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Challenges and Solutions in Implementing a Healthy Indonesia Program with a Family Approach

Tantangan dan Solusi dalam Implementasi Program Indonesia Sehat dengan Pendekatan Keluarga

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ABSTRACT
The Healthy Indonesia Program with a Family Approach (PISPK) is conducted by puskesmas by integrating existing resources, with the family's target. All families will get access to comprehensive health services. The implementation of PISPK since 2016 has not been optimal because it has many obstacles. The analysis aims to identify the obstacles, and to find solutions to implemented PISPK optimally. Implementation research was carried out using Participatory Action Research (PAR). The team (researcher and subject) implemented PISPK together based on stages that integrated into puskesmas management, at 4 puskesmas in South Lampung. Researchers assisted and recorded data collected qualitatively (self-assessment, in-depth interviews, Focus Group Discussion), and quantitatively. There are any obstacles occurred in the implementation of PISPK such as the absence of regulations and cross-sectoral supports; lack of knowledge and support from village officials, community leaders, and the public; limited resources; lack of understanding of the substantive; application; lack of data analysis capabilities. These obstacles can be minimized by making some breakthroughs, such as advocacy and issuance of local government regulations on PISPK involving cross-sectors; increase socialization; periodic coordination, monitoring, and evaluation; making innovations (On Job Training, collaboration with universities and health volunteer, Healthy Family Coverage Pocket Book, developing data analysis methods). The implementation of PISPK has many obstacles that can be minimized by optimizing existing potentials and support from stakeholders. Puskesmas need to increase socialization; team organizing; data analysis; coordination, and routine monitoring evaluation. Pusdatin needs to improve KS applications to be more user-friendly.

ABSTRAK
Program Indonesia Sehat dengan Pendekatan Keluarga (PISPK) dilaksanakan oleh puskesmas dengan mengintegrasikan sumber daya yang ada secara berkesinambungan, dengan target keluarga. Setiap keluarga akan mendapatkan akses terhadap pelayanan kesehatan yang komprehensif. Pelaksanaan PISPK dinilai belum optimal karena adanya berbagai kendala. Analisis bertujuan untuk mengidentifikasi permasalahan implementasi PISPK, dan mencari solusi agar pelaksanaannya berjalan lebih optimal. Riset implementasi dilakukan menggunakan pendekatan Participatory Action Research (PAR). Peneliti bersama subjek mengimplementasikan PISPK berdasarkan tahapan yang terintegrasi dalam manajemen puskesmas. Penelitian ini dilaksanakan di empat puskesmas Kabupaten Lampung Selatan. Peneliti melakukan pendampingan dan pencatatan data yang dikumpulkan secara kualitatif (self-assessment, wawancara mendalam, Focus Group Discussion), dan kuantitatif (analisis data keluarga menggunakan excel dan SPSS). Kendala yang dihadapi dalam pelaksanaan PISPK, yaitu belum adanya peraturan daerah dan dukungan lintas sektor; kurangnya pengetahuan dan dukungan dari aparat desa,

TOMA, dan masyarakat; keterbatasan sumber daya; kurangnya pemahaman konsep PISPK dan Prokesga; aplikasi Keluarga Sehat; kurangnya kemampuan analisis data. Melalui pendampingan, kendala tersebut dapat diminimalisir dengan melakukan beberapa terobosan, yaitu menerbitkan regulasi pemerintah daerah tentang PISPK yang melibatkan lintas sektor terkait; meningkatkan sosialisasi; koordinasi, monitoring dan evaluasi berkala; membuat inovasi (On Job Training, kerjasama dengan perguruan tinggi dan kader, Buku Saku Cakupan Keluarga Sehat, pengembangan metode analisis data). Implementasi PISPK mengalami beberapa kendala, yang dapat diminimalisir dengan mengoptimalkan potensi yang ada dan dukungan dari pemangku kepentingan. Puskesmas perlu meningkatkan sosialisasi; pengorgani-sasian tim; analisis data, serta koordinasi dan monev berkala. Pusdatin perlu meningkatkan aplikasi KS yang lebih user-friendly.

INTRODUCTION

The Healthy Indonesia Program with a Family Approach (PISPK) is implemented by health centers by conducting family visits in their working areas. Activities carried out by Integrate Individual Health Efforts (UKP) and Community Health Efforts (UKM) on an ongoing basis, based on data and information on 12 indicators from the Family Health Profile (Prokesga).[1] This is aimed at increasing access of families and their members to comprehensive health services (promotive, preventive, curative and basic rehabilitative); support the attainment of district / city Health Sector Minimum Service Standards (SPM); support the implementation of the National Health Insurance (JKN); and support the achievement of the goals of the Healthy Indonesia Program in the Strategic Plan of the Ministry of Health (Renstra) 2015-2019.[2] Through home visits, health center officers not only know about health problems but also the condition of Healthy and Clean Living Behavior (PHBS) in the family. Based on the collected data, it is hoped that the health center will be able to prepare a proposal for activity (RUK) based on evidence.[1]

The implementation of PISPK is guided by Permenkes No. 39 of 2016, carried out in stagesstarting in selected areas (9 provinces) and then in 2017 the target achievement was accelerated until 2019 in all provinces, districts or cities reaching 9754 puskesmas.[1,2] Permenkes also describes the roles and duties of each level (central, provincial, district or city, and puskesmas). The provincial, district or city health offices play a role in preparing resources, coordination and technical guidance, and monitoring evaluation.[1]

However, the implementation of PISPK to date has not been optimal because it is not in accordance with the existing guidelines. This can be seen in several studies, among others, the evaluation of the implementation of PISPK in eight provinces carried out by the Research and Development Center for Public Health Efforts at the Research and Development Agency in 2016, generally shows that only a few districts or cities have started to prepare and collect initial data. The obstacles encountered include: PISPK is not yet a priority activity, limited budget and human resources at the puskesmas.[3] Further analysis of the evaluation also shows that cross-sectoral roles are indispensable in implementing PISPK.[4]

Similar results were also shown in the analysis of the implementation of the PISPK at Puskesmas Mijen, Semarang. Apart from budget constraints, human resources, infrastructure, as well as unscheduled monitoring processes have become obstacles in implementing the PISPK.[5]

Seeing these obstacles, Implementation Research is needed to understand the context, assess performance, provide solutions to the constraints of a predetermined policy or program.[6,7] The analysis in this paper aims to identify implementation problems of Permenkes No. 39 of 2016 in the District South Lampung, and looking for a solution that is carried out jointly between the researcher and the executor (subject) so that this policy can be applied in the field optimally.

MATERIAL AND METHOD

Implementation research uses the Parcipatory Action Research (PAR) approach. Research subjects (health offices, puskesmas) are actively involved in all stages of the research. The researcher acts as a companion (consultant) and at the same time records all stages of the activity through instruments arranged based on research principles. Mentoring was carried out in one village at four puskesmas in the district. South Lampung (Puskesmas Way Urang, Tanjungsari, Tanjung Bintang and Karanganyar). This location is selected representing urban, rural and coastal health centers. The selected puskesmas have met the inclusion criteria in this study, namely has attended training and implemented PISPK in 2016.[8]

Assistance is carried out based on the stages of implementing the PISPK in the puskesmas which are integrated into puskesmas management, including the preparation stages, planning (P1), implementation mobilization (P2) and monitoring-control-assessment (P3). Data were collected at each stage qualita-tively and quantitatively. Qualitative data was carried out by self-assessment, observation preparation (discussion), indepth interviews, Focus Group Discussion (FGD). Self-assessment of informants in charge of KS at the health office and puskesmas to assess the extent of PISPK implementation during 2016-2017.

The preparatory stage is carried out through discussions on team organizing, infrastructure, funding, and outreach. The implementation stage is carried out with assistance during home visits, interviews with village heads and community leaders, as well as FGDs for puskesmas officers. In addition, data analysis assistance was also carried out, formulating solutions to problems faced in the field, and preparing RUK. Then proceed with mentoring at the P2 stage in cross-sector mini workshops and P3 during monitoring and evaluation (Figure 1).

Quantitative analysis was carried out using excel and SPSS on home visit data, which were then used in the preparation of RUK puskesmas and advocacy materials to local governments. All data in this paper are presented the matically in terms of regulation, the role of the health office, and the implementation of PISPK in puskesmas.

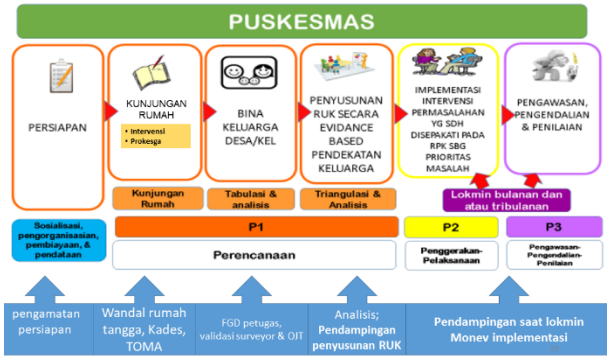

Figure 1. Stages of Implementation Research on the Implementation fo PISPK

RESULTS

Implementation of PISPK in terms of regulatory aspects, and the role of health offices in the locus of assistance can be seen in Table 1. Lampung Province and Kab. South Lampung already has several regulations related to PISPK indicators, but does not yet have a special PISPK regional regulation. Advocacy carried out by the team got results with the issuance of the South Lampung Regent Regulation No. 48 of 2017 concerning the implementation of PISPK. Through this Perbup, all related sectors play an active role in the success of the implementation of PISPK.

The preparation of human resources has been carried out by the Provincial Health Office, in this case the Lampung Health Training Center (Bapelkes) by organizing Healthy Family Training for surveyors, Puskesmas Management for heads of puskesmas and TU Heads, in accordance with the activity instructions from the center (BPPSDM). Healthy family training was held before puskesmas management. However, the results of the self-assessment showed that after the training, because the head of the puskesmas had not been exposed to PISPK, the puskesmas had not directly implemented the program. Therefore, the Litbangkes team made a breakthrough by including the head of the puskesmas in the KS training so that they were able to understand PISPK more comprehensively and could become the main driving force for PISPK activities in puskesmas.

In order to improve coordination between fields in carrying out coaching, a Decree of the Head of the Provincial Health Office on the PISPK regional guidance team with the coordinator is in the Yankes Division. Each sector acts as a district or city coach. In addition, routine coordination meetings are held which are attended by all districts or cities and regular quarterly evaluations. Meanwhile, the PISPK coordinator at the District Health Office. South Lampung is held by the Public Health Division. This does not reduce coordination between provinces and districts. In accordance with its role in resource development, the district health office facilitates changes to the BOK budget plan prepared by the puskesmas in the previous year for the 2nd quarter of 2017, the issuance of a Circular of the Head of the District Health Office. South Lampung regarding the obligation of each pus-kesmas to visit Healthy Families, issued a decree on the Team for Healthy Family Guidance in Kab. South Lampung. Each sector in the District Health Office will become a supervisor at the designated puskesmas. Following up on the Decree and Circular of the Head of the District Health Office, the head of the puskesmas issued a Decree a Healthy Family Team. Regular meetings, and improvements to the PISPK reporting system are carried out by the District Health Office. South Lampung through a plan to compile a "Healthy Family

White Book", containing the Healthy Family Index in 11 PISPK locus puskesmas. This was disclosed by the informants, as follows:

"We have a district policy that we are like eeee ... if there is EHRA in sanitation, after the survey, they have what is called the Sanitation White Book. So, if we will later publish the Healthy Family White Book, we can later ... "(Responsible for a healthy family of the district health office)

The implementation of PISPK assistance at puskesmas is integrated with puskesmas management summarized in Table 2-4. The preparation, planning stage (P1) is shown in Table 2, where the identified obstacles, including inadequate socialization, limited human resources, funds and infrastructure have been tried to be overcome jointly by the team. Internal socialization was carried out to all health workers, while external socialization was carried out more intensively through mini-workshops and meetings involving related parties (sub-districts, villages, hamlet heads, RW, RT, and military).

Table 1. Research Findings and Solutions to PISPK Implementation in Terms of Regulations and the Role of the Health Office Based on the Results of Assistance

Theme	Research Findings	Alternative Solutions Proposed	Activities Carried Out and The Result
Regulation	**Province:** - There is no regulation on PISPK yet. - There are already regulations related to PISPK indicators (Pergub 1000 HPK Prog-ram with Family Approach; Exclusive breastfeeding; KTR)	There needs to be a commitment from the regional leaders-hip in the form of regulatory support, in the form of a Regent Regulation or Regional Regulation concerning PISPK	- MoU of Head of Research and Development Agency with Head of Provincial Health Office (March 2017) - PISPK team advocacy to local governments
	Districts: · There is no PISPK regulation (period March to August 2017) · There are already supporting regulations (Perbup Lamsel regarding STMB)		PKS Head of Center for Research and Development of SD Yankes with the Regent of South Lampung (March 2017) Regent Regulation No. 48/2017 on PISPK (September 2017)
Public Health Office	Province: Prepare human resources through training for the healthy family and puskesmas management	Healthy Family training includes the head of the puskesmas	The head of the puskesmas has a more comprehensive understanding of PISPK
	Province: PISPK coordinator in the field of health care, there is no PISPK guidance team	Decree of the PISPK coach team at the provincial level was prepared	Issuance of a provincial-level PISPK guidance team Decree
	District: PISPK coordinator in the Community Health Sector, no decree for PISPK guidance team, No staff training refresh	Decree of the PISPK coach team at the district level was prepared	- The issuance of the decree of the PISPK guidance team at the district level, Circular Head of the South Lampung Office
		Refresh training is carried out	- Refresh training is carried out
	PISPK coordination meeting along with other program activities (not routine)	Implementation of routine PISPK coordination meetings	Regular PISPK coordination meetings are held
	Monev is carried out simultaneously with other monev programs	Conduct monev for the imple-mentation of PISPK in accor-dance with Monev guidelines for PISPK (Dirjen Yankes)	Monev implementation is in accor-dance with Monev guidelines of PISPK (Dirjen Yankes), District: compiling a "Healthy Family White Book"

Source: Results of Self Assessment, Discussion, In-depth Interview with Responsible for a healthy family of Provincial and District/City Public Health Offices

The limitation of trained human resources was overcome by carrying out information sharing and On Job Training (OJT) for other health workers who did not have the opportunity to attend PISPK training at health training center. This is based on a workforce analysis which shows that the puskesmas actually has sufficient resources, especially nurses and midwives, both civil servants/honorary/TKS. In addition, the local government supports the provision of personnel by appointing village nurses in 260 villages with funding sources from the Village Fund Allocation based on South Lampung Regent Regulation Number 7/2017 concerning Technical Guidelines for the Preparation, Implementation and Reporting of the District Village Revenue and Expenditure Budget. South Lampung for Fiscal Year 2017.

Puskesmas have facilities and infrastructure in the implementation of Individual Health Efforts (UKP) and Community Health Efforts (UKM) as well as adequate competency of officers. All puskesmas are capable of providing services and treatment for hypertension, tuberculosis (TB), family planning, Antenatal Care (ANC). The implementation of UKM such as School Health Efforts, Occupational Health Efforts, and Posyandu are routinely carried out. All puskesmas actively participate in community communication forums and are also involved in village or sub-district development and planning deliberations. This is a potential that supports the implementation of PISPK.

Field organizing was carried out by forming a PISPK team based on the Decree Head of the Puskesmas which contained the division of tasks and family guidance based on each target area. Funding for transportation, procurement of tensimeter, Prokesga and Pinkesga utilizes the Health Operational Cost and JKN ca-pitation, although it still needs to be adjusted according to the technical guidelines. As told by one of the following informants:

"PISPK funds mainly come from Health Operational Cost. Only the menu needs improvement, last year because the menu was different, after it was implemented many couldn't, because the operation was not suitable because there was a repeat visit." (Head of the puskesmas)

The home visit stage carried out by the surveyor experienced obstacles, including not all household members at the time of the visit. This condition can be assisted by cadres to make repeat visit agreements. Refreshing the filling of the Prokesga and equalizing the perception of the operational definition of the PISPK indicator are carried out periodically to minimize errors. This is based on the results of validation which show that there are still surveyors' errors in understanding the Prokesga flow and operational definition indicators. For example, information about exclusive breastfeeding is asked of all families who have children under five regardless of the age of the toddler; he did not observe the source of clean water. As the informant said as follows:

"The puskesmas officer came to the house ... Asked him whether he had a well, a toilet, had a continuous cough or not, smoked or not, had high blood pressure or not, had a BPJS card or not, whether the mother did family planning or not. We are in tension too. But our well and our toilet were not seen." (Ms. R_informan community)

Table 2a. Results of Research Findings and PISPK Implementation Solutions in terms of Puskesmas Management, Preparation, Planning (P1) Phase Based on In-depth Interviews with Head of Puskesmas and FGD Officers

Theme	Research Findings	Alternative Solutions are Proposed	Activities Carried Out and The Result
Socialization	District: internal and external socialization is still lacking	Special internal and external meetings were held to discuss PISPK	Socialization was carried out internal and external levels of the district public health office
	Puskesmas: internal and external socialization is still lacking		Socialization was carried out internal with the whole health center staff, outreach external cross-sector
Human Resources	- Limited trained human resources - Understanding of the flow and operational definition is still lacking	*Refresh training* for those who have been trained. On Job Training (OJT) for health center health workers who have not been trained by the Head of National Health Agency	The implementation of refresh training and OJT
	Potential: South Lampung Regent Regulation Number 7 of 2017		Lifting power Village Nurses in 260 villages with funding from the Village Fund Allocation
	Sufficient Individual Health Efforts (UKP) facilities, active Community Health Efforts (UKM) activities Head of puskesmas attended Healthy Family training	Utilizing existing potential	
Organizing	There is no Decree to puskesmas team	Decree of the PISPK team of puskesmas and Team organizing	Decree PISPK Team of puskesmas
	Visits made yet organized		Division of tasks per house, RT/ RW and village
Financing	Using the health operational cost budget and capitation JKN	Need to optimize existing funds (Health Operational Cost, Capitation, Village Fund Allocation)	Revising and optimizing existing funds (Health Operational Cost, Capitation)
	Not too brave enough to use health operational cost funds because there are no clear technical guidelines	Socialization of Permenkes No. 19 of 2017 concerning Technical Guidelines for Funding PISPK	Dissecting Permenkes No. 19 of 2017 and used as the basis for PISPK financing
	PISPK activities in April and May have not been budgeted for in the health operational cost	Revised health operational cost budget, and use of capitation funds For a promotional preventive visit	- It was agreed that the Health Operational Cost revision; - Use of capitation funds for completeness of infrastructure
Preparation Infrastructure	Limited number of tensimeters	Tensimeter procurement	Procurement of tensimeter with capitation funds, using health workers' personal tensimeter
	Prokesga and Pinkesgater limit	Reproduction of Prokesga and Pinkesga	The reproduction of Prokesga and Pinkesga uses Health Operational Cost or capitation funds
Visit House	Not all household members can be found at the time of visit needing a repeat visit	Increasing the number of home visits with OJT, involving PTM cadres, health students through Field Learning Practices (PBL)	Home visits involve trained cadres and health students through PBL (target areas) primarily Poltekes, Univ. Malahayati (MoU Provincial Health Office with Higher Education)
Filling Out a Questionnaire	Surveyors still do not understand the flow of filling out Prokesga and Operational Definition indicator	Need to refresh the material Prokesga from the teaching module	Assistance in the process of data collection and material refresh Prokesga from the public health office and the Litbangkes team
Intervention When Puldata	He has not yet understood the PISPK concept, not only data collection but also direct intervention by its nature education	Need to re-understand the basic concepts and objectives of PISPK (interviews, direct intervention & recording findings beyond the 12 indicators)	Delivering feedback to the Puskesmas make changes to the concept of home visits
	Pinkesga is still not widely used for IEC facilities	Increased utilization of the Health Research and Development Center: compiling the Pocket Book Healthy Family Coverage, kept in the family	Use of Pinkesga and the Family Coverage Pocket Book
	Findings outside the 12 indicators are still ignored		

Table 2b. Results of Research Findings and PISPK Implementation Solutions in terms of Puskesmas Management, Preparation, Planning (P1) Phase Based on In-depth Interviews with Head of Puskesmas and FGD Officers

Theme	Research Findings	Alternative Solutions are Proposed	Activities Carried Out and The Result
Entries and Data tabulation (with Pusdatin)	Data entry process is hampered (slow)	Pusdatin: Improvement data management by separating the application server and data base, additional capacity data processing devices	The Pusdatin team is making improvements: increasing the number of servers, android version (offline)
	The change from the 2016 healthy family application to the 2017 application, there is data missing	Data entries that do not appear because of the incomplete briging process	Pusdatin: do improvement
	Puskesmas do not have individual data	Pusdatin: data can be requested by the health center, improved access application menu *raw data*	Puskesmas make letters requesting raw data to Pusdatin; manual data analysis (using *Litbangkes templates*)
	Puskesmas administrators and surveyors cannot see the regional IKS score	Calculating IKS takes time due to the application server and data base still one	To see IKS for temporary areas (up to sub-district level) a username is given on the web: https:// demoks.kemkes.go.id The calculation of IKS for temporary village/RW/RT areas is done manually (template *Litbangkes*)
Data analysis	Has not done data analysis	- The importance of PISPK data in the preparation of RUK - The Litbangkes team trained individual data analysis with excel and SPSS data from Pusdatin	Conduct data analysis with puskesmas officers; presents data as advocacy material to Village government and local government

Source: Results of In-depth Interviews with TOMA, Community; FGD with Surveyor and Head of Puskesmas; Data Analysis Assistance

In addition, surveyors need to be reminded again about the importance of direct intervention through Educational Information Communication (EIC) using Pinkesga or other media and recording health problems outside the 12 indicators. These findings will then be followed up by the program holders (black tires). In order to facilitate implementation and increase family knowledge, the National Research and Development Agency helps to make a Pocket Book of Healthy Family Coverage which contains the results of PISPK (healthy family/pre-healthy/unhealthy), educational materials and important notes that need attention.

Another condition that must be considered is the editing and cleaning of data by the coordinator prior to entry. However, this stage has not yet been carried out. the majority of each team immediately made an entry. The obstacles experienced in this process include: 1) data entry is hampered (slow) if it is carried out during the working hours of the puskesmas, it can only be entered if the entry is made at night more than 22.00 WIB; 2) the change in the 2016 to 2017 version of the healthy family application causes not all data that has been entered to appear on the healthy family web dashboard; 3) puskesmas do not have individual data because the data goes directly to the central server; 4) healthy family index is not calculated up to the districts/village/RW/RT level.

In an effort to overcome this, the team coordinated with Pusdatin, which was followed up by: 1) increasing the number of servers to increase data capacity with a target of one province with one server, 2) improving the logic process for calculating IKS, 3) to see IKS for temporary areas (up to the sub-district level) is

given a username at https://demoks.kemkes.go.id. In addition, the National Research and Development Agency bridged it by analyzing individual data using excel and SPSS templates.

The results of the PISPK data analysis show that the coverage per indicator from one village to another can be different. TB patients who seek treatment according to standards, hypertension sufferers receive regular treat-ment, and smoking problems are still the indicators with the lowest coverage in these four villages. However, only a part of the family who participated in family planning is also a problem that needs attention in Jatimulyo Village, while JKN membership is also the lowest coverage in Jatibaru and Jatimulyo Villages (Table 3). The data presented are then discussed, and priority issues are determined and used in the preparation of short and long-term activity proposal plans (RUK). The importance of PISPK data in the preparation of this activity proposal plans was revealed by kepala puskesmas, as follows:

"Data coverage of 12 PISPK indicators and family or village Healthy Family Index can be used to compile evidence-based RUK." (Head of puskesmas)

In addition, the implementation of the PISPK was very useful. Home visits can simultaneously promote services so as to increase both outpatient and inpatient care; as well as monitoring sanitation and monitoring BGM toddlers, as well as improving the assessment in Payment Capitation Based on Service Commitment Fulfillment (KBKP). Such as the statement of the head of the Head of Community Health as follows:

"Home visits are carried out within the framework of PISPK as well as carrying out contact activities for JKN members so that the KBKP will increase." (Head of the puskesmas).

Table 3. Coverage of PISPK Indicators in Four Assisting Locus Villages in South Lampung Regency 2017

PISPK Indicator	Scope (%)			
	Kertosari Tj Sari Puskesmas	**Jatibaru Tj Bintang Puskesmas**	**Jatimulyo Karanganyar Puskesmas**	**Wayurang Wayurang Puskesmas**
Families participate in the Family Planning program	69.7	85.6	57.8	81.1
The mother gave birth in a health facility	95.2	94.9	92.9	87.2
Babies receive complete basic immunization	100.0	99.2	89.0	95
Babies receive exclusive breast milk	89.5	84.5	91.0	98.1
Toddlers get growth monitoring	88.3	81.5	64.9	94.4
Patients with pulmonary tuberculosis receive standard treatment	22.2	27.3	46.4	36.6
Hypertension sufferers take medication regularly	8.2	11.5	23.7	22.3
People with mental disorders receive treatment and are not neglected	66.7	39.3	74.4	16.7
None of the family members smoke	29.5	32.1	31.4	51.0
The family is already a member of the National Health Insurance	77.9	24.4	26.0	69.2
Families have access to clean water facilities	98.0	97.8	99.7	98.7
Families have access to or use healthy latrines	98.0	98.1	99.5	98.1

Source: Results of PISPK Data Analysis in Four Locus Community Health Centers

The next stage is shown in Table 4. The Implementation Mobilization stage (P2) involves delivering the results of the analysis and socialization of PISPK activities by involving cross-sectors involved in mini workshops. This re-socialization is important because the results of in-depth interviews with village heads and community leaders show that understanding and support for the implementation of PISPK is still lacking, as quoted from the interview as follows:

"Never heard of it, but I don't understand it. There was a coordination meeting in the District of the Health office. Healthy in all respects both physically, spiritually and financially."(Village Head)

"Activities carried out by health workers are clearly health, but do not understand clearly." (Community Leader)

The results obtained from the PISPK home visits were used to formulate joint commitments between the puskesmas and cross-sectors regarding the problems at hand. For example, the Karanganyar Puskesmas agreed with the sub-district to include a component of the assessment of families with TB (PISPK results) as one of the requirements for house renovation (an activity funded by Village Fund Allocation) to minimize TB problems; latrine arisan to solve sanitation problems. Innovations, break throughs made by agreements that have been built by the puskesmas and village governments need to be monitored and evaluated (P3 stage) so that the planned activities run well.

DISCUSSION

In line with Permenkes No. 75/2014 and No. 43/2019, puskesmas carry out PISPK by integrating Individual Health Efforts and Community Health Efforts activities and opti-mizing existing resources effectively and efficiently. The implementation process is carried out properly and correctly and with quality, based on the results of a situation analysis supported by evidence-based data and information by utilizing available resources. This is done to be able to implement health efforts according to standards, so as to realize the performance targets that have been set.[9,10]

Table 4. Results of Research Findings and PISPK Implementation Solutions in Terms of Puskesmas Management Implementation Mobilization Stage (P2) and Monitoring-Control-Assessment (P3)

Theme	Research Findings	Alternative Solutions are Proposed	Activities Carried Out and the Result
Movement of Implementation (P2)			
Workshop Mini Cross Sectors	Knowledge across sectors about PISPK is still lacking	Socialization of PISPK; Advocacy: Presenting the results of the Healthy Family Index RW/ hamlet; Make agreements with activities to solve health problems	Socialization and arrangement joint commitments with cross-sector related health.
	Population data (Supas, Raskin data) are not in accordance with field conditions	Synchronizing the number of families in the village or districts;	Coordination in synchronization of the number of families in the village or districts
Monitoring-Control-Assessment (P3)			
Post Evaluation Monitoring Lokmin	Activity yet fully implemented due to constraints of too short a time, many other activities	Monitoring and evaluation of activities that have been planned or agreed upon	The results of monitoring and eva-luation of several activities that have been carried out: MoU with SMA regarding No Smoking Area and implementation of the Co-Smoker examination on high school students, latrine arisan

Source: Results of Assistance and Observation of the Implementation of P2 and P3

Trained puskesmas officers make visits to families in their working areas with the aim of increasing community access to health facilities.[1,2] This is done considering that the family is the most important social center and institution for health development since the individual is born, grows and develops.[11,12] The family also has a major influence on health habits, providing protection and facilities for healing efforts.[11] Through home visits, puskesmas not only provide integrated UKP services for all age groups, but also Community Health Efforts so that they really provide services that follow the life cycle. In addition, home visits are also intended to empower families and communities to overcome health problems at hand.[2,13] Remembering health problems is not only affected bygenetics, behavior, but also social and environmental factors.[12] For example, in an RT/RW/sub-district/village environment with conditions that are difficult to access clean water, or difficult to reach health services, the level of health in that area will be low. Community organization (community organization) is needed to find health problems, both at the RT/RW or sub-district/village level.[13]

Several programs that are similar to PISPK include, Tap the Door to Serve with Heart which has been implemented in DKI Jakarta. This activity is based on Regulation of the Governor of DKI Jakarta Province No.115/2016, where the health team (doctors and paramedics) visited houses that were prioritized in areas prone to health problems with the economic conditions of the lower middle-class residents (row villages, flats, and densely populated slum neighborhoods). Apart from asking a number of questions related to health indicators, the offi-cers also provided treatment for ART with health problems.[14] Through this activity, the puskesmas can map the most diseases in the community, and know the health conditions of their environment directly.[15] The same is also inIn Timor-Leste, there is a health team consisting of 1 doctor, 2 nurses, 2 midwives and 1 laboratory analyst in each village for family promotion and curative. The health team will coordinate with the government, community leaders and other relevant sectors to improve health status.[11] Through these programs, health workers will know about family health problems in their working area and be able to formulate policies that are in accordance with field conditions through collaboration with re-lated sectors.

The results of the assistance shown in Table 1-4 show that the implementation of PISPK in the field faced several obstacles, both from regulation to technical implementation. However, all these obstacles can be minimized by: 1) stakeholder support (Perda/Circular/ Decree); 2) increasing socialization to village officials, TOMA and the community; 3) developing human resources with On Job Training (OJT), cooperation with nearby universities and cadres, and conducting refresh training; 4) optimization of existing funding sources; 5); application improvements, and 6) making innovations in the analysis program; and 7) coordination and monitoring of periodic evaluations. This cannot be separated from the role of the public health

office in advocacy, optimal resource development, coordination, guidance and monev as well good cross-program and cross-sector cooperation.[16]

Through outreach and advocacy to local governments, and across sectors, the implementation of PISPK will receive full support from the regulatory and multi-sector side. This condition is very necessary considering that health problems require effective coordination between sectors, and clear regulations and political will.[11] For example, the availability and accessibility of public transportation affects access to healthy food and health care.[12] No less important is the role of TOMA as an extension, activator, motivator, facilitator and catalyst for PISPK, helping to prepare complete documents, assisting puskesmas officers in home visits.[17] In addition, public knowledge also needs to be improved so that there will be no rejection during visits and the interventions can be carried out properly.[18] Increasing the role of village officials, TOMA and the community can be done through increased socialization through cross-sector mini work-shop and leafleat/audiovisual media.

Limited human resources is a problem that has been widely expressed, not only in the assistance locus puskesmas but also in several other health centers such as those experienced at Mulyaharja (Bogor), Mijen (Semarang) and Tegal Sari (Medan) Puskesmas.[19,20,21] Optimiz-ing the potential of existing human resources in puskesmas, both honorary staff/TKS/contracts and cadres, Individual Health Efforts and Community Health Efforts activities can reduce the obstacles that occur.[8,22] Human resources improvement can be done through OJT, cooperation with nearby universities and cadres to increase outreach.[8,23] The Sentolo Puskesmas in DIY uses contract labor during family visits and interventions, which is able to reduce the workload of the puskesmas staff.[22] Cadres have a role in mobilizing, identifying health problems, becoming a bridge between health workers and the community. This is also in line with the WHO report which shows that in Southeast Asian countries, cadres have great influence to support health services in the community.[11] Collaborating with universities, students helping home visits will also provide experiences for health workers before actually going to the community. Other than that, *refresh training* Concerning the concept of PISPK and Prokesga is also needed in order to improve surveyors' skills as spearheads in conducting interviews. This is important considering that training holds the main key to implementing PISPK. Through regular training, it is hoped that there will be a common perception among surveyors about operational definition of the PISPK indicators. The accuracy of the data obtained will determine the direction of the Puskesmas policy later.[23,24]

Constraints in funding for PISPK can be overcome by synchronizing funds from various programs and sectors. In addition to utilizing BOK funds, the puskesmas capitation can also invite *Corporate Social Responsibility* (CSR) in the region and across related sectors. For example, the use of Village Fund Allocation from village administrations, Healthy Village Houses from

the Ministry of PDTT Village, and others will facilitate the achievement of healthy community goals.[8,5] Synchronization of PISPK with Germas will also facilitate the achievement of targets in the Health Sector Minimum Service Standards which are the responsibility of the regional head.[25]

Regulatory support from the central government with the issuance of Permenkes No. 19/2017 has made puskesmas better understand the use of Health Operational Cost funds for the implementation of PISPK. The Permenkes states that dana Health Operational Cost available at each level can be used to finance activities covered in the activity menu at health service facilities that receive BOK funds, including: 1) Local transport in village, sub-district, district/city areas for health workers, across sectors including cadres; 2) official travel or transport for civil servants and non civil servants; 3) Purchase of consumable goods; 4) Material/material spending to support promotive and preventive services; 5) Printing and copying expenses; 6) Shopping for food and beverages; 7) Organizing meetings, socialization, meetings; and 8) PNS and non PNS honorarium. The use of capitation funds for BLUD puskesmas refers to the provisions, while for non-BLUD puskesmas, the capitation fund allocation for the payment of operational cost support for health services is used for drug costs.[26]

Organizing in teams, editing Prokesga before entry and innovating in utilizing data are needed so that PISPK data can be presented properly. Training in data analysis with excel formulations and SPSS to calculate Healthy Family Index and coverage indicators at the family/RT/RW/village/puskesmas level as developed by the Litbangkes Agency is needed. Another example is the use of intermediate applications that can be linked to the healthy family application carried out by Puskesmas Bloto Mojokerto. Data that has been entered in the intermediate application can go directly to the central server, the puskesmas still has individual data.[27]

Through PISPK data, the head of the puskesmas and the team can identify the condition of the area at each level. At the family level, the puskesmas can identify what health problems each family faces, identify the potential of the family to overcome the health problems faced. Likewise at the RT/RW/sub-district or village level, as well as at the sub-district level. The Puskesmas can then deter-mine the priority of health problems faced by using ultrasound and the ease of solving them (F) refers to the ability of the family/RT/RW/sub-district/village/district or puskesmas, making root problems and incorporating problem solving into the RUK.[13,28,29] Puskesmas by utilizing all the potential resources that exist within and outside its work environment can intervene based on the root of health problems at the family level so that Healthy Family Index can be increased.

The activity plan that has been prepared by the puskesmas can then be used as advocacy material for the village head and the Village Consultative Body in village development plan-ning deliberations. This is in line with the Regulation of

the Minister of Villages, Development of Disadvantaged Areas, and Transmigration No. 16 of 2018 concerning the priority for the use of village funds in 2019, states that one of the prio-rities for using village funds is for the health sector.[30]

Through implementation research with Participatory Action Research (PAR), subjects are able to understand the obstacles in implementing the PISPK, take decisions and take actions to overcome problems that occur in the field, so that the implementation of the PISPK can run more optimally. After the data analysis, there was an awareness of the importance of PISPK data as a support in the preparation of evidence-based plan for proposed activities, which had an impact on increasing the number of contacts and Service Commitment-Based Capitation Payments.[31] All stages of these activities need assistance from district/provincial health offices that can be synchronized in technical guidance and monitoring activities. Monev is carried out through graded validation from the head of the puskesmas, district/city public health office, provincial public health office, and central regional supervisors.[32] The implementation of PISPK assistance in one village at each local health center within one year is a limitation of this research so that the results of the implementation of the action plan have not been completed.

CONCLUSION AND RECOMMENDATION

The implementation of PISPK has en-countered several obstacles, including: the absence of regional regulations and cross-sectoral support; lack of knowledge and support from village officials, TOMA, and the community; limited resources; lack of understanding of the concepts of PISPK and Prokesga; Healthy Family application; lack of data analysis skills. These constraints can be minimized by optimizing existing potentials and strengthening support from stakeholders (local government). Puskesmas need to increase socialization; team organizing; optimization of human resources (refresh training and OJT), funds, existing infrastructure; making innovations in analytical programs; as well as coordination and monitoring of periodic evaluations. The central government needs to make improvements to the Healthy Family application to better accommodate field needs (user-friendly). Through PISPK, puskesmas can identify health problems in their area based on evidence based and carry out targeted activity planning with support from related sectors.

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