responsible for one administrative area of government, namely the sub-district or part of the sub-district. In each district, there must be at least one Puskesmas. The role of the health center in PIS-PK is to change the paradigm into healthy paradigm. Based on the principle of a healthy paradigm, Puskesmas must encourage all interests to support efforts to improve and enhance health interests that encourage individuals, families, groups, and communities.[5]

Since the enactment of Permenkes Number 39 of 2016 concerning the Implementation of the PIS-PK, 2019 is the fourth year. In 2017, a total of 2,926 PIS-PK locus were established in 514 districts/cities, 34 provinces, then in 2018, to 6,205 Puskesmas and in 2019 all Puskesmas will become PIS-PK locus, which are 9,993 Puskesmas.[6]

In 2017 with 30% Puskesmas (2,926 Puskesmas) as the locus, 4,8 million families were received and intervened initially (24.6% of the target 19,7 million families). Furthermore, in 2018 the implementation of PIS-PK increased along with the increasing number of Puskesmas locus that implemented, 60% of Puskesmas (6,205 Puskesmas) can reach 25,2 million families have been supported and intervened early (64,05% of the target 39,4 million families). This shows that every year the process of PIS-PK implementation is getting better. Nevertheless, from the results of monitoring and evaluation submitted at the 2019 National Health Work Meeting, there are still many problems faced in the implementation of PIS-PK.[6]

PIS-PK is one of the ways for health centers (Puskesmas) to improve access of the community to health services by visiting families. This study aimed to find the obstacles of PIS-PK implementation.

II. METHOD

In this study, we conducted a writing system using the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-analysis) methods through articles related to the implementation of PIS-PK published in accredited and indexed journals from the Google Scholar and Indonesia OneSearch (IOS) databases with the initial keyword "Pelaksanaan PIS-PK" was found 186 search results. After that, a critical assessment of the selected article was using the PRISMA method with the results of the full-text article reviewed by 5 articles. Because the topic of discussion was only within the scope of Indonesia, the database used in the search for references was limited. This study reviewed the problem of implementing the PIS-PK. At the initial stage, we classified titles and abstract studies that would be used as study literature. References were only seen relating to the implementation of PIS-PK and the obstacles that

occur in its implementation, and not only discuss certain indicators.

Literature data were sought and summarized according to the scope of this study. The main part of the review study contains the title, abstract, and discussion screened to identify studies that include relevance for reference. A reviewing thorough of the contents of the referenced studies

was also done so that it was easy to find the essence of the relevant studies. The criteria for grouping this study would lead us to the conclusion. The research data from our literature was summarized in the form of a structured study result table and explained according to the study results. The conclusions in this review study were combined based on the results of the reference conclusions.

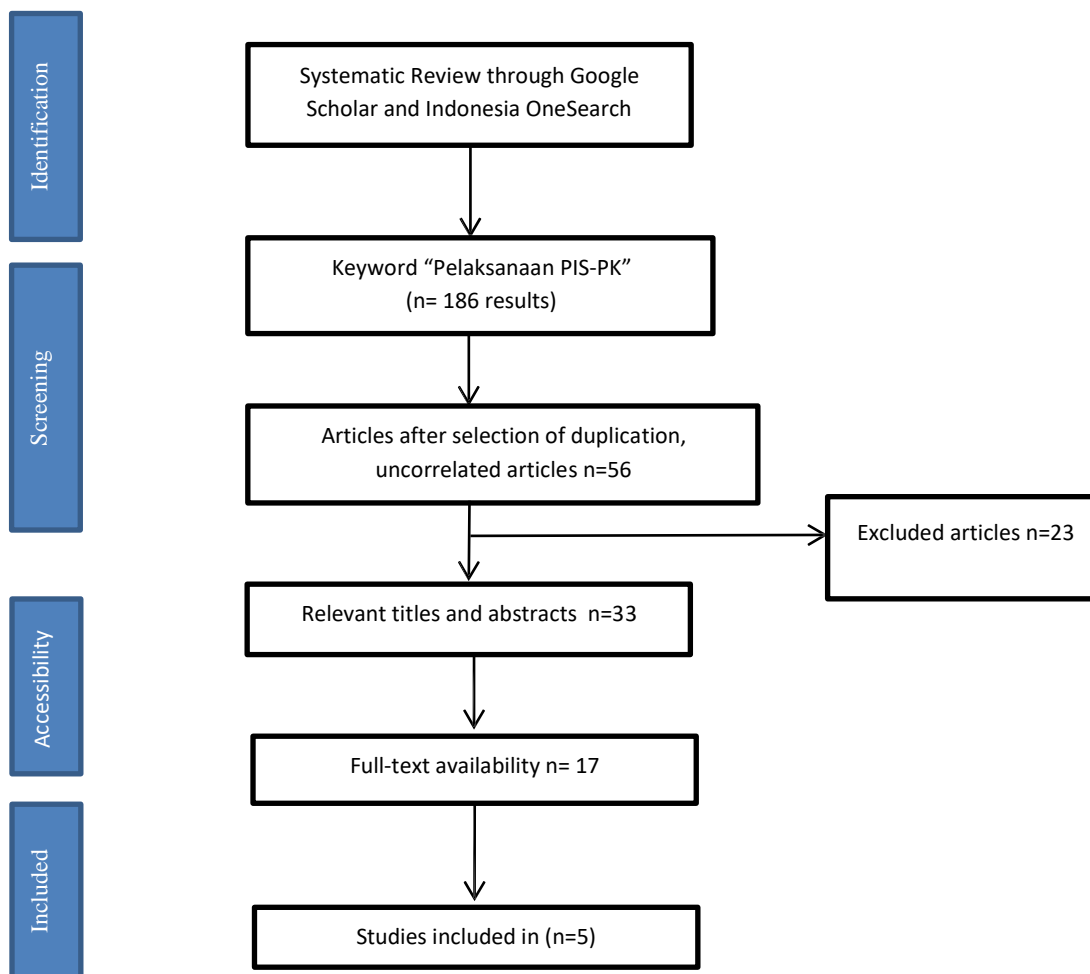


Fig. 1 The PRISMA Method (Preferred Reporting Items for Systematic Reviews and Meta-analyses)

III. RESULTS

From the 5 studies of literature reviewed, it was found that 3 articles were reviewed by the qualitative descriptive method and 2 articles were reviewed by a mix of quantitative and qualitative methods. It is known that the implementation of the

PIS-PK has been implemented by puskesmas in several areas, but there are several influencing factors that can hold up the success of the program. The results of data extraction from 5 articles are listed in Table 1.

Table 1. Data Extraction Results

No	First Author	Title	Journal	Purposes	Method	Results
1	Akbar Fauzan	Implementation of the Healthy Indonesia Program with a Family Approach (PIS-PK) at the Mulyaharja Health Center	Promotor, Jurnal Mahasiswa Kesehatan Masyarakat Vol 2 No. 3 June 2019	To know the Implementation of the Healthy Indonesia Program with the Family Approach (PIS-PK) at the Mulyaharja Health Center in 2018	Qualitative Descriptive	The implementation of PIS-PK conducted has followed the concept set by the Puskesmas, Permenkes no 39 2016 runs smoothly. There are still obstacles in entering data conducted by the Mulyaharja Community Health Center, inadequate numbers of human resources and in the implementation of the lack of facilities and infrastructure needed by surveyors.
2	Eri Virdasari	Analysis of Healthy Indonesia Program Family Data Collection Activities with Family Approach in Semarang City Health Center (Case Study at Mijen Health Center)	Jurnal Kesehatan Masyarakat (e-Journal) Vol 6 No. 5 October 2018	to analyze the implementation of family data collection activities seen from the input, process, and output.	Qualitative Descriptive	Input variables indicate that the availability of personnel is adequate, but is constrained in the competence and workload of officers, funds, infrastructure, and policy use. The variable process shows that the implementation is not following the guidelines or plans, due to uneven socialization, improper distribution of tasks, and scheduled supervision. In the output variable, the implementation is not following the specified schedule and target. Family data collection activities are still 69% of the 100% target.
3	Markus Gelar Kumara Agni	Daerah Istimewa Yogyakarta (DIY) Readiness in Implementing Healthy Indonesia Program with Family Approach	Jurnal Formal (Forum Ilmiah) Kesmas Respati Vol 3 No 1, April 2018	to know the readiness of DIY especially puskesmas in implementing PIS-PK, identify the obstacles, and recommend solutions.	Qualitative-Quantitative Explanatory Descriptive	DIY readiness in implementing PIS-PK is considered weak in terms of the availability of trained human resources and understanding of tasks and all problems, as well as the availability of ready-to-use health equipment. For this reason, more training needs to be done to improve staff literacy and procure needed medical equipment. The implementation of PIS-PK so far has been obstructed due to the limited number of puskesmas staff for data collection, lack of community collaboration, and non-smooth online applications when puskesmas enter the data.

No	First Author	Title	Journal	Purposes	Method	Results
4	Ratna Sari Dewi	Analysis of the Implementation of the Healthy Indonesia Program with a Family Approach in the District of Kota Juang, Bireuen Regency in 2018	Majalah Ilmiah Universitas Almuslim Vol 11 No 1, June 2019	analyze the implementation of PIS-PK in Kota Juang District Bireuen Regency in 2018	Mix Method (Qualitative-Quantitative)	Quantitative research results obtained that funding, infrastructure, and government support are related to the implementation of PIS-PK. Meanwhile, the results of qualitative research in the field of funding, funds were disbursed from the BOK, because the budget had not yet been disbursed so that the implementation was delayed. From the government support, the level of local government has been implemented well, but in the village, it is still constrained by the village head who has not been socialized to the community. There is only 1 PIS-PK admin. The infrastructure sector has been fulfilled but not enough. In the field of community conditions, not all of them are ready with PIS-PK due to a lack of socialization. Field of relations with the center, there is still problems internet network.
5	Zahratul Aini	Government Management in the Implementation of a Healthy Indonesia Program with a Family Approach (PIS-PK) in Pekanbaru District Pekanbaru City in 2017-2018	JOM FISIP Vol 6 Edisi 1 January-June 2019	To get a description of Government management in PIS-PK health services in Pekanbaru City, Pekanbaru City District, 2017-2018	Qualitative Descriptive	PIS-PK management is carried out through a structured process by the Regulation of the Minister of Health of the Republic of Indonesia by collecting health data for all family members, blinding and managing the Puskesmas database, analyzing, formulating intervention health problems, and arranging Puskesmas plans. in promoting, preventing, curative and rehabilitative efforts, Conducting health services (inside and outside the building) through the life cycle approach, Conducting information systems the reporting of puskesmas. The obstacle factors are HR, PIS-PK Program Application, Socialization, and Infrastructure facilities.

IV. DISCUSSION

Based on the analysis of the article, obstacles of the implementation of PIS-PK in Puskesmas in several regions were found.

Human Resources

Human resources in this program are health workers who have been exposed to information and/or participated in training for healthy families (PIS PK). Health resources at the service level as coordinators should have managerial competence, planning, and program consultants. Similarly, the resources in the Community Health Center are

needed as the main implementer of activities in the health center and the community (family).[7]

The implementer of the Family Approach at the Puskesmas is all Puskesmas health workers, consist of:

1. Head of Puskesmas
2. Family Coach, namely Puskesmas health workers who have attended training or have knowledge of the Healthy Indonesia Program with Family Approach. Family coaches are responsible for collecting family health data, conducting Prokesga analysis in the target area, coordinating across programs to intervene in family

problems in the target area, and monitoring family health.

3. Managers of technical programs at the Puskesmas, such as doctors, MCH program managers, P2P, nutrition, environmental health, health promotion, and other program managers at the Puskesmas
4. Data management staff at the Puskesmas
5. Puskesmas Management Team.[8]

Based on research it is known that the number of human resources in puskesmas is insufficient to implement PIS-PK.[3][5][9][10][11]

Recruitment of data collection officers can be carried out if the results of the analysis of staff need that additional staff is needed by taking into account the availability of personnel at the Puskesmas, the number of families in the Puskesmas work area, working area, geographical condition of the work area, and funding. The data collection officers recruited were health workers and non- health workers.[2]

Failures that often occur in the implementation of a program are often caused by inadequate, or incompetent personnel in their fields. Increasing the number of staff is not enough to solve the problem of implementing the policy, but it requires sufficient staff with the necessary expertise and capabilities (competent and capable) in implementing the policy.[7]

Facilities and infrastructure

In supporting the implementers (surveyors) to data collection on PIS-PK, the availability of infrastructure funding facilities is one of the important things and needs to be considered.[5]

Facilities and infrastructure in the implementation of PIS-PK needed to support the implementation of family data collection activities at the Puskesmas, namely: Prokesga, Pinkesga,

computers, internet connections, tensimeter, stethoscopes, family folders, storage rooms, transportation devices, transportation cards, ID cards, stationery, applications, and sticker.[10]

The instruments needed at the family level are as follows:

1. Family Health Profile (Prokesga), in the form of a family folder, which is a means to record family data and individual data of family members. Family data includes components of a healthy home (access/availability of clean water and access/use of healthy latrines). Data on individual family members include individual characteristics (age, sex, education, etc.) and the condition of the individual, such as illness (hypertension, tuberculosis, and mental disorders) and behavior (smoking, participating in family planning, monitoring growth and development of toddlers, exclusive breastfeeding, etc.).
2. Family Information Package (Pinkesga), in the form of flyers, leaflets, pocketbooks, or other forms, which are given to families according to their health problems, for example, Flyers on Pregnancy and Childbirth, Growth Toddler, Hypertension, and others.[2]

Availability of facilities and infrastructure used to support the data collection of PIS-PK is basically good and complete, but it is still limited and insufficient [5][9][3][10][11] such as tensimeter, stethoscope, computer/laptop, transportation, Pinkesga, stickers, and family folders.

Infrastructure facilities that are not available or sufficient quantities yet, are caused by no funds for procurement. Budget constraints also affect limited infrastructure.[12]

Infrastructure facilities are significantly related to the implementation of PIS-PK. The analysis shows the value of the Odds Ratio (OR) of 7.6, meaning that good infrastructure will provide an opportunity for the implementation of PIS-PK by 7.6 times compared to infrastructure that is lacking.[10]

Funding

The implementation of PIS-PK can be funded from a variety of cost sources available at the Puskesmas, for example the Regional Expenditure Budget (APBD) from regional income, JKN capitation funds, Physical Special Allocation Funds for the basic health services sub-sector and non-Physical Special Allocation Funds in the form of Health Operational Assistance (BOK), Village Funds, Tobacco Excise Profit Sharing Funds, Cigarette Taxes and Corporate Social Responsibility (CSR) funds and other legitimate sources of funds. All sources of funding above are expected to be used effectively and efficiently by each Puskesmas to implement the PIS-PK that refers to the provisions of the use of each funding source. The funding sources that will be described in this guideline cover the integration of BOK, JKN capitation funds, and other APBD.[13]

Funds received by the puskesmas to carry out family data collection activities originate from BOK and BLUD funds. The BOK fund that has been received by the puskesmas in the amount of 50 million is insufficient to meet the various needs of the puskesmas in carrying out family data collection activities, such as to hold socialization/meetings, the cost of duplicating forms and Pinkesga, and the cost of transportation,[3] the budget is legalized late by the government.[10]

Funding is significantly related to the implementation of PIS-PK. The analysis shows the value of Odds Ratio (OR) 8.33, that good funding will provide an opportunity for the implementation

of PIS-PK by 8.33 times compared to less funding.[10]

Limited funds result in the limitation of all components related to the wellness of the activities such as socialization budgets, transport officers, doubling of questionnaires, doubling of Pinkesga, computer, laptop, and signal.[12]

Inputting Data

Family Coach conducts health data collection in the family using forms of Prokesga and electronic (Healthy Family application). The data by the Puskesmas data manager is input into the database and processed. Family data is processed to calculate the Healthy Family Index (IKS). The Puskesmas management team, together with the family coach and the person in charge of the programs, analyze the data that has been processed, formulate an intervention on health problems and prepare a follow-up plan to be carried out by the Puskesmas.[8]

Based on the results from one of the literatur that the implementation of PIS-PK has been completed, the results achieved are in accordance with the concept that has been set by the Puskesmas and it run smoothly. However, there are still obstacles in the data inputting.[5]

Healthy Family applications both android and website versions are still often have some error, so it can not be run as it should because the network is not strong enough and the system cannot translate the questions in Prokesga.[3] Online data input was difficult and slow. The application didn't show IKS. To get IKS, some puskesmas use a separate format to input data offline and calculate the IKS by themselves.[9] There are signal disturbances, the network system is slow, the data input is late, the data input process is often done at night and causes the input data to be accessed late to the center.[10]

The PIS-PK application cannot be used completely, because the puskesmas employees who are supposed to calculate the IKS using this application still use manual methods and require a long time. The difficulty in using PIS-PK application, due to the ineffectiveness of the PIS-PK application is very influential to hold up the implementation of PIS-PK. The PIS-PK application is an important factor in every implementation of the Healthy Indonesia Program with the Family Approach (PIS-PK) in an organization..[11]

The Healthy Family Web Application (KS) is a regional health information system application that applies nationally that connects online and is integrated throughout the Puskesmas, District / City Health Service, Provincial Health Service, and Ministry of Health. Gradual and continuous development is carried out to improve health services in the field of health service facilities and to increase the availability and quality of health management data and information through the use of information technology. Gradually this system will be developed according to the conditions and readiness for implementation from the operational level, which will lead to improved system performance, integration and consolidation of data with community service systems between SKPD, horizontal level data exchange (with other districts / cities), data level exchange vertical (to the provincial and national level), and so on which will have implications for the addition of various features of the Healthy Family Web Application (KS) itself.[14]

Cross-Sectoral Cooperation

The role of stakeholders in the family approach includes:

1. Role of Puskesmas

In the Family Approach, the Puskesmas has a role as a database of family data collection results, implementing the strengthening and

integration of UKM and UKP programs, monitoring and evaluating the implementation as a whole with the concept of Puskesmas management as well as monitoring health insurance membership.

2. The role of district/city health offices

In addition to play a role in coaching and mentoring, the District / City Health Offices also play a role in monitoring and evaluating the implementation of the Healthy Indonesia Program with the Family Approach at the district/city level, preparing resource support, socialization and advocacy, human resource training, reporting and referral of secondary UKM .

3. Role of the Provincial Health Service

The Provincial Health Office monitors and evaluates the Family Approach at the Provincial level, prepares resource support, conducts socialization and advocacy, training of trainers of human resources as well as reporting, coaching and mentoring, and tertiary UKM referral.

4. The role of the Ministry of Health

The Ministry of Health conducts the preparation of regulations, development of resources, monitoring, and evaluation of the achievement of national program integration such as public health programs, health efforts, prevention of disease control, and implementation of regulations in the regions.[8]

From one study that was reviewed, that social, economic and political environmental conditions responded well to the presence of PIS-PK, but there were still resistance from the community for PIS-PK assistance, this made the data collection less than optimum.[5]

Activities planning is the preparation phase of PIS-PK. However, the socialization carried out is not evenly distributed and the population data obtained is not appropriate, so the puskesmas need

to check the data up to the RT level so that the data obtained is valid.[3]

External socialization is needed to get support from the subdistrict head, village head, and staff. This is done for listing households in real terms for planning the organization of the field and is needed in helping socialization to the community related to family data collection by officers so that it is expected that there will be no more rejection from residents towards attendance of officers.[15]

Obstacles to get complete data about a family could be because the occupants of the house were difficult to find or even refused to be visited. To overcome these obstacles the results of the discussion led to the importance of socialization and cooperation with cross-sectoral (RT, RW, and kelurahan). By coordinating and collaborating with them or even involving them in conducting visits, they will get more cooperation and understanding from residents. Involving across sectors is also recommended in the PIS-PK technical guidelines.[9]

Government support is significantly related to PIS-PK. Analysis of the closeness of the relationship shows that the value of the Odds Ratio (OR) 7.1, means that good government support will provide an opportunity for the implementation of PIS-PK by 7.1 times compared to the government support that is lacking. The condition of the community has not been well socialized due to the level of socialization with people who have not been informed about the implementation of PIS-PK. Government support in the implementation of PIS-PK, it was found that no village head took policies and supported the implementation of activities.[10]

Socialization is needed to get support from the Camat, Lurah and the staff. This is done for the benefit of listing households in a kelurahan/RW/RT in real terms for planning the organization of the field and is needed in helping socialization to the community related to family data collection by

officers so that it is expected that there will be no more rejection from residents to the attendance of officers. However, there is no certainty of time in implementing family data collection activities so that family members sometimes cannot be found during family data collection.[11]

The successful implementation of the Family Approach to achieve a Healthy Family is largely determined by the commitment and cooperation of many parties, from the Puskesmas, the District/City Health Service, the Provincial Health Service to the Ministry.[16]

V. CONCLUSION

From several studies, the implementation of PIS-PK is appropriate with the Guidelines for the Implementation of PIS-PK. The number of PIS-PK officers is insufficient compared to the number of family heads in each work area. The process of inputting data as reporting data collection on the Healthy Family application still has technical obstacles. Facilities and infrastructure to support the implementation of PIS-PK are available but insufficient. Disbursement of activity funds is often late causing the implementation to delay. Cross-sectoral cooperation has been established but has not reached all lines yet. Puskesmas are expected to optimize the existing human resources, conduct inter-sector coordination and collaboration to optimize family data collection, increase staff competency through healthy family training, and conduct budget planning related to the implementation of PIS-PK.

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