Analysis of Policy Implementation for The Improvement Capability of Internal Government Supervisory Apparatus (APIP) at Inspectorate General of Ministry of Health

Policy Implementation Analysis on Exclusive Breastfeeding in Working Area of Cicalengka Community Health Center in Bandung Regency West Java

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The Factors of Management, Communication, Partnership, and Innovation in the Implementation of Posbindu (Integrated Health Post) NCD: A Study in Kelurahan Gunung Batu Bogor City
Analysis of Policy Implementation for The Improvement Capability of Internal Government Supervisory Apparatus (APIP) at Inspectorate General of Ministry of Health

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Abstract. The capability of the Internal Government Supervisory Apparatus (APIP) is the ability to carry out supervisory tasks consisting of three interrelated elements: capacity, authority, and competence. The objective of this research is to give policy recommendations for enhanced APIP capability in the Inspectorate General of the Ministry of Health. This research is a descriptive study with qualitative analysis method with in-depth interview and literature study. Results of this research indicate that there are some obstacles: the socialization done only to some employees of Itjen; no Special Team on the process of improving APIP capability; the time and task division is unclear; has no special budget yet; there has not been a derivative rule from the Internal Audit Charter (IAC); no reward and punishment system; no documentation of supervision working papers; the policy has not been internalized. This research concludes that the implementation of the policy has not been reached optimally based on PERKA BPKP Number PER-1633/K/JF/2011. Communication is the most influential factor in the implementation of APIP enhancement policy. The recommendation from this research are consistently socialize to employees within the Inspectorate General, make Standard Operating Procedures (SOP), allocate budget activities in 2018, create memorandum of understanding with other agencies, and self-assessment and program evaluation absolutely must do continuously.

Keywords: Internal Audit Charter, capability of APIP, communication, program evaluation

INTRODUCTION

In order to realize good governance in Indonesia, the Government tries to make a bureaucracy reform. One of the main areas of the reform is in the field of supervision, in which improving a governance that is free from corruption, collusion and nepotism. Therefore, Indonesian Government issued a President Regulation Number 81 Year 2010 on Grand Design of Bureaucratic Reform 2010-2025. In the field of supervision, bureaucracy reform aims to improve a clean and free of corruption, collusion, and nepotism governance. (Sekneg, 2010). The control over the government activities to achieve an effective, efficient, transparent and accountable financial management must be conducted by referring to Government Regulation Number 60 Year 2008 on Internal Government Control System (IGCS). Government Regulation Number 60 Year 2008 is one of the important milestones in the effort to realize a good and clean governance (Sekneg, 2008). Government Regulation Number 60 Year 2008 purely adopts five elements of internal control from Internal Accounting Office (IAO) which is a part of Committee of Sponsoring Organization (COSO), which includes: (1) Control Environment, (2) Risk Assessment, (3) Control Activities, (4) Information and Communication, and (5)
Monitoring. The implementation of those elements is expected to be able to provide adequate confidence in the implementation of activities in a certain government agency.

Control Environment is the basic foundation underlying a government internal control system. One of the elements of the IGSC Control Environment is the realization of the effective role of the Internal Government Supervisory Apparatus or Aparat Pengawasan Intern Pemerintah (APIP). Achieving effective APIP is an obligation of government institution leaders in maintaining and creating a control environment that leads to conducive and positive behavior. Under the Government Regulation Number 60 Year 2008, the effective role of APIP must fulfill: (1) Providing adequate confidence in the obedience, austerity, efficiency, and effectiveness of the achievement of the tasks and functions of government agencies; (2) Providing early warning and improve the effectiveness of risk management in the execution of duties and functions of government agencies; and (3) Maintaining and improving the quality of governance in the performance of duties and functions of government agencies.

APIP is a government element established with the task of implementing internal supervision within the environment of central and/or local government. The Article 49 of Government Regulation Number 60 Year 2008 states that the APIP consists of Badan Pengawasan Keuangan dan Pembangunan or Finance and Development Supervisory Agency (FDSA); The Inspectorate General or any other names that functionally executing the internal supervision; Provincial Inspectorate; and Regency/City Inspectorate. APIP in every government agency has different conditions, both in terms of management, resources owned, and the surrounding environment (BPKP, 2011). This leads to the diversity of the level of APIP capability value in Indonesia. To realize the effective APIP, we need a general pattern of APIP capability development. The Institute of Internal Auditors (IIA) has developed the Internal Audit Capability Model (IACM). The IACM demonstrates the steps to move forward from a less strong internal supervision level to a strong and effective state, linked to a more mature and complex organization (IIARF, 2009).

The Internal Audit Capability Model is a framework that identifies the fundamental aspects needed to do internal supervision effectively in public sector. It describes the path of evolution for the public sector organizations in order to develop an internal supervision that is effective to fulfill the requirements of organization management and professional expectations. It shows the steps to a strong and effective condition of internal supervision capability. (BPKP, 2015b). The IACM can also being self-assessed by each APIP with the Key Process Area (KPA) and is completed with the steps to the improvement of its level. IACM consists of five levels, i.e level 1: initial, level 2: infrastructure, level 3: integrated, level 4: managed, and level 5: optimized. The higher the level is, the better the capability will be. In this method, there are six elements that is measured, which are: (a) roles and services; (b) human resources management; (c) professional practice; (d) accountability and performance management; (e) cultural and organizational relations; and (f) governance structures (BPKP, 2011).

The statistics that is taken from the 2010 Global Internal Audit Survey show that there are only 3% public sector internal auditors in the world who are at level 3. In Indonesia, based on the capability level assessment at 474 APIP of Ministries, Institutions, and Local Government per December 31st 2014, there are 85.23% APIP at level 1, 14.56% at level 2, and 0.21% at level 3. In 2019, it is expected that all APIPs will be at level 3 in accordance with the target of Rencana Pembangunan Jangka Menengah Nasional or National Medium-term Development Plan 2015-2019 (BPKP, 2015a). In the IACM structure, the level 3 (integrated) shows that APIP is able to assess the efficiency, economics effectiveness of a certain activity and able to provide a consultation regarding management, risk management, and internal control. This capability is an international standard to state whether the APIP capability in a ministry or institution is already good.

The results of FDSA assessment on APIP capability of Inspectorate General of Ministry of Health in 2015, only get level 2 (infrastructure) with improvement. Based on the gap between the results (level 2) with the level that should be achieved (level 3), it is necessary to conduct research to know and analyze the factors influencing the implementation of policy in APIP capability improvement in Inspectorate General of Ministry of Health to conform with the national target. The purpose of this study is to analyze the factors that influence the policy assessment of improving the performance of Government Internal Supervisory Apparatus (APIP) in Inspectorate General of the Ministry of Health, including communication, resources, bureaucratic structure, and disposition factors.

Theoretical Review

The logical framework of APIP capability assessment that is developed in Indonesia is basically refers to the Internal Audit Capacity Model (IACM) developed by The Institute of Internal Auditor (BPKP, 2011). Based on the Technical Guidelines of Capacity Improvement of Government Internal Supervisory Apparatus made by FDSA (BPKP, 2011), the APIP capability assessment tool which is developed in Indonesia has been made to be more easily understood in its implementation. All elements of APIP capability, which are Role and Service, Human Resource Management, Professional
Practice, Accountability and Performance Management, Culture and Organization Relations, and Organizational Structure are assessed by using fulfillment of statements (240 statements) developed for all Key Process Area (41 KPAs). Based on these results, we will be obtained general conclusions APIP capability, which are grouped into five levels (BPKP, 2011).

The definition of public policy by R. Dye is “whatever government choose to do or not to do”. It states that any government activity, either explicit or implicit, is a form of a certain policy. Meanwhile, Lasswell (1951) wanted a public public policy also include a research method of a policy process and research findings that gave the most important contribution to fulfill the needs of intelligence (Indiahono, 2009). In the view of a political expert, David Easton, 1972, as cited by (AG Subarsono, 2005), a policy can be seen as a system consisting of input, conversion, and output. Many experts state that in implementing a policy, its success will be determined by the number of variables and how those variables interconnected each other. Implementation readiness also determines the effectiveness and success of a policy (Ayuningtyas, 2015).

According to Edward in (Nawawi, 2009), the implementation is influenced by four variables related to each other, which are (1) Communication, (2) Resources, (3) Disposition, and (4) Bureaucratic Structure.

To achieve communication success, the implementer must know the policy goals that must be achieved and the target that must be done. All of these should be informed to the target group thus reducing the implementation distortion. Therefore, it is needed to do three things, which are good distribution (transmission), the clarity received by the implementer, and the consistency in the implementation of the policy.

The implementation of a policy must be supported by resources, both human resources, materials, and methods. Although the goals, targets, and content of the policy has been communicated clearly and consistent, but if the implementer has lack of resources to implement, the implementation will not be effective and efficient. These resources consist of human resources, budget, facilities, and also implementation and authority.

A disposition in policy implementation is the behavior that must be undertaken by the policy implementer, such as commitment, honesty, communicative, cleverness and democratic nature. A good implementer should have a good disposition, so he can run the policy as well as desired and as determined by the policy makers. If the policy implementation has a different behavior or different perspective with the policy makers, the implementation process becomes ineffective and inefficient.

In the bureaucratic structure, the organization provides a simple map to show in general its activities and the distance from the peak shows its relative status. According to Edwards, the organization has two main characteristics, which are SOP (Standard Operating Procedure) and fragmentation.

![Image](https://example.com/image.png)

**Figure 1. Defining Factors of Policy Implementation**

**METHOD**

This study is an analytical study with qualitative analysis through in-depth interview and document tracing to analyze factors related to the capability improvement of Government Internal Supervisory Apparatus (APIP) in Inspectorate General of Ministry of Health. The research was conducted in May - June 2017 in Jakarta. The in-depth interviews were conducted with Inspectorate General of Ministry of Health, Inspectorate General of Ministry of Finance and FDSA.

**RESULTS AND DISCUSSION**

APIP capability assessment using IACM in the Ministry of Health has been done 3 times, i.e in 2012, 2015, and 2017 (currently in process). The results of the assessment in 2012 concluded that the Inspectorate General of the Ministry of Health has fulfilled the criteria in accordance with the conditions at level 2 (BPKP, 2012). The assessment in 2015 concluded that APIP of the Inspectorate General of the Ministry of Health was at level 2 with improvement (BPKP, 2015a). The assessment (evaluation) was done by using self-assessment approach. The Inspectorate General of the Ministry of Health carries out its own assessment of its supervision management. The self-assessment was done only when the assessment would be conducted by FDSA and not annually conducted. The comparison of the assessment results in 2012 and 2015 can be seen in table 1 below.
of policy transmission should be accompanied by clarity of information so that the transmitted policy can be accepted clearly so that policy implementers and policy targets are able to know the purpose, objectives and targets of the policy. The unclear information will hamper policy implementation (Ratri, 2014). Until now the process of delivering information has been quite clear delivered by the implementers of the policy although not all of them get the information.

Third, in order to improve the rapidity and effectiveness of the policy implementation process, the commands given must be consistent and clear. The inconsistency of the command will encourage policy implementers to take very loose actions in implementing the policy (Ratri, 2014). This is what happened in the Inspectorate General of the Ministry of Health. The implementation of this policy has not been done consistently, seen in the assessment results in 2015 that experienced a reduction compared to the assessment results in 2012. There are several improvement efforts can be taken, for example reforming the Audit Working Papers, conducting workshop or training so that all employees know about the APIP capability improvement process, and the most important thing is making an understanding and commitment from the leaders and the ranks of its supporters to make this policy consistent. It can be concluded that communication on policy of APIP capability improvement in Inspectorate General of Ministry of Health has not run well.

2. Resource

According to Edward (1980), resource is an important factor in supporting the successful implementation of a policy. The resource includes the adequacy of the number and competence of staff to carry out their duties, the adequacy of relevant information on how to implement the policy and how the resource factors are involved in implementing the policy; the authority to ensure that policies are implemented as desired, and the facilities needed to translate policies into functional services such as office buildings, equipment, land and funds (Supriadi, 2012). Resource variables in this study focused on four types of resources, which are human resources, budget, facilities, and policy instruments.

First, the availability of the human resource of Inspectorate General of Ministry of Health APIP is sufficient to implement this policy. The number of auditors in Inspectorate General of Ministry of Health is 166 people out of a total of 315 employees. In terms of number and levels of auditors, it is already sufficient to implement the IACM. Taskforce Team has been formed and is in the process of making the Decree. The problem is the different busyness of the employees, especially the auditors who often get official duties out of the area in a long time. It makes it difficult to find

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**Table 1. Results of APIP Improvement Capability Assessment in Inspectorate General of Ministry of Health of 2012 and 2015**

<table>
<thead>
<tr>
<th>No</th>
<th>Assessment Element</th>
<th>2012</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Element I: Role and Services</td>
<td>Level 3:</td>
<td>Level 1: Initial</td>
</tr>
<tr>
<td></td>
<td>Human Resources Management</td>
<td>integrated</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Element II: Human Resources Management</td>
<td>Level 2:</td>
<td>Level 2: infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>infrastructure</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Element III: Professional Practice</td>
<td>Level 2:</td>
<td>Level 1: Initial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>infrastructure</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Element IV: Accountability and Performance Management</td>
<td>Level 2:</td>
<td>Level 2: infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>infrastructure</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Element V: Culture and Organization Relations</td>
<td>Level 3:</td>
<td>Level 2: infrastructure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>integrated</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Element VI: Management Structure</td>
<td>Level 2:</td>
<td>Level 1: Initial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>infrastructure</td>
<td></td>
</tr>
</tbody>
</table>

Based on Table 1, it is known that overall there is a decline in APIP capability assessment results in Inspectorate General of the Ministry of Health in 2015 when compared with the assessment results in 2012.

The following sections convey the factors that influence the implementation of the policy.

1. Communication

The communication of a program can only be implemented well if it is clear to its executors. This concerns the process of delivering information, clarity of information and consistency of delivered information (Akhb, 2010). First, the information delivery process. The implementation of policy capability improvement of APIP in Inspectorate General of Ministry of Health did not escape from the transmission process that is through socialization. The socialization that has been done was only limited to certain employees of Inspectorate General of Ministry of Health, it has not been done to all employees comprehensively. The new socialization was conducted at the level of the leaders of Inspectorate General of Ministry of Health and middle auditors (auditor madya). Furthermore, it was expected that the middle auditors will do socialization or training in their own office to the auditors who are below their levels. However, it has not been done comprehensively, so the delivered information has not been completely disseminated. The result of this action is not all of the policy implementers know the importance of this policy and are not involved in the implementation. This policy has not been internalized by all of the Inspectorate General of the Ministry of Health employees.

Second, is about clarity of the information. The process
time to gather together. When assessments are conducted in 2012 and 2015, there was no specific team focusing on self-assessment. Newly formed in 2017 a unit of officers (Taskforce Team) consisting of middle auditors (technical controller) derived from the representatives of each Inspectorate I, II, III, IV and Investigation and chaired by the Head of Program and Information of The Secretariat of Inspectorate General of Ministry of Health. It is expected that this task force will be able to mobilize other auditors to prepare all matters related to the IACM assessment and work in accordance with applicable audit standards.

Special competences of the human resources that are involved in this policy is not necessarily needed. A few competences that have to be possessed are having the performance audit capability and perform audit with the 3Es principal (effective-efficient-economical), able to have good coordination with others, understand the core team of Inspectorate General of Ministry of Health, and the most important thing is having a strong commitment to be involved in the acceleration of the APIP capability improvement in Inspectorate General of Ministry of Health.

Second, regarding the budget, according to Edward III, the limits of the budget makes the quality of the service that supposed to be given to the society also limited (Akiib, 2010). The budget is needed to fund the operational costs on the implementation of the policy, such as to pay the wages of policy practitioner, facility procurement, program operational and other expenses (Ratri, 2014). To implement this policy, the Inspectorate General of Ministry of Health does not provide the budget solely to improve the capability. All this time, the implementation of capability improvement of APIP used the budget that is scattered in different budget posts, such as human resource development budget is taken from employee training budget, meetings outside office hours is using the coaching meeting budget, and other expenses that uses the budget of the strengthening of supervision that is a part of Program and Information. The lack of special budget is one of the reason that the implementation of the policy is not considered as important by the employee of the Inspectorate General of Ministry of Health. This matter suits the Edward III theory that states the limited budget also makes limited service, in this matter is the implementation of capability improvement of APIP in Inspectorate General of Ministry of Health.

Third, facility or infrastructure that is used in the operational of implementing a policy can be in form of building, land, equipment and tools must all be functional to ease the service delivery in policy implementation (Ratri, 2014). In this matter, the facility that is provided by the Inspectorate General of Ministry of Health to support the competence of the implementation of the policy, including the base rules of facility or the SOP, is not available yet.

Fourth, policy instruments is the base and the similarity of procedures in achieving the desired goals. The lack of rules and a special SOP to support the capability improvement of APIP in Inspectorate General of Ministry of Health becomes an obstacle in implementing the policy itself. The derivative rules that made made must refer to Internal Audit Charter (IAC) that is already available to simplify the implementation.

3. Bureaucratic System

Bureaucracy becomes one of the most frequent organization as policy practitioner. In this research, the investigated bureaucracy are inter-agency supervisions and coordination. The concept of bureaucracy first introduced by Max Weber, after that Dwijowijoto (2004:63) in (Supriadi, 2012), said that organization is including a standard, formal and followed by procedures structure. A structure is a unity of a certain part or people that is formal in nature so that if translated to another meaning, it is the same as system.

Inspectorate General of Ministry of Health has done a coordination with other ministries regarding the supervision. Among them are Ministry of Transportation, Ministry of Agriculture, Ministry of Education and Culture, and the Ministry of Internal Affairs. The coordination done with the Ministry of Internal Affairs are monitoring and joined audit for Dana Alokasi Khusus (Special Allocation Budget) in the health sector. Coordination with the Ministry of Transportation is in the form of a cooperation to benchmark the efficiency of the goods and services procurement in the ministry that is very significant with the value reaching beyond trilions of Rupiah. While the coordination with the Ministry of Education and Culture is sharing about the problem of the title Wajar Tanpa Pengecualian (Unqualified Opinion) as the program have similar characteristics which is both ministry has many work units and spread throughout Indonesia. The Ministry of Agriculture is being contacted to have cooperation in peer review of the reports on results of supervision. All of these coordinations are in the informal state, as the Memorandum of Understanding is yet to be made.

A supervision from FDASA is done in form of socialization, guidance, evaluation, and monitoring upon the implementation of policies until the APIP in Inspectorate General of Ministry of Health is able to do a self-assessment. The guidance that is done aims to improve the level of capability to the demanded level or above.

4. Disposition

Disposition includes the will, desire, and tendency of the policy actors to execute the policy seriously so that the goal of the policy can be achieved. The process of
disposition needs knowledge, understanding and deepening upon the policy, which leads to the action of acceptance, indifference and even refusal of a certain policy. According to Edward (1980) in (Supriadi, 2012), if the implementation of the policy desired to be effective, then the policy implementer not only have to know what to do and have the capability to do it, but also must have the desire to implement the policy.

The gesture of the leader in Inspectorate General of Ministry of Health is very supporting and encouraging all the employees to support the implementation of this policy. Furthermore, the existence of strong commitment is also shown by joining into the an internal audit forum in Indonesia, Asosiasi Auditor Intern Pemerintah Indonesia or Indonesian Government Internal Auditors Association (IGIAA). IGIAA is a professional organization that have the members of individuals and work units of APIP. Thework unit of APIP is a government institution that was formed with the duty of internal supervision in the environment of central and/or local government (AAIPI, 2014). The Inspectorate General of Ministry of Health is actively participate as the Vice-Head of the Audit Standard Committee in IGIAA.

Unfortunately, other employees of Inspectorate General of Ministry of Health are not so supportive on this matter. Most of them are not yet to care and aware to understand the importance of IACM. Since only few employees are focused on implementing this policy, many obstacles are encountered. The busyness when doing routine tasks becomes one of the them.

In the process of policy implementations, it is often to imposed incentives and sanctions to support the policy implementation so it will run smoothly. The goal by giving incentives is to improve the motivation of the policy implementer to achieve organization goals (A Subarsono, 2005). The Inspectorate General of Ministry of Health has not given direct incentive upon this implementation of the policy. The incentive will be given through a Decree that is still in the forming phase. However, based on the in-depth interview, it is known that the incentive factor does not have a significant impact upon the policy implementation of APIP capability improvement in Inspectorate General of Ministry of Health. Whereas, incentive is needed to make the task force unit maximizes their work and as a binder for the team responsible in carrying out its duties in accordance with existing rules.

Based on the in-depth interview, it is known a few obstacles that are faced by the Inspectorate General of Ministry of Health in order to achieve level 3 in APIP capability. In table 2 is shown the obstacles that are faced by Inspectorate General of Ministry of Health in every process of policy implementation and the comparison with the Inspectorate General of Ministry of Finance.

<table>
<thead>
<tr>
<th>No</th>
<th>Policy Implementation Component</th>
<th>Inspectorate General of Ministry of Health</th>
<th>Inspectorate General of Ministry of Finance</th>
<th>Obstacle</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Communication</td>
<td>Done through socialization but not reaching all employees, so it is yet to be internalized by all employees</td>
<td>Communication done not only to all Inspectorate General Ministry of Finance to all Echelon I in the ministry and the Minister of Finance</td>
<td>The policy has not given direct incentive upon this</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Done through socialization</td>
<td>Through socialization inside General Inspectorate of Ministry of Finance and coming to other Echelon I to describe the unit’s involvement</td>
<td>Socialization has not reached everyone, so the understanding is not equal</td>
</tr>
<tr>
<td>2</td>
<td>Consistency</td>
<td>Yet to be consistent</td>
<td>Consistent</td>
<td>Lack of commitment</td>
</tr>
<tr>
<td>3</td>
<td>Bureaucratic Structure</td>
<td>Done informally</td>
<td>Done informally</td>
<td>No Memorandum of Understanding</td>
</tr>
<tr>
<td>4</td>
<td>Disposition</td>
<td>Commitment from the leader, but not supported comprehensively</td>
<td>Commitment from the leader and employees of Inspectorate General of Ministry of Finance</td>
<td>The policy has not internalized yet and not all personnel are empowered maximally in accordance to their competence</td>
</tr>
</tbody>
</table>

According to that matter, the solution that can be given to the Inspectorate General of Ministry of Health to achieve level 3 (integrated) capability of
APIP are:

a. Putting the APIP capability improvement program into Rencana Aksi Program (Plan of Action) of Inspectorate General of Ministry of Health 2015-2019
b. Creating a task force unit who is focused on the IACM assessment and putting it into a Decree
c. Creating a human resource development plan that supports the supervision activity
d. Allocating a special budget for APIP capability improvement in 2018
e. Creating rules in the form of Surat Keputusan Inspektur Jenderal (The Decree of Inspectorate General) or a technical guidance
f. Doing a standard cost variance analysis review in the phase of internal supervision
g. Creating Memorandum of Understanding with other institutions to strengthen the cooperation in supervision sector
h. Providing incentives to the special team that implemented the policy and create its Decree
i. Creating a reward and punishment system.

CONCLUSION

1. Policy implementation of the APIP capability improvement in Inspectorate General of Ministry of Health has not achieved its optimal outcome referring to the technical guidance in the FDSA Chief’s Rules Number: PER-1633/K/JF/2011;

2. Communication, resources, bureaucratic structure and disposition factors have not work optimally due to each components stagnancy in most of the part:
   a. No communication transmission regarding about the policy of APIP capability improvement in Inspectorate General of Ministry of Health;
   b. Resources, which in this case human resources and facility in the Inspectorate General of Ministry of Health have been adequate in terms of quantity, but no commitment from the human resources to implement the policy, no policy instrument and budget support;
   c. Bureaucratic structure in Inspectorate General of Ministry of Health such as supervision and inter-agency coordination have done well, but informally without Memorandum of Understanding;
   d. The form of disposition in Inspectorate General of Ministry of Health is the support and commitment from the Inspectorate General leader to the success of the APIP capability improvement policy implementation. However, it is not fully supported by the employees of Inspectorate General who are still ignoring the policy. No special incentive given to the policy implementer.

3. Communication is the most impactful factor upon the policy of APIP capability improvement in Inspectorate General of Ministry of Health.

RECOMMENDATIONS

Inspectorate General of Ministry of Health:

1. Inspectorate General as Government Internal Supervisory Apparatus (APIP) in the Ministry of Health consistently socialize to the employees in the internal of Inspectorate General and Echelon I employees in the ministry;
2. Putting the assessment of APIP capability improvement program to the Plan of Action of Inspectorate General of Ministry of Health 2015-2019;
3. Creating derivative rules from Internal Audit Charter such as Operational Guidance and Technical Guidance for the policy implementation of APIP capability improvement;
4. Creating the Standard Operational Procedure regarding the assessment of APIP’s capability that is needed as the basis of policy implementation;
5. Allocating the budget to improve the capability of APIP in the 2018 activity plan;
6. Creating Memorandum of Understanding to strengthen the cooperation in the supervision part between Ministry of Health and other institutions, such as but not limited to:
   a. Ministry of Transportation: cooperation in workshop regarding the procurement of goods and services;
   b. Ministry of Agriculture: cooperation in inter-agency peer review;
   c. Ministry of Education and Culture: make a ministry audit guidance with a very large number of work units to the level of districts;
   d. Ministry of Internal Affairs: cooperation in the field of audit upon Dana Alokasi Khusus (DAK) or Special Budget Allocation.
7. Self-Assessment and Program Evaluation to be done continuously;
8. Improving the commitment of the leaders in implementing the APIP policy through the forming of the acceleration team of APIP capability improvement;
9. Need support and commitment from all of the employees in the Inspectorate General of Ministry of Health in the implementation of APIP capability improvement policy.

Financial and Development Supervisory Agency:

1. Doing supervision to the Inspectorate General of Ministry of Health as an annual routinity to know that the process of APIP capability improvement policy implementation is done well and correctly so that the assessment outcome of level 3 is achieved as targeted;
2. Creating rewards for the Ministry or Agency that has a positive progress in improving the APIP capability.
REFERENCES


Policy Implementation Analysis on Exclusive Breastfeeding in Working Area of Cicalengka Community Health Center in Bandung Regency West Java

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Abstract. Data and information on the health profile of Indonesia in 2016 showed only 29.5% of infants receive exclusive breastfeeding until 6 months, the low level of exclusive breastfeeding made the government issue a regulation on exclusive breastfeeding in Government Regulation Number 33 of 2012. The study aimed to analyze the policy implementation of exclusive breastfeeding at Cicalengka Community Health Center. The study used qualitative analysis with in-depth interview method, focus group discussion and literature study. The result of this study shows that breastfeeding policy implementation in health centers is not optimal, as seen from the low coverage of exclusive breastfeeding. Socialization of the policy has not been done as a whole, the time and task division is unclear and has no special budget and the standard operating procedures is not really used in carrying out the policy. Communication is the most influential factor in the implementation of the policy. There is no support and commitment from all employees in the implementation of exclusive breastfeeding policy. The suggestion is to consistently socialize to employees and the public, carry out supervision in an effort to secure the policy, run the Standard Operating Procedure (SOP), allocate budget activities in 2018, create a memorandum of understanding with other agencies, and Self-assessment and program evaluation absolutely must do continuously.

Keywords: exclusive breastfeeding, policy implementation, community health center.

INTRODUCTION

United Nation Children Fund (UNICEF) and World Health Organization (WHO) recommended that it is better that children are solely given Exclusive Breastfeeding for at least 6 (six) months in the attempt to reduce the number of illness and mortality upon babies. The addition of solid food is given after the baby is older than 6 months old, continued by breastfeeding until the children reaching 2 years old (WHO, 2015). UNICEF stated that as much as 30,000 deaths of infants in Indonesia and 10 million deaths of children in the world can be prevented through providing Exclusive Breastfeeding for six months since birth, without giving additional food or drinks to the infants every year. This matter is supported by Lancet (2010) that stated providing Exclusive Breastfeeding can lower the infant mortality rate by 13% and reduce the prevalence of stunting children.

The Infant Mortality Rate (IMR) in Indonesia is 32 deaths per 1,000 births based on Indonesian Survey of Demographic and Health (ISDH) 2012. These numbers are below the target of Millennium Development Goals (MDGs), which is 23 per 1,000 births (Depkes, 2013).
The way of providing Exclusive Breastfeeding is one of the efforts to reach the target of IMR reduction, in order to suppress IMR and reduce 30,000 infant mortality in Indonesia and 10 million infant mortality in the world through providing Exclusive Breastfeeding for as long as six months since the first hour of birth without giving any food.

Community Nutrition Refinement Program (CNRP) in Indonesia has targeted the scope of Exclusive Breastfeeding to be 80%. However, providing Exclusive Breastfeeding for six months is still too difficult to do. Government Regulation No. 33 of 2012 made by the government based on the low level of Exclusive Breastfeeding in Indonesia, in order to make the healthcare facilities and mothers to be more aware that Exclusive Breastfeeding is important and make sanctions if this policy is not implemented. The result of the research that is published by Journal Pediatrics in Ghana shows that 16% of infant mortality can be prevented by breastfeeding the infants since the first day of birth. In 42 countries show the reduction of childhood mortality rate is higher because of the Exclusive Breastfeeding which reaches 13% compared to other public health interventions. (Roesli, 2013)

In the plan of action of the community nutrition guidance in 2010-2014, it is stated that infants aged from 0-6 months will have Exclusive Breastfeeding. This target also stated by Indonesian government since 2000. However, in the reality by the year of 2014, the national coverage of Exclusive Breastfeeding has only reached 52.3% which has yet to reach the target. In the Province of West Java, by the year of 2013 the coverage of Exclusive Breastfeeding for infants aged 0-6 months is 33.7%. Only one province that reached the target which is the Province of West Nusa Tenggara which is 79.7%. The Province of West Java, West Papua, and North Sumatra are the three provinces with the lowest achievements. (Kemenkes, 2014)

According to Health Profile of Cicalengka Community Health Center 2016, the percentage of Exclusive Breastfeeding for infants aged 0-6 months in the working area of Cicalengka Community Health Center in 2016 is 27%. The low number of Exclusive Breastfeeding for six months is because the understanding regarding the importance of it is still low, the lack of information and knowledge of the mothers regarding the nutrition content and the advantages contained inside breast milk along with the condition of working mothers, especially the one who lives in urban area. (Dwi Sunar, 2012). According to that problem, this research is conducted to know how the Policy Implementation of Exclusive Breastfeeding in the working area of Cicalengka Community Health Center.

METHOD

This research conducts an analytical descriptive study with qualitative method through in-depth interview, Focus Group Discussion (FGD) and document search to get the depiction of policy implementation of Exclusive Breastfeeding in the working area of Cicalengka Community Health Center. The type of this research is a qualitative research with Rapid Assessment Procedure (RAP) approach. The qualitative research is a research specifically using a technique to obtain the answers or in-depth information upon opinions, perceptions, and people’s feelings (Kresno, dkk, dalam Buchari, (2013)). The triangulation of sources done by gathering data from different sources which are correlated each other, while triangulation of methods done by using more than one method which is in-depth interview and Focus Group Discussion (FGD).

RESULTS AND DISCUSSION

The informants for in-depth interview are 7 people who are experienced and are on duty upon giving medical healthcare, consist of the representative of Public Health Office of Bandung Regency, Healthcare Technical Implementer Unit of Cicalengka, Puskesmas Cicalengka DTP (Cicalengka Community Health Center that provides inpatient care), Village Midwife, and Village Cadre. The educational backgrounds of the informants have been appropriate with their current positions, also, their experience in carrying out the task can be seen from their year of service which have been over 4 years. While the method of FGD is conducted to 12 civilians lives in the Cicalengka area, consist of 6 mothers that provides Exclusive Breastfeeding and 6 mothers that do not.

The policy of Exclusive Breastfeeding contains all of the conditions that regulate about Exclusive Breastfeeding in order to protect, support, and promote Exclusive Breastfeeding. This matter is in line with a global analytic comparative research upon The Policy of Breastfeeding. It concludes that the higher percentage of women giving Exclusive Breastfeeding are in the
countries that have regulations on off work times upon the women who are doing breastfeeding. (Heymann, Raub, & Earle, 2013).

From the result of the research, there is a Local Regulation which is one of the supports from the Local Government in implementing the national policy. The Local Regulation is written as The Local Regulation of Bandung Regency Number 8 of 2009 on Maternal, Neonatal, Infant and Child Health (MNICH) in Bandung Regency. However, this Local Regulation is not delivered equally, there are only a few informants know about this regulation. With that being said, it is needed to review how the communication works in order to socialize the policy of Exclusive Breastfeeding. This Local Regulation explains that every infant and child has the right to get Exclusive Breastfeeding for six months and breastfeeding until 2 years old.

The policy of Exclusive Breastfeeding in Indonesia gains a full support from the government, seen by the year 2012 a Government Regulation Number 33 of 2012 on Exclusive Breastfeeding was issued. It contains the conditions for the health facility, health workers, community and family to support the mothers to be able to provide Exclusive Breastfeeding. Based on the report of Provincial Health Office in 2013, the coverage of Exclusive Breastfeeding in the Province of West Java is 33,7%. While the implementation of Exclusive Breastfeeding policy in Bandung Regency seen from its coverage is 31,88%, and the coverage of Exclusive Breastfeeding in the working area of Cicalengka Community Health Center is 27%.

**Depiction of Exclusive Breastfeeding**

According to Government Regulation Number 33 of 2012, Exclusive Breastfeeding is breastmilk that is given to infants since their birth until 6 months old, without adding and/or replacing with other foods and drinks. This research analyzed on what opinions came from the implementers of the policy upon the meaning of Exclusive Breastfeeding through in-depth interview with nutrition officer, managers of Mother and Child Health program, and midwife. Aside from that, the author also conducted FGD upon mothers who do Exclusive Breastfeeding as well as mothers who do not do Exclusive Breastfeeding.

This research found that there is still any perception difference of Exclusive Breastfeeding among Community Health Center officers, cadre, and mothers who do Exclusive Breastfeeding as well as who do not. The lack of knowledge of mothers about Exclusive Breastfeeding is basically reasoned, when the author asked whether the mothers have attended a counseling regarding Exclusive Breastfeeding, there were mothers that never attend it, never goes to the Community Health Center and only came to Integrated Service Post only to do weighing and then came back home.

According to Suradi (1989), one of the factors that influence the success of breastfeeding is the mother’s knowledge of lactation. Someone that has knowledge about breastmilk and breastfeeding will affect the behavior that stated by the change of breastfeeding pattern towards the better.

**The informant’s Definition of Exclusive Breastfeeding**

From the results of the FGD about the definition of Exclusive Breastfeeding from all the mothers who provide Exclusive Breastfeeding and those who do not provide Exclusive Breastfeeding, they know the meaning of Exclusive Breastfeeding, but most of them tell the definition in an incomplete way, as shown from these statements:

- “asi yang selama 6 bulan diberikan tanpa makanan apapun” (A4) (breastmilk that is given 6 months without any additional food)
- “asi full, asi lebih bagus daripada air tambahan” (A6) (full breastmilk, breastmilk is better than additional drinks)
- “Susu ibu sendiri tidak campur susu lain” (B1) (mother’s milk only, without the mix of other milks)
- “bagus daripada susu sapi” (B4) (better than cow’s milk)

The definition of Exclusive Breastfeeding is also put forward by a few informants when conducting in-depth interview:

- “Memberikan ASI saja dari 0 sampai 6 bulan” (Z4) (Only breastfeeding from the age of 0 to 6 months)
- “Pemberian ASI dari mulai bayinya lahir sampai dengan bayinya 6 bulan, khusus full enggak dikasih minum, enggak dikasih makan, enggak dikasih susu formula, enggak dikasih apapun selama enam bulan tanpa berhenti.” (Z6) (Providing breastmilk since the infant was born until the age of six months, fully breastfeeding, without other drinks, without other foods, without formula milk, without any additional intake for six months without stopping)
- “Banyak manfaatnya artinya ASI yang 0 bulan sampai 6 bulan” (Z7) (Many advantages upon the breastfeeding that occurs from 0 to 6 months old)
- “Pemberian ASI sampai usia 6 bulan tanpa ada makanan dan minuman pendamping seperti PASI.” (Z5)
(Breastfeeding until 6 months old without complementing foods and drinks such as Breastmilk Replacement (BR))

Components of Policy Implementation

Communication

The path of communication in delivering the information regarding Exclusive Breastfeeding policy in the working area of Cicalengka Community Health Center starts from the Exclusive Breastfeeding policy which being delivered by the Public Health Office directly to the Community Health Center and Breastfeeding Counselor through a several of medias. The communication will be effective if there are feedbacks between the receiver and the source of information. The process of communication in the effort to support the policy of Exclusive Breastfeeding can be seen in this table:

Table 2. Communication Process of the Exclusive Breastfeeding Policy

<table>
<thead>
<tr>
<th>No.</th>
<th>Level</th>
<th>Form of Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Public Health</td>
<td>Communication in the form of meeting with the Breastfeeding Counselor in every Community Health Center, through the distribution of posters, Mother and Child Health book, and the guidebook of Exclusive Breastfeeding.</td>
</tr>
<tr>
<td>2.</td>
<td>Community Health Center</td>
<td>Communication in the form of monthly workshop meetings, cross-sector meeting, district coordination meeting, and counseling of Exclusive Breastfeeding.</td>
</tr>
<tr>
<td>3.</td>
<td>Integrated Service Post</td>
<td>Socialization and Counseling of Exclusive Breastfeeding, Pregant Women Class, Child’s Mothers, Leafllet and Mother and Child Health Book Distribution</td>
</tr>
</tbody>
</table>

The policy implementation of Exclusive Breastfeeding also undergoes a transmission process through socialization. In the implementation, the socialization is conducted to all the employees, cross-sector, and the society through meetings e.g monthly workshops. The socialization is delivered by the Breastfeeding Counselor that has been trained by the Regency Health Office. Aside from that, the Breastfeeding Counselor should also advocate private companies that is in the district around the Community Health Center. According to the interview, it is known that socialization is also conducted to the level of Integrated Service Post through group counseling by the village midwives on duty because there is only one Breastfeeding Counselor in each Community Health Center. However, the village midwives have not had special training from the Breastfeeding Counselor. It is hoped that the Breastfeeding Counselor that is positioned in the Community Health Center can do socialization or training in the Community Health Center to the midwives. Aside from that, the utilization of developed media and mostly used by the society e.g flyers and social media can be a consideration for the

Community Health Center to be used as a mean of communication.

The second is clarity, the process of policy transmission should be accompanied with the clarity of information so that the policy that has been transmitted can be received clearly so that the policy implementor can know the intents, goals, and objectives of the policy. The obscurity of information will hamper the policy implementation (Ratri, 2014). Until now, the process of information delivery is clear enough delivered by the field worker even though not all implementers have that information. The socialization is conducted tiered through internal meetings and trainings.

Third is consistency. The work instructions should be consistent so that the process of policy implementation would be quicker and more effective. The inconsistency of instructions will make the tendency of the field workers to take loose actions in implementing the policy (Ratri, 2014). This matter is seen in the data stated by different informants regarding the received information and the coverage of breastfeeding that is still low.

Communication will be considered as effective when the communicated information reached the destination as expected by the communicator. The knowledge of implementors upon the content of the policy will improve automatically if the communication goes effectively. An effective communication amongst the implementors that mastering the content of the policy will affect on the attitude of the implementers of the program that will eventually affect the performance of the policy (Sudarwati, 2012). It can be concluded that communication about the Exclusive Breastfeeding policy in the working area of Cicalengka Community Health Center has not done well.

Resources

The resources mentioned by Edward that is supported by Meter, Horn, and Grindle in policy implementation includes human resources and financial resources (Massie in (Sagala, 2010)). According to Edward (1980) resources is a key factor in supporting the success of policy implementation. The resources meant here are include the adequacy of number and competency of the officers to do their job, adequacy of relevant information on how to implement the policy and how the factors of resources involved in the policy implementation.

The authority to guarantee that the policy is implemented as desired and the existence of the facility needed to implement the policy to be a functional service such as office buildings, tools, lands, and funds. The limitation of resources can be interpreted to be the ineffectiveness of law and regulation, low level of service, and undeveloped state of rational regulation
The variables of resources in this research are focused on three types, that is Human Resources, Financial Resources, and Facility Resources.

In Human Resources, the availability of officers is still not enough to implement this policy if we see the target of pregnant mothers in the Bandung Regency which are 75,000 people, but they only have one midwife assigned in every village and there are still 10 villages that do not have any officers. The total number of midwives who are the Local Government employee and private employee are 800 people, and the number of parajri or traditional midwife is 800 people, with the coverage of birth at 87% and there are still 3% born with the help of parajri. Besides, there is a problem of many programs outside the Exclusive Breastfeeding that make the midwives have many duties all at once, that leads the program of Exclusive Breastfeeding to be left out. The competency from the perspective of education is already appropriate, but the problem is that there is a gap of knowledge between officers that have underwent training to be a Breastfeeding Counselor and those who have not. All of the informants stated that it is needed to have trainings for all of the officers inside the Community Health Center, however, it is constrained by the budget.

Second, is the budget. According to Edward III, budget limitedness will cause the quality of services that should be provided to the community is also limited (Akib, 2010). Budgets are required to fund the operationalization of the policy implementation, for instance to pay the salaries of policy implementers, the provision of facilities, program operationalization and many more (Ratri, 2014). In Bandung Regency, there are budget expenditures and local expenditures of Public Health Office which have been used to train Breastfeeding counselors. Meanwhile, in Community Health Center there are fund of Biaya Layanan Umum or Public Service Cost (PSC) and Biaya Operasional Kesehatan or Health Operational Cost (HOC). From the in-depth interviews, some employees do not know about the budget that support the Exclusive breastfeeding program. The absence of special budget is one of the causes of the ineffectiveness of this policy implementation.

Third, is the facilities and infrastructure which are used for the operationalization of the policy implementation. It can be in the form of buildings, land, tools and any other facilities that make the provision of services in policy implementation becomes easier (Ratri, 2014). The facilities used in the promotion of Exclusive Breastfeeding are in the form of media counseling, flipcharts and leaflets, while the infrastructure provided is in the form of a breastfeeding corner. Overall, the role of Puskesmas in preparing the facility is good enough. However, the breastfeeding corner is not functioning properly because the design of the room is not attractive enough for the mother to use the breastfeeding corner, the lack of instruction to the mother to use the facilities provided, and the breastfeeding counselor room in which too far with child room.

The organizer of public facility in the form of Healthcare Facilities must support the success of Exclusive Breastfeeding program based on 10 (ten) steps to the success of breastfeeding described in Article 33 of Government Regulation on Breastfeeding, which includes:

- developing a written policy on breastfeeding and communicate it to all healthcare staff;
- training all healthcare staff in the skills of implementing the breastfeeding policies;
- informing all pregnant women about the benefits and management of breastfeeding;
- assisting the mothers in initiating early breastfeeding within at least the first 60 (sixty) minutes of childbirth;
- helping the mothers how to breastfeed and maintaining their breastfeeding activity even if the mothers are separated from their baby;
- giving only breast milk to the newborns unless there is a specific medical indication;
- applying rooming-in maternal care to her baby for 24 (twenty four) hours;
- recommending the breastfeeding as the request from the baby;
- not giving pacifier to the baby;
- encouraging the establishment of breastfeeding support groups and refering the mothers to that group after being discharge from the Healthcare Facilities.

### Bureaucratic Structure

Bureaucracy becomes one of the most frequent organizations that implements the policy. In this research, the researched bureaucracy is the inter-agency coordination. In the process of policy implementation, the inter-agency coordination is required to avoid complex, twisted and long-term issues in order to implement the policy in a proper and quick way.

The concept of bureaucracy was first introduced by Max Weber, Dwijowijoto (2004: 63) in (Supriadi, 2012), stated that the organization is include a standardized, formal and procedured structure. Structure is a unity of a certain part or person that is formal. So, when it is being translated with another term, it is similar to a system.

As Wahab (2015) stated that coordination is not only how to communicate the information or establish a suitable organizational structure, coordination is also concerns the fundamental issue of the practice of the power implementation. The Public Health Office of Bandung Regency has
coordinated with Doctor Selasih to cooperate in the form of Breastfeeding counselor training procurement, but inter-agency cooperation such as with private companies, *Petugas Lapangan Keluarga Berencana* (Family Planning Field Officer), and Local Government has not been well established. At the level of Community Health Center, coordination efforts have been done between breastfeeding counselor midwives with fellow midwives and nutrition officers. In addition, coordination efforts are also carried out by teh Community Health Center to Cross Sector such as the Family Planning Field Officer, *Pembinaan Kesejahteraan Keluarga* (Fostering Family Welfare group), Community Leaders, and District level in form of non-formal information delivery on Exclusive Breeding policy. All those forms of coordination are only done nonformally because the Memorandum of Understanding has not been made. Based on the bureaucratic structure factor, there is no clear SOP related to the implementation of breastfeeding counseling activity. It makes the breastfeeding counselor midwives perform breastfeeding counseling without any SOP guidance. Another study found that without SOP, a good implementation can not be expected because in the end of the day, the officers do the work according to their own understanding as there is no instrument that controls the quality of work (Purwaningrum, 2011). Aside from that, every activity must be accounted for by making a report as an evidence that the activity has been implemented and it is going to be used as a performance benchmark. The existence of SOP is intended to provide a clear, understandable, and written concept on procedural documents in every activity (Alifah, 2012).

**Disposition**

Disposition includes the will, desire, and tendency of the policy actors to execute the policy seriously so that the goal of the policy can be achieved. A disposition will emerge among policy actors if it will benefit the organization and individual. This disposition process requires knowledge, understanding and deepening of the policy which leads to the action of acceptance, indifference and even refusal of a certain policy. The policy that being rejected by the implementer because of the implementing organization is not benefited with the existence of the policy, then it will lead to a disposition that hamper the policy implementation. In this research, the disposition that is observed is the attitude of the implementer in the form of commitment, support, and tendency of exclusive breastfeeding program implementation in the area of Cicalengka Community Health Center. According to Edward (1980) in (Supriadi, 2012), if the policy wants to be implemented effectively, then the policy implementer must not only know what to do and have the ability to implement it, but they also must have a desire to implement the policy. Some implementers of Exclusive Breastfeeding policy are committed to run the Exclusive Breastfeeding program in the form of counseling training, counseling, running the program well, creating Decree and SOP as well as ensuring that all mothers must be able to exclusively breastfeed.

Unfortunately, the delivered commitment has not been in written form, it is only an oral form. Therefore, there is no evidence that all employees are committed. While the mothers who exclusively breastfeed must commit to provide Exclusive Breastfeeding for 6 months and keep breastfeeding until the age of 2 years which also supported by maintaining a nutritious diet.

**Forms of Support**

According to (Lubis, 2000), family support is an important supporting factor for the Exclusive Breastfeeding program. Basically, family support provides emotional and psychological support for the mothers in breastfeeding. The result of the research shows that the whole group of mothers who do Exclusive Breastfeeding and mothers who do not do Exclusive Breastfeeding received support from their family in the form of advice that reminds about breastfeeding. The obstacles that make the mothers do not do Exclusive Breastfeeding are only a little milk came out, the baby does not want to suckle, and the mothers do not want to be bothered. All those things cause the family to support the mothers to give formula milk when the breast milk volume is a little. Another support received by the mothers are in the form of support from health cadres who always remind them and also the media that provides articles and advertisements on television about breastfeeding. While the support from health workers has done well by providing knowledge about Exclusive Breastfeeding and providing facilities for breastfeeding and counseling when there are obstacles when giving Exclusive Breastfeeding.

<table>
<thead>
<tr>
<th>No.</th>
<th>Institution</th>
<th>Forms of Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Public Health Office of Bandung Regency</td>
<td>Creating a Local Regulation on Maternal, Neonatal, Infant and Child Health (MNICH) - Holding a Breastfeeding Counselor Training</td>
</tr>
<tr>
<td>2.</td>
<td>Community Health Center/Health Workers</td>
<td>Providing Breastfeeding Corner - Initiating an Early Breastfeeding - Facilitating a Rooming-in Maternal Care - Socializing about Breastfeeding when the Mothers Come to Integrated Service Post Every Month - Holding a Children Class Thrice a Month - Holding a Mother Class Once a Month</td>
</tr>
<tr>
<td>3.</td>
<td>Cadre</td>
<td>Reminding to give Exclusive Breastfeeding</td>
</tr>
</tbody>
</table>
In the Government Regulation No.33 of 2012, the community must support the success of Exclusive Breastfeeding programs either individually, in group, or organizationally. The support can be implemented through:

a. providing a thought contribution related to the determination of the policy and / or the implementation of the Exclusive Breastfeeding program;
b. disseminating information to the community regarding Exclusive Breastfeeding;
c. monitoring and evaluating the implementation of Exclusive Breastfeeding programs; and / or
d. providing time and place for mothers in giving Exclusive Breastfeeding.

The implementation of support from the community is done by referring to 10 (ten) steps to the success of breastfeeding for the community.

CONCLUSIONS

Based on the coverage of Exclusive Breastfeeding in Cicalengka Community Health Center, there are only 27% of mothers who exclusively breastfed. With that being said, it can be concluded that the implementation of Exclusive Breastfeeding policy in Cicalengka Community Health Center is not working properly. This is because the implementation component has not been worked in accordance with existing policy such as:

1) There has been no effective communication regarding the policy of Exclusive Breastfeeding in the area of Cicalengka Community Health Center, so we still find several phenomenons such as different information acceptance and the sustainability of information delivery which is not yet optimal. The socialization regarding the policy has not covered the overall target of Exclusive Breastfeeding policy.
2) The human resources and facilities at Cicalengka Community Health Center have been adequate in quantity, but there is no commitment of the human resources to implement the policy, and there is no policy instrument as well as budget support.
3) The bureaucracy structure at Cicalengka Community Health Center in the form of inter-agency coordination has been conducted, but it still lack in the creation of Memorandum of Understanding of the cooperation. Some officers execute the activities according to their ability, not based on existing SOP.
4) The disposition at Cicalengka Community Health Center is in the form of health officer, family, media, cadres and Public Health Office of Bandung Regency attitudes who have supported and committed to the successful implementation of Exclusive Breastfeeding policy, but not fully supported by family attitudes when facing the situation of only a little milk came out.

RECOMMENDATIONS

Based on the conclusion of the researchers, there are several recommendations proposed:

a. For The Public Health Office
   1) The Public Health Office of Bandung Regency should conduct a monitoring and evaluation effort on the implementation of Exclusive Breastfeeding policy in healthcare facilities such as but not limited to Community Health Center by conducting direct supervision to the field;
   2) The Public Health Office of Bandung Regency should perform socialization to healthcare facilities located in Bandung Regency consistently;
   3) Socializing of Exclusive Breastfeeding policy to other institutions such as private companies and other government agencies through a circular letter accompanied by Exclusive Breastfeeding Handbook and proven by an MoU between agencies;
   4) Conducting a training of Breastfeeding Counselors gradually, so that every healthcare facility has Breastfeeding counselor;
   5) Conducting self-assessment and program evaluation continuously;
   6) Allocating budget for the Exclusive Breastfeeding program on the activity budget 2018, so that its implementation do not experience funding constraint;
   7) Improving the commitment of the leaders in the Exclusive Breastfeeding policy implementation through the establishment of a special team of Exclusive Breastfeeding program as a form of an oversee of the policy.

b. For Cicalengka Community Health Center
   1) Conducting direct socialization from breastfeeding counselor to the officers who directly play socialization role to society such as but not limited to midwives;
   2) Conducting socialization, monitoring and evaluation directly to the community, especially breastfeeding mothers, so that the Exclusive Breastfeeding policy is delivered.

<table>
<thead>
<tr>
<th>No.</th>
<th>Institution</th>
<th>Forms of Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td>Family</td>
<td>- Reminding to give Exclusive Breastfeeding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Giving Formula Milk if the Breastmilk is not Come Out</td>
</tr>
<tr>
<td>5.</td>
<td>Media</td>
<td>- TV Advertisement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Internet Articles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Pink Book about Mother and Child Health</td>
</tr>
</tbody>
</table>
properly;
3) Establishing a support group of mothers who exclusively breastfeed in each village as a means of information for new breastfeeding mothers;
4) The support and commitment from all employees in Cicalengka Community Health Center are needed in the implementation of Exclusive Breastfeeding policy;
5) Utilizing social media as a means of communication in the delivery of information related to Exclusive Breastfeeding policy.

c. For Policy Researchers
1) Establishing special regulations in order to ensure that the purpose and objectives of the policies made by the government are truly communicated to the people;
2) Conducting research related to the implementation of Exclusive Breastfeeding policy in depth and comprehensively of each sector involved.

REFERENCES


Analysis of Factors Related to Employee Behavior in Implementing Patient Safety Program at Insan Permata Woman and Child Hospital Tangerang

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Abstract. Insan Permata Woman and Child Hospital was facing Patient Safety Incidence especially for period of mid to late 2016 there were 12 incidents and 11 phlebitis cases. This indicated a gap between the conditions in the field and the ideal situation that should be achieved. This study aimed to see how the behavior of employees in implementing patient safety program and the factors that influence it. The sample of this study were 151 respondents as sample, consist of health and non health workers. The patient safety program focused on the accuracy of patient identification, reduction of risk of infection and reduction of risk of falling patients. This research was a quantitative research followed by qualitative method. The results showed that most employees already had good patient safety behavior, age and attitude were the most affecting factors in patient safety behavior. The lack of socialization of accreditation and patient safety, poor monitoring and some incomplete facilities should become the concern for the hospital as it was considered to have great influences in the daily implementation of patient safety program.

Keywords: patient safety, patient identification, hand washing, risk of falling

INTRODUCTION

Patient safety is a system where hospital makes safer care of patients including risk assessment, identification and management regarding the risks of patients, report and analysis of incidents, the capability to learn from incidents and its follow-up also the implementation of solution to minimize the risks and prevent injuries caused by mistakes from activities or not taking the right action. In patient safety, there is a term of patient safety incidents, which are every accidental events and conditions that results or potentially resulting accidents that could be prevented upon patient. The incidents consist of Adverse Event, Near Miss, No Harm Incident, Reportable Circumstance and Sentinel Events (Kemenkes. 2011).

The occurrence of patient safety incidents in a hospital will cause the decrease of trust from society towards the hospital. This is because the hospital is considered to have low quality of services, because patient safety has high correlation to the quality and image of the hospital. The quality of service in a hospital can be measured through accreditation. The Act Number 29 of 2004 on Medical Practice and Act Number 44 of 2009 on Hospital are mandated to all hospitals to undergo accreditation. Accreditation is a process to assess the healthcare organization by accreditation agency based on predefined standards. There are two types of accreditation in Indonesia, international and national accreditation. International Accreditation uses standard from Joint Commission International (JCI) and National Accreditation uses standard from Komisi Akreditasi Rumah Sakit (KARS).
No.1195/MENKES/SK/VIII/2020 (Kemenkes, 2010). In the standard of accreditation by KARS 2012, which refers to JCI standard edition 4 of 2011, there is one specific group that discusses about patient safety, that is Kelompok Sasaran Keselamatan Target (SKP) or Target Safety Goals Group (TSG). The SKP group consists of 6 goals: (1) the accuracy of patient identification, (2) effective communication improvement, (3) drug safety improvement of high-alert medication, (4) certainty of exact location, procedure, and operation patient, (5) infection risk reduction regarding health service and (6) risk reduction of falling patient.

Insan Permata Mother and Child Hospital that has only been 3 years old has a few targets in 2017, which are cooperation with BPJS Kesehatan or Social Security Administrator of Health, change of status to Type C General Hospital and undergo the accreditation. Basically, the preparation towards accreditation has been conducted since 2015, the Working Group Team and work program of SKP have been formed, but they have yet to work maximally. The records of patient safety incidents have only been working since 2016 by KSP Working Group. According to the data, there are 12 incidents and 11 cases of phlebitis happened in Insan Permata Mother and Child Hospital and listed in the table below:

### Table 1. Table of Patient Safety Incidents

<table>
<thead>
<tr>
<th>No.</th>
<th>Time of Incident</th>
<th>Incident</th>
<th>Type of Incident</th>
<th>Work Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29/07/2016</td>
<td>Drug Preparation Mistake</td>
<td>No Harm Incident</td>
<td>Pharmaceutical Installation</td>
</tr>
<tr>
<td>2</td>
<td>01/08/2016</td>
<td>Falling from bed</td>
<td>Adverse Event</td>
<td>Nursing Installation</td>
</tr>
<tr>
<td>3</td>
<td>26/08/2016</td>
<td>Drug Administer Mistake</td>
<td>Adverse Event</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>4</td>
<td>24/09/2016</td>
<td>Drug Preparation Mistake</td>
<td>No Harm Incident</td>
<td>Pharmaceutical Installation</td>
</tr>
<tr>
<td>5</td>
<td>30/10/2016</td>
<td>Drug Discoloration</td>
<td>Near Miss</td>
<td>Pharmaceutical Installation</td>
</tr>
<tr>
<td>6</td>
<td>31/10/2016</td>
<td>Drug Preparation Mistake</td>
<td>No Harm Incident</td>
<td>Pharmaceutical Installation</td>
</tr>
<tr>
<td>7</td>
<td>31/10/2016</td>
<td>Patient Does Not Wear Identity Bracelet</td>
<td>Near Miss</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>8</td>
<td>10/11/2016</td>
<td>Patient Identification Mistake</td>
<td>Near Miss</td>
<td>Nursing Installation</td>
</tr>
<tr>
<td>9</td>
<td>14/11/2016</td>
<td>Patient Identification Mistake</td>
<td>Near Miss</td>
<td>Nursing Installation</td>
</tr>
<tr>
<td>10</td>
<td>21/11/2016</td>
<td>Patient Identification Mistake</td>
<td>Near Miss</td>
<td>Nursing Installation</td>
</tr>
<tr>
<td>11</td>
<td>25/11/2016</td>
<td>Drug Ordering Mistake</td>
<td>No Harm Incident</td>
<td>Nursing Installation</td>
</tr>
<tr>
<td>12</td>
<td>12/12/2016</td>
<td>Slipped in Bathroom</td>
<td>Adverse Event</td>
<td>Nursing Installation</td>
</tr>
</tbody>
</table>

Source: Patient Safety Incidents Data of KSP Working Group of 2016

### Table 2. Phlebitis Incidents Table

<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Ward</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7/7/16</td>
<td>Tulip 1</td>
<td>Febris</td>
</tr>
<tr>
<td>2</td>
<td>15/7/16</td>
<td>Anggrek 1</td>
<td>DHF</td>
</tr>
<tr>
<td>3</td>
<td>4/8/16</td>
<td>Tulip 2</td>
<td>Obs febris</td>
</tr>
<tr>
<td>4</td>
<td>16/8/16</td>
<td>Anggrek 1</td>
<td>Gastroenteritis</td>
</tr>
<tr>
<td>5</td>
<td>17/9/16</td>
<td>Tulip 1</td>
<td>Typhoid</td>
</tr>
<tr>
<td>6</td>
<td>4/10/16</td>
<td>Tulip 2</td>
<td>Typhoid</td>
</tr>
<tr>
<td>7</td>
<td>16/10/16</td>
<td>Anggrek 1</td>
<td>Febris</td>
</tr>
<tr>
<td>8</td>
<td>7/11/16</td>
<td>Tulip 1</td>
<td>Type II DM</td>
</tr>
<tr>
<td>9</td>
<td>19/11/16</td>
<td>Tulip 2</td>
<td>DHF</td>
</tr>
<tr>
<td>10</td>
<td>5/12/16</td>
<td>Anggrek 1</td>
<td>DHF</td>
</tr>
<tr>
<td>11</td>
<td>21/12/16</td>
<td>Tulip 2</td>
<td>DHF</td>
</tr>
</tbody>
</table>

Source: Patient Safety Incidents Data of KSP Working Group of 2016

**METHOD**

This is a quantitative research that continued with qualitative methods. The research time is from April to May 2017 at Insan Permata Mother and Child Hospital, Tangerang.

The research sample consists of 151 individuals which include the employees working in Insan Permata Mother and Child Hospital that consists of registration, administration, cashier, storage, finance, marketing, procurement, employee affair, nutrition, pharmaceutical, radiology, medical records, laboratory, nursing division, and management unit. The inclusion criteria for this research is all employees that have a Decree from Hospital Director. Meanwhile the exclusion criteria in this research is employees who are on leave, maternity leave, assignment or study permit and not willing to be a research respondent.

Primary data collection is conducted by doing observation, distributing questionnaire and doing in-depth interview to confirm the results of questionnaire processing. The questionnaire consists of introductory sheet, informed consent, respondent identity, 10 knowledge question and 40 behavioral, guide and procedures, cooperation, attitude, motivation, physical work area and communication question with the choice of answer consists of ‘yes’ and ‘no’ along with 4 Likert scale. The interviewed informants are three people from KSP Group, Head of Nursing Division, Head of Medical Division, Head of General Affair Division, and the Director. Apart from that, the secondary data is also analyzed through document review. The questionnaire is first gone through trials to assess the validity and reliability before it is distributed.
RESULTS AND DISCUSSION

Results

Table 3. Respondent Characteristics (n = 151)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>≤ 40 years old</td>
<td>136</td>
<td>89.4 %</td>
</tr>
<tr>
<td></td>
<td>&gt; 40 years old</td>
<td>15</td>
<td>10.6 %</td>
</tr>
<tr>
<td>Gender</td>
<td>Male</td>
<td>41</td>
<td>27.2 %</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>110</td>
<td>72.8 %</td>
</tr>
<tr>
<td>Education</td>
<td>Low</td>
<td>62</td>
<td>41.1 %</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>89</td>
<td>58.9 %</td>
</tr>
<tr>
<td>Work Experience</td>
<td>≤ 3 years</td>
<td>90</td>
<td>59.6 %</td>
</tr>
<tr>
<td></td>
<td>&gt; 3 years</td>
<td>61</td>
<td>40.4 %</td>
</tr>
<tr>
<td>Employment Status</td>
<td>Health Worker</td>
<td>89</td>
<td>58.9 %</td>
</tr>
<tr>
<td></td>
<td>Non-Health Worker</td>
<td>62</td>
<td>41.1 %</td>
</tr>
</tbody>
</table>

Respondent characteristic in terms of age shows that respondents have a wide and uneven variety of ages starting from 17 to 62 years old. Therefore, the calculation of middle value is conducted and it is obtained the 40 years old mark. For research purposes, the ages of respondents are divided based on the middle value then formed a group of respondents aged ≤ 40 years old and another group of respondents aged > 40 years old. Meanwhile, for the variable of education, respondents are grouped into low education and high education group. Low education group consists of respondents with the last education of Elementary School, Middle School, and High School, while the high education group consists of respondents with the last education of Diploma to Doctoral studies. The respondent status is divided into Health Worker and Non-Health Worker where the ones that is considered as Health Worker includes medical specialist, dentist specialist, general practitioners, dentists, nurses, midwives, pharmacists, pharmacist assistants, medical checkers, laboratory analysts, radiographers, nutritionists, public health workers and environmental health expert, the people apart from those categories are put to Non-Health Workers.

The normality test result upon the answer of respondents generally is a normal data to ease research analysis on knowledge, guidelines and procedures, attitude, motivation, physical working condition, cooperation and communication variables which would be done in regards of mean value. If the grade of the respondents are below the mean value, then will be categorized in the poor group. And if the grade of respondents above the mean value, then will be categorized as good group.

Table 4. Results Categorization of Each Variables (n=151)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percentage (%)</th>
<th>Average</th>
<th>Value Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge Variable</td>
<td>Good</td>
<td>64</td>
<td>42.4 %</td>
<td>9.08</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>87</td>
<td>57.6 %</td>
<td></td>
</tr>
<tr>
<td>Guide and Procedure</td>
<td>Good Perception</td>
<td>109</td>
<td>72.2 %</td>
<td>4.89</td>
</tr>
<tr>
<td>Variable</td>
<td>Poor Perception</td>
<td>42</td>
<td>27.8 %</td>
<td></td>
</tr>
</tbody>
</table>

Table 4 shows that more than half of the respondents still have below average of knowledge regarding patient safety. But when seen from the high average of 9.08, it means that in general, respondents understood the basic principal of patient safety. Most of the respondents have good perception upon guidelines and procedures of patient safety, attitude, motivation, and cooperation. But, some of the respondents still have poor perception upon physical work area.

In the table above also listed that most of the respondents have good attitude in implementing the patient safety program. This shows that respondents are adequately identify the patients using two kinds of identity, handwashing with the standard from WHO and five moments of handwashing, also able to describe to the patient or family of patients regarding the risk of falling.

Chi Square test is done to understand the correlation between each of the independent variables towards the dependent variables. The value of \( p \) will be compared to the value of alpha (0.05), where if the value of \( p < \) alpha, it is said that there is a correlation between independent and dependent variable and vice versa, if \( p > \) alpha then it is said that there is no correlation between the independent and dependent variable.

Table 5. Chi Square Test Results

<table>
<thead>
<tr>
<th>No.</th>
<th>Variable</th>
<th>( p )-value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Guidelines and procedures</td>
<td>0.106</td>
<td>No Correlation</td>
</tr>
<tr>
<td>2</td>
<td>Attitude</td>
<td>0.000</td>
<td>Correlated</td>
</tr>
<tr>
<td>3</td>
<td>Motivation</td>
<td>0.001</td>
<td>Correlated</td>
</tr>
<tr>
<td>4</td>
<td>Work Experience</td>
<td>0.969</td>
<td>No Correlation</td>
</tr>
<tr>
<td>5</td>
<td>Age</td>
<td>0.053</td>
<td>No Correlation</td>
</tr>
</tbody>
</table>
Based on the statistical analysis results, it is obtained that from the 11 tested variables, there are only 2 variables that have a correlation with the behavior of the employees in implementing the patient safety program, which are attitude and motivation. However, for the variables with the value of p > 0.25 will still be continued to Multivariate Test. This means that guidelines and procedures, age, gender, cooperation and communication will be entered to multivariate test.

This test is conducted a modeling which enter all the variables that have passed bivariate selection followed by the release of variables that have sig value > 0.05 incrementally, starting from the variable with the largest sig., but still keeping in mind the change in the value of coefficient B on other variables should not be more than 10%. If there is a change in the value of coefficient B over 10%, then the variable must be put into the model again because it is a confounding. The modeling method used is called stepdown method.

**Table 6. Multivariate Test results**

<table>
<thead>
<tr>
<th>No.</th>
<th>Variable</th>
<th>B</th>
<th>S.E</th>
<th>Wale</th>
<th>df</th>
<th>Sig</th>
<th>Exp (B)</th>
<th>95% CI for Exp (B)</th>
<th>Lower</th>
<th>Upper</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Age</td>
<td>1.417</td>
<td>0.401</td>
<td>12.140</td>
<td>1</td>
<td>0.000</td>
<td>3.842</td>
<td>1.310</td>
<td>0.534</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Attitude</td>
<td>1.318</td>
<td>0.592</td>
<td>27.106</td>
<td>1</td>
<td>0.000</td>
<td>4.636</td>
<td>2.577</td>
<td>8.800</td>
<td></td>
</tr>
</tbody>
</table>

Based on the table above, it can be seen that there are two variables with p value <0.05 which means it has significant influence towards employee behavior in implementing patient safety program. Both variables are age with p = 0.000 and attitude with p value = 0.000. Based on the table above, it can estimate employee behavior using age and attitude variables.

The interpretation for each variable are:

a. Employees with a good attitude will cause employee behavior in applying patient safety 4.5 times better than employees who have less good attitude after controlled by age variable;
b. Every 1 year of age increasement, the behavior of the employee in applying patient safety will decrease by 0.2 times.

**Discussions**

Policies, guidelines and procedures are important factors to ensure the patient safety program goes according to the existing corridor. Patient safety policies, guidelines and procedures have been made by hospitals on the basis of government regulation. Routine socialization is conducted since the hospital began to make preparations towards accreditation. Socialization is conducted by involving all hospital employees through daily intensive meetings done by each working unit and also weekly routine meetings done with management and other units. However, when the priority of the hospital changed to focus on the preparation of cooperation with BPJS Kesehatan and hospital type change into General Hospital, the socialization becomes not routine and hospital employees seem to forget the accreditation, especially the patient safety. The distribution of guides and procedures to units has not been done so that the guidelines and procedures are difficult to find and being implemented, in addition, the availability of facilities and infrastructure that are not yet routinely made makes the procedures implementation is harder.

According to Gibson et al., (1997), the age factor affects behavior because in principle, if a person gets older, it will increase the maturity and the absorption of information that will affect his behavior. In contrast to the literature, based on the results of research, it is known that the research respondents generally include the age group ≤ 40 years, with the most age range is between 21-25 years of 63 respondents. The statistical results indicate that age has a negative relationship to employee behavior in implementing patient safety program which every 1 year of age increasement, the employee behavior in applying patient safety will decrease as much as 0.2 times. This may happen because the young employees tend to be more obedient, more thorough, open with changes and have a great desire to learn.

According to Notoatmodjo (2007), education determines the breadth of knowledge, in which a person with low education is very difficult to accept something new. This principle indirectly affects employee behavior. Education in this term is a formal education obtained in school. Unlike the theory, the results showed that education has no relationship to employee behavior in implementing patient safety program. In fact, it is not only formal education that needs to be considered in working, but also supportive training, socialization or intense coaching will also contribute to improve the knowledge and skills of employees.

Knowledge is a dominant and very important thing in the formation of someone’s action. From the experience of some researches, apparently, actions that are not based on good knowledge will not produce...
good results. Basically, employees at Insan Permata Mother and Child Hospital understand the basic principles of patient safety, especially regarding patient identification, hand washing and reduction of falling patients risk. It is seen from the high average value, which is 9.08, there are approximately one-third of employees are still lacking or unaware of the order of Patient Safety Goals by KARS Standard Version 2012, this may be due to lack of socialization. In addition, the high turn over of the employees causing a lot of new employees never received any socialization about patient safety. Socialization is not only in the form of regular meetings, but also in the form of information and education media such as banners or posters about the safety of patients placed in strategic places so that it can be seen by everyone. Insan Permata Mother and Child Health Hospital itself has only one patient safety poster in the pharmacy waiting room, and several posters of five handwashing moments and six handwashing steps according to WHO in other units.

The depiction of patient safety behavior in general is good, the employees are basically have enough awareness and responsibility to provide safe service to patients. But the controlling activities are still weak, even from the unit level, awareness and sense of responsibility that already existed gradually can be reduced. If we see the age variable, most of the age range is between 21 - 25 years, which if calculated roughly, the age range is in accordance with the calculation of the age of first graduate employee with the level of education Diploma or Bachelor. Therefore, strong controlling is necessary in directing employees to implement safety behavior appropriately, especially for young employees.

Attitude is the view or feeling of someone which accompanied by a tendency to act toward something (Barsky et al., 2011). An attitude is not necessarily manifested to be an action automatically (overt behavior). To realize the attitude into a real action, the supporting factors or a possible condition is required, e.g facilities (Notoatmodjo, 2007). The lack of understanding related to patient safety due to lack of socialization, not optimal monitoring and evaluation, and not supportive facilities and infrastructure is possibly causing less good attitude in a few number of respondents. This is in line with the results of research which states that attitudes have a significant relationship (4.5 times) toward employee behavior in implementing patient safety program. As long as the view of employee regarding patient safety is not good enough, the employee behavior will also be less good as well.

The intensity describes how hard a person is trying and being a central element in motivation, but a great power will not produce satisfactory performance results unless the effort is channeled in a direction (Pinder, 2008). The direction in this term is monitoring from the superiors.

In carrying out its functions, the management is expected to have sufficient capability in directing employees. One of the abilities in this term is the ability to motivate existing human resources. With the motivation given, it is expected that employees will be eager in implementing the patient safety program. This is in accordance with the results of research that motivation has a relationship to employee behavior in implementing patient safety program. Based on the results of the study, some respondents who still have poor motivation caused by the lack of awareness and understanding of patient safety importance due to lack of direction and monitoring from the supervisors and management directly, and also the lack of availability of facilities and infrastructure that support. From the in-depth interview it is known that up to now the head of the room (Karu) is not always stand-by at the unit headed at office hour due to Karu being included in the shift schedule, and the team head (Katim) appointed to each shift also can not fulfill the monitoring function maximally.

As stated by Notoatmodjo (2007) that to realize the attitude into a real action, the supporting factors or a possible condition is required, e.g. facilities. This indicates that complete facilities and infrastructure are essential to the continuity of the patient safety program. Most respondents said the workspace is often less cold and noisy so the employees may feel less comfortable in working. It was also found that hand washing soap, tissues and handrubs were not routinely replenished. In the pharmacy waiting room, and several posters of five handwashing moments and six handwashing steps according to WHO in other units.

Communication is essential for work efficiency and coordination between implementers, teams and leaders. Communication is considered to be effective if it has
some aspects in it, namely clarity, accuracy of information, context, flow and culture in the delivery. In Insan Permata Mother and Child Hospital, the communication that runs mostly via oral so that the potential for error is very large. In addition, some written instructions are often difficult to read which results in the information delivered can not be accepted by the information receptor. Although statistical results show that perceptions of communication have no relationship to employee behavior in implementing patient safety programs, but in practice, poor communication remains a constraint.

CONCLUSIONS

Insan Permata Mother and Child Hospital strongly supports the patient safety program, seen from the availability of policies, guidelines and procedures in accordance with government regulations to regulate the implementation of patient safety programs, accompanied by the completion of facilities related to patient safety.

Based on the results of the research, it is known that most respondents have applied good patient safety behavior. From the results of statistical analysis, it is found two variables that have relationship to employee behavior in implementing patient safety program, namely attitude and motivation. However, after further analysis, it was concluded that the most significant effect on patient safety behavior was attitude and age. However, although other variables are considered to have no relationship to patient safety behavior, a corresponding increase is needed to reduce the constraints.

The lack of socialization, monitoring and some facilities and infrastructure which are not routine available are the things we need to pay attention into because it is related to the understanding and awareness of employees in implementing patient safety program.

RECOMMENDATIONS

From the conclusions above, there are some recommendations that can be taken into consideration for the hospital:

1. Improving the understanding of employee about patient safety by re-activating socialization activities regularly and adding socialization media such as banners or posters of patient safety placed in strategic places;
2. Incorporating the socialization of patient safety program into the new employee's initial orientation activities so that all new employees will be exposed to patient safety early on;
3. Improving the monitoring efforts through optimizing the role of incharge staff on each shift. The team leader is not only focus on the service only, but also monitor the implementers and the availability of facilities related to the implementation of patient safety;
4. Distributing patient safety procedures equally to all hospital units in order to increase the knowledge and understanding of employee about patient safety;
5. Completing facilities and infrastructure related to patient safety so it is expected to reduce obstacles in the implementation of patient safety program.

REFERENCES

Analysis of Partnership of Private Practice Midwife in The National Health Insurance Program in District Bungo Jambi Province

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Abstract. On January 1, 2014, the government began to implement the National Health Insurance (NHI) program to realize social welfare for the whole community. Midwifery and neonatal care in the NHI program involves Puskesmas/family doctors and Private Practice Midwife (PPM) as its network. PPM participation in the NHI program in Bungo District was still lacking, only 12 (54.5%) PPM have cooperated with family doctors from 22 existing PPM. This study aimed to get an overview of PPM participation in the NHI program in Bungo District, Jambi Province. The study used qualitative research approach with Rapid Assessment Procedure design, purposive sampling, and conducted in-depth interview to 10 PPM, Head of Health Office, MPKP BPJS Health Manager, and Chairman of Bungo Regency Section of Indonesian Midwife Organization (IMO). The study was conducted from January to July 2017. The study found that the knowledge, perceptions and attitude towards NHI program were good, but the perceived toward the claim and predetermined tariff procedures were not so good. PPM motivated to join the NHI program as many patients had become NHI participants. Support from the Government, NHI, and IMO were low, either in the form of socialization, or policies. Therefore, the study suggest an improvement in claims procedures, tariffs, and an increase of socialization from government, NHI and IMO on NHI program related to obstetric and neonatal care.

Keywords: Private Practice Midwife, National Health Insurance, participation

INTRODUCTION

The purpose of health development is directed to increase awareness, willingness, and ability to live healthy for everyone so that the highest level of public health improvement can be realized (Budiman, 2015). Based on the 1945 Constitution article 28H and the amendment of the 1945 Constitution in Article 34 paragraph (2), states that the state develops social security system for the community. This confirms that every individual and every citizen has the right to health care, including the poor.

The issuance of Law Number 40 Year 2004 regarding the National Social Security System (SJSN) becomes a strong proof that the government has a great commitment in realizing social welfare for the whole
society. In accelerating the implementation of SJSN thoroughly for the people of Indonesia then established a Social Security Administering Agency (BPJS) with Act No. 24 of 2011. In accordance with Law No. 24 of 2011 on January 1, 2014 National Health Insurance program (NHI) begins (Thabrany, 2015).

With the implementation of the NHI program organized by BPJS Health, then automatically the existing health insurance such as Jamkesmas, Jamkesda, and Jampersal enter into NHI Program (Indonesia, 2014). The general purpose of NHI is to make it easier for the public to access health services and obtain quality health services, so that the basic health needs of each population are met (Thabrany, 2014).

The providers of health services in the NHI program include all health facilities that cooperate with BPJS Health both government owned health facilities, local government, and private that meet the requirements including Private Practice Midwife (PPM) (Ministry of Health RI, 2014).

PPM is a private midwife practice that provides services within the scope of midwifery, where midwives with competence and authority possess, can provide obstetric care to patients. Midwives as one of the health workers providing services directly to the community, especially in the case of midwifery services, can contribute to the decline of Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) (Helmizar, 2014).

PPM as a midwifery provider now can work together in NHI program, but in the implementation of NHI program still cause confusion and question for midwives, because PPM can not cooperate directly with BPJS and must join to first level of health facility network(Puskesmas) or self-employed physician. So for now from all the PPMs in Indonesia, only about 2,000 midwives join the first-level health facility (PHC) / family doctors and more than 45,000 midwives choose to practice independently (Widiyani, 2014).

The participation of PPM to work together in the NHI program can not be separated from the concept of midwife behavior as individuals involved in the cooperation. Behavior of internal and external things. Internal factors that influence behavior include knowledge, perception, motivation, interest, and emotion while those included in external are physical, socio-cultural, economic, political, stakeholder, resource (fund, policy, and information system) and so on (Notoatmodjo, 2007).

Based on IMO data of Bungo District of Jambi Province in February 2017, stated that the total number of midwives is 554 people. Number of midwives who have self-employment or PPM is 22 people. According to data from BPJS Branch of Bungo Regency in February of 2017, there are 12 (54.5%) PPMs who have cooperated with BPJS Kesehatan (IMO Bungo District, 2017). This indicates that the PPM in Bungo District has not fully participated in the NHI program. Based on the results of preliminary interviews to several PPMs in Bungo District, it was found that cooperative procedures were considered inconvenient to PPM so they were reluctant to cooperate in the NHI program.

**Literature Review**

According to Notoatmodjo (2007) many internal and external factors influence behavior. Internal factors include knowledge, perception, motivation, interest, and emotion while external factors are physical, socio-cultural, economic, political, stakeholder, and resources (i.e. fund, policy, and information system). According to Gibson et al (1996) there are three factors influencing performance, i.e individual variables, organizational variables, and psychological variables. Individual variables, consisting of abilities and skills, work experience, family background, socioeconomic level, and demographic factors (age, gender, ethnicity, etc.), organizational variables, i.e leadership, job design, other resources, organizational structure, and so on, and psychological variables, namely perceptions of work, attitude, motivation, personality, and so forth.

The participation of the PPM to work together in the NHI program can not be separated from the concept of midwife behavior as individuals involved in the cooperation that are influenced by internal issues including knowledge, perceptions, attitudes, and motivations, and external issues that include stakeholder support, resource support, and reward system (Notoatmodjo, 2007 and Gibson, 1977).

The participation of the PPM in the NHI program creates confusion and doubt for midwives, as PPM can not cooperate directly with BPJS and must join the network at first level health facility (Puskesmas) or private practice doctor. Based on the research by Listyowati et al (2015) that PPM in Kota Denpasar and Kabupaten Gianyar generally know about NHI, but not understand in detail about NHI policy especially related to Midwifery and Neonatal. Generally, they get
socialization from the Indonesian Midwives Association (IMO), Health Office, and Puskesmas. In terms of tariffs, PPM says is still low which made them less enthusiastic to participate in NHI. The networking system makes them difficult to become a provider of NHI. In addition, there are fee deduction from the network which makes PPM increasingly do not want to become a network provider with family doctors. However, on the other hand, excluding PPM from the NHI program can hamper government efforts to reduce MMR and IMR, and to promote Family Planning programs.

**METHOD**

We used a Rapid Assessment Procedure (RAP), conducting in-depth interview to 10 PPM, Head of Health Office, Management MPKP BPJS Health, and Chairman of Bungo District section of IMO. Data collection was conducted from May to June 2017. Data collected include knowledge, perception, attitude, motivation, stakeholder support, resource support, and reward system. We utilize different sources, and document review, to triangulate the finding.

In this study, we had informants and key informants. We divided informants into 2 categories based on the participation of the NHI program, the PPM who participated and did not participate. Meanwhile, key informants consisted of Chairman of IMO, Head of Health Office and Management of MPKP BPJS Health.

**RESULT AND DISCUSSION**

**Characteristics of Informants**

We found 5 PPM who participated in the NHI program in 3 districts. The oldest was 60 years old, while the youngest was 31 years old. Half of the informants are over 40 years of age. In terms of length of private practice it varied from 1 to 23 years, with majority between 14-17 years. In terms of education, most of the informants were D III Midwifery and some of them D IV Midwifery. We also found 5 informants who had not joined the NHI program, residing in 2 districts. By age, majority of them were between 39-42 years old with only 1 informant 60 years old. Variation of private practice were from 1 to 28 years, with most of them between 6 to 14 years. In terms of education, most of the informants are educated in D III Midwifery, 1 informant is educated by DI Midwifery, and 1 informant was a graduate (S1) in Public Health, previously D III Midwifery. While the key informants, their age varied between 27 to 51-year-old, and with education most graduate and 1 of them was postgraduate.

As basic characteristics (age, duration of self-employment, and education) between participating PPMs and not yet participating in NHI programs were similar, it can be concluded that age, duration of independent practice, and education have no role in participation in the NHI program.

**Knowledge**

The knowledge studied in this research includes knowledge of informants about midwifery and neonatal services, cooperative procedures, claims procedures, and socialization. Knowledge of PPM who participated and did not participate in the NHI program on midwifery and neonatal services showed that most informants, both PPM who participated or who had not joined the NHI program, stated that they already know the NHI program related to obstetric and neonatal services, namely ANC, PNC / neonate, and KB.

"... for PPM is limited ... ANC 4 times ... labor .. normal delivery that our pathology should not .. keep PNC is there again ... KB” (2.y)

"Services that can be in PPM, ANC, mothers, PNC ... KB may also” (7.n)

The obstetric and neonatal services included in the NHI program include: antenatal care, postnatal care, newborn examinations, postnatal care, and family planning services (BPJS Health, 2015).

Most informants, both PPM who participated or not in the NHI program, knew the procedures to cooperate in the NHI program. Almost all informants said that the cooperative procedures in the NHI program were not too complicated, the PPM must first join network with the doctor, and create a cooperation agreement between the doctor and the PPM. The cooperation procedure between PPM and NHI program organized by BPJS Health is through Puskesmas / family doctor. The requirements in this cooperative procedure consist of SIPB, Taxpayer Identification Number (NPWP), cooperation agreement with physician or Puskesmas, and a letter of willingness to comply with the provisions related to NHI (Permenkes RI, 2013).

Regarding the claims procedure, most of the informants both who participate or not joined the NHI program
knew the claims procedure including the administration that must be completed in filling a service claim that has been given. The mechanism of claim, was done by submitting claims monthly to the first-level health facilities (Puskesmas / family doctors) on services had been provided to participants in the preceding month. Papers to be completed in submitting a labor claim include original receipt in triplicate, three-fold FPK, and recapitulation of service (patient name, identity number, address and telephone number of patient, disease diagnosis, date of admission and date of treatment, number of days of service, amount of package rate, bill). While papers that should be each available in each patient was a photo copy of BPJS / Health Insurance/ Jamkesmas / KIS Card, KTP and Family Card (Participant KK Participant), Pantograph, Birth Certificate (SKL), payment receipt from FKTP, MCH services according to the services provided which have been signed by pregnant / maternity ward and the handling officer (BPJS Health, 2015).

There were still informants who were less aware of cooperative procedures and claims procedures due to the lack of socialization of the NHI program, especially tailored designed socialization of BPJS for PPM. Although most PPM informants had already received socialization regarding PPM participation, socialization was only obtained from IMO regular meetings of IMO, while the Health Office and BPJS Health never provided it. This socialization, created enough knowledge about NHI program related to obstetric and neonatal services, but not yet affected to the increase in the number of PPMs joining the NHI program.

**Perception**

PPMs both who participated or not in the NHI program were positive for the cooperative procedures in the NHI program, but were negative towards the determined claims and tariff procedures. All informants mentioned that the tariff undervalued the service that PPM provided, so there were some PPM asked additional cost to the patient for the use of consumables and facilities that have been provided. This was not justified because according to Law No. 40 of 2004 on National Social Security System, health facilities including midwives should not charge additional fees outside of the established tariff (Permenkes RI, 2013).

These low compensation and lengthy disbursement time reduced PPM participation in the NHI program. The delay in fee disbursement in return reduce the quality of the subsequent health service, as procurement of consumables and medicines could not be met properly. So PPM should be allowed to ask additional fees other than the prescribed tariff. Government hospitals or health centers have received funding for building construction, equipment purchases, and staff salaries. It is unfair for the PPM which is privately owned to cover operational expenses. Therefore it was more realistic for the PPM to ask additional money to recover the operational expenses. Participants who directly choose PPM should pay extra on its own choice. This procedures, if allowed, would increase interest in PPM joining the NHI program.

PPM informants who participated in the NHI program state no objection on the mechanism of cooperation if they have to go to the doctor, but stated objecting if through Puskesmas. While a small number of PPM informants who did not participated in the NHI program, stated objections both to the Puskesmas and doctor.

"It's hard if you want to join BPJS ... have to deal with the doctor also ... haa ... that's a bit heavy now ..." (6.n)

"If you can not have to go through the doctor .. not to mention through the Puskesmas .. the procedure is complicated .." (8.n)

The concept of networking is very important for social insurance systems like BPJS Health. Furthermore, the concept of networking emphasizes on the quality of service, the mechanism, so that the service is seen as a team. Networking system is actually intended to have a collaboration between doctors with midwives so that there is no competition in providing midwifery services and family planning (Linggasari, 2015). For PPM cooperation with Puskesmas, the requirements were the same as procedure with to private practice doctor, added with cooperation agreement / MCC signed by PPM and Head of Puskesmas and known by Head of Local Health Service.

For factors that support participation in the NHI program, most of PPM stated that at present, most of the community became BPJS participants. In addition, there were desire to provide services to patients. This finding is in line with Zakiah study (2015) which stated the participation of PPM on the NHI program due to the midwife dwesired to maintain patient visits and at the same time, introduced other services, such as infant massage, pregnancy exercise, feminine care etc. Some are claiming to follow the NHI program to
continue previous government programs and to devote themselves to their profession as well as to help communities through cross-subsidy underprivileged with relatively wealthy patients. Majority OF PPM said that the inhibiting factors were inadequate tariff, lengthyness of reimbursement time, and the complicated procedure of collaboration.

According to standard of tariff In Health Insurance Program, for midwifery, neonatal and family planning services was as follows: antenatal care (at least 4 (four) times) was Rp. 25,000 / examination, posnatal care (PNC) / neonate was Rp. 25,000, - / visit, installation or withdrawal of IUD / Implant: Rp. 100,000, family planning injection: Rp. 15,000, - every time, and package of normal vaginal delivery was Rp. 600,000, - (including of maternal / infant accommodation and infant care) (Permenkes RI, 2013).

As these tariffs were considered too low, PPM withdrew additional fees. This certainly contrary to Law No. 40 of 2004 on the National Social Security System, as stated above. Therefore, tariff review was neccesary. The amount of tariff should be determined based on agreement between BPJS and association / organization of health facility in a region. In turn, this would create a more adequate tariffs on the average.

Attitude

All PPM informants who participated in the NHI program, assessed the mechanism / procedure of cooperation for PPM is good enough, while PPM informants who have not participated in the NHI program, mostly assess the cooperation mechanism / procedure is still troublesome because it must network with doctors who have cooperated with BPJS and assess the requirements of cooperation that are prepared quite a lot.

The claims mechanism of PPM by claiming to the first level of Faskes (Puskesmas / family doctors) collectively each month on services already given to participants in the preceding month, and materials to be completed in submitting a labor claim include original receipt of triplicate 3 (three) stamped, three-fold FPK, and recapitulation of service (patient name, identity number, address and telephone number of patient, disease diagnosis, date of admission and date of treatment, number of days of service, amount of package rate, bill). While the file must be there from each patient that is a photo copy of BPJS / Askes / Jamkesmas / KIS Card, KTP and Family Card (Participant KK Participant), Partograf, Birth Certificate (SKL), payment receipt from FKTTP, MCH services according to the services provided which have been signed by pregnant / maternity ward and the handling officer (BPJS Health, 2015).

Regarding the tariff that has been determined all the informants PPM rate tariffs are still lacking. The PPM informant sometimes also feels aggrieved, when any action has been given to the patient but can not be claimed because it is not on the pre-determined tariff list. Meanwhile, according to BPJS Health, PPM who provide midwifery and neonatal services outside the provisions can not do pengilamiman for the service, so the midwife withdraw payment from the patient or not paid at all. To avoid this from happening, the PPM should further improve the ability to decide on the diagnosis and what actions should be taken and the decision to make a referral (BPJS Health, 2015).

The attitude of PPM informants to PPM participation in the NHI program, all of them are positive. but to be negative about the prescribed claims and tariff procedures. There is still a negative PPM, possibly due to lack of knowledge, and negative perceptions about the NHI program. Although PPMs are negative about the NHI program, they continue to participate in the NHI program if improvements from the NHI program, cooperative procedures and claims are easier, and an increase in service rates.

Motivation

According to the PPM informants who participated in the NHI program, most of the reasons underlying their participation in the NHI program are that nowadays the average patient is already a participant of BPJS or general participants, whereas according to PPM informants participate in the NHI program, the reason underlying a small part of PPM informants not participating is complicated cooperative procedures, they also have to network with physicians, BPJS tariffs are felt to be lacking.

Motives or motivations are the impulses of the human self that directs them to perform certain actions or behaviors. Encouragement is based on the needs or desires that need to be met. Motivation will also relate to desire, desire, encouragement, and purpose (Notoatmodjo, 2007). With the motivation of PPM based on all patients being BPJS patients and to keep their PPM running, it is expected that PPM can be
motivated to keep participating in NHI program because it is in accordance with the desire, desire, encouragement, and purpose of PPM.

Stakeholder Support

Most of the PPM informants who participated and who have not joined the NHI program say they have not received direct support from the Health Office and BPJS Kesehatan, either in the form of socialization or an appeal to cooperate in the NHI program. While from IMO, most informants said there is already support, either in the form of socialization or in the form of an appeal to join cooperate in NHI program.

The role of Provincial and Regency / Municipal Health Offices in implementing NHI is to manage / maintain health care provision in accordance with the provisions and cooperate with BPJS for district / city budgets. As manager / organizer of health care insurance, Dinas Kesehatan plays socialize NHI program (Yandrizal and Syriac, 2014). Similarly, BPJS has the authority to cooperate with other parties in administering the Health Insurance program and has the duty to provide information on Health Insurance to participants and the public. While the form of support from IMO organizations in the NHI program is to advocate to related parties to clarify the role of midwives in NHI by proposing midwives to direct the Cooperation Agreement (PKS) with BPJS; socialization to IMO officials and members about the NHI program; drafting PPM cooperation as a network with first-rate health service facilities in collaboration with BPJS; joining the Professional Organization Task Force for NHI in the implementation of NHI; and was involved in the formulation of regulations in the Ministry of Health and other ministries (Law RI, 2011).

Lack of support either in the form of socialization or appeal from the Health Office and BPJS to PPM participation in this NHI program according to the assumption of the researcher can lead to the lack of willingness of PPM to participate in the NHI program.

Resource Support

All PPM informants stated that there is no policy supporting PPM cooperation in NHI program either from Health Office, IMO, or from BPJS. Lack of support from the Health Office, IMO, and BPJS, will negatively affect PPM participation in the NHI program.

Based on the research results of the Women Research Institute (WRI), there are several recommendations submitted related to policy changes that can optimize BPJS Health reaches 70% if independent midwife practice is included in the FKTP service. The recommendation is to revise Permenkes Number 71 Year 2013 Article 2 paragraph (2) in order to reach women participating NHI who do not get service at Health Center, revise Minister of Health Regulation Number 71 Year 2013 Article 8 paragraph (3) by adding active role of BPJS Health in facilitating midwife cooperation independent of FKTP networking, publication and distribution of facility networking guidebooks prepared by BPJS Health, and publication of Ministry of Health circulars for the distribution of the manual to local government / health offices (YSKK, 2015).

Reward System

Regarding the awards given by the Health Office, BPJS and IMO for PPM who have participated in the NHI program, most of the PPM informants said no award was given yet. In implementing a program, one of the ways to motivate the program actors is by giving rewards, either in the form of a charter of awards, facilities and infrastructure, or can be in the form of trainings, so that PPM is more motivated to work in accordance with the competence and authority.

In the reward system is also asked about whether or not there is a reduction of claims return from the network. Regarding these deductions all PPMs participating in the NHI program say there is no claiming cuts from their network physician either at the time of claim reimbursement through the account of the network physician or now through the PPM bank account concerned.

The NHI Program Implementation Guidelines state that in the implementation of NHI, PPM as a midwifery and neonatal care provider is a network of FKTPs that have collaborated with BPJS Health. In the framework of administrative guidance on PPM as a network, FKTP outside the Regional Government may charge a coaching fee with a maximum of 10% of the total claim (Permenkes RI, 2014). With this provision, family doctors may impose maximum 10% deduction.

In the case of a PPM area networked with FKTP owned by the Regional Government, for example
with Puskesmas, then the claim is made through FKTP owned by the Regional Government. After being paid by BPJS, FKTP owned by the Regional Government immediately pay the whole PPM network in accordance with the amount of claims to the services provided. In the Government FKTP, the capitation funds used for the Service are allocated between 40% -60% of the total non-tax state revenue (PNBP) revenues and the rest is used to support the operational costs of health services.

CONCLUSION

Conclusions of the study were as follows:

a. The characteristics of PPM who participated and did not participate in the NHI program (age, duration of self-employment, and recent education) were similar, based on PPM characteristics can be inferred not to be the background of their participation in the NHI program.

b. Knowledge of PPM who participated and did not participate in the NHI program on NHI program were mostly good, which included knowledge of midwifery and neonatal services, cooperative procedures, and claims procedures

c. Most of the perceptions and attitudes of PPMs who participated and did not participate in the NHI program were positive for the cooperative procedures in the NHI program, but to perceive negative towards the determined claims and tariff procedures.

d. The motivation of PPM to participate in the NHI program was because majority of patient now is BPJS participants.

e. Most of the PPMs who participated and did not participate in the NHI program stated that support from the government, BPJS and IMO was lacking, either in the form of socialization, appeals, or policies that support PPM participation in the NHI program.

f. Most of the PPMs who joined the NHI program said there was no reward given to PPM who had participated in the NHI program.

g. Factors that encourage PPM participation in the NHI program was that majority of patients were BPJS participants, and desire to provide services.

h. Factors that discourage PPM participation in the NHI program was inadequate determined tariffs and lengthy disbursement time for claims.

RECOMMENDATION

a. Needs to socialize to all midwives including PPM from Government, IMO, and BPJS related to NHI program, in particular about the claim procedures and determined tariff.

b. Tariff should be reviewed through involvement of health facility associations / organizations in terms of rates, length of service fee disbursement, and cooperation agreements.

PPM who joined the NHI program should be awarded by giving training / seminars on midwifery and neonatal services and assisting facilities and infrastructure for PPM.

Research Ethics

The ethics research certificate was obtained from the Commission on Ethics Research and Public Health Service of FKM UI on May 10, 2017.

REFERENCES


The Factors of Management, Communication, Partnership, and Innovation in the Implementation of Posbindu (Integrated Health Post) NCD: A Study in Kelurahan Gunung Batu Bogor City

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Abstract. By 2015, 68% of deaths in Indonesia are due to non-communicable diseases (NCD) and are forecast to increase to 74% by 2030. Riskesdas data of 2013 show that 69.6% of cases of diabetes mellitus and 63.2% of cases of hypertension have not been diagnosed. The government has been trying to proactively make efforts to prevent NCD through the implementation of Posbindu (Integrated Health Post) NCD, but visit Posbindu NCD in the work area of Pasir Mulya Puskesmas, Bogor City is very diverse. The purpose of this study is to analyze the factors of management, communication, partnership, and innovation in the implementation of Posbindu NCD and determinants of the implementation of Posbindu NCD. We conducted in-depth interviews, focus group discussions, document review and observation at two Posbindu NCD with the highest number of visits and the lowest in Gunung Batu Village, Bogor City in 2017. We interviewed 15 informants, consisting of cadres, in charge of NCD Puskesmas, in charge of Puskesmas Pembantu and supervisor of Posbindu NCD. This research found 4 factors, namely management (human resources, fund, and facilities), innovation, communication and partnership that influence the result of Posbindu implementation. Therefore, to run effectively the Posbindu NCD program, then 4 of those factors need to be optimized.

Keywords: Management, Non-Communicable Disease, Posbindu NCD

INTRODUCTION

Non-communicable disease (NCD) becomes a challenge in the development of world health. By 2015, World Health Organization data show that 68.4% of deaths are due to Non Communicable Diseases and are projected to increase by 2030 to 73.9%. That is, in the world there is an increase in death due to NCD every year. NCD has become a major health problem besides the problem of infectious diseases that still not over (Ministry of Health, 2013).

Basic Health Research (Riskesdas) in 2013 showed that 69.6% of cases of diabetes mellitus (DM) and 63.2% of cases of hypertension are still undiagnosed. Many people do not realize that he was suffering from NCD
because the course of NCD disease often showed no specific symptoms and clinical signs. The prevalence of pre-diabetes in the Fountaine (2016) study shows that one in ten Indonesians fall into the category of impaired blood sugar tolerance, which if no intervention and secondary prevention will become diabetics. The high prevalence of undiagnosed diabetes indicates a lack of awareness of high-risk individuals for self-examination into health care. This has implications for delays in handling and complications resulting in even earlier deaths (Fountaine, 2016; Rahajeng et al., 2014).

Fauzia’s research (2013) on the utilization of Posbindu NCD by the population aged 15-44 years found the number of visits is still low. Factors that cause low visitation rate are health service organization factors including policy variables that are upstream and multi-commentary problems that are less applicable in the field. The lack of resource variables also resulted in NCD's Posbindu not optimal. Consumer factors that influence the utilization of the difference of perception to Illness (ill) and disease (disease) and lack of socialization as the main determinant of low utilization Posbindu NCD. The condition of Posbindu NCD officers and cadres who often also serve as duty also contribute to the low utilization of Posbindu NCD (Fauzia, 2013). In the research on Posyandu, there is positive correlation of communication factor (leadership) with Posyandu's effectiveness, the better the more effective communication posyandu (Maryati, 2015).

Jones in Maryati (2015) argues that control, innovation and efficiency determine the effectiveness of the organization. The public health program can run successfully (based on Frieden's health effectiveness program theory) if the organization performs 6 keys, ie (i) innovation to improve evidence base action, (ii) technical guidelines that provide a clear focus on intervention , (iii) good management especially through monitoring, evaluation and improvement of the program, (iv) partnerships with the public and private sectors, and (v) timely and appropriate communications to the health community, stakeholders and the community, and (vi) political commitment which can add resources and support the effectiveness of action.

The city of Bogor experienced an increase in the number of cases of NCD and the downgrading of the Public Health Development Index (IPKM) from the rank of 72 in 2007 to be ranked 188 in 2013. Similarly, NCD indicator is still below the indicator of West Java province 0.6029 and national Indonesia 0.6267 (Ministry of Health, 2014).

Interviewing Bogor City Health Office and person in charge of NCD program, we obtained information that hypertension and diabetes are the two non-communicable diseases (NCD) in Bogor City. Out of 24 Puskesmas in Kota Bogor, Pasir Mulya Health Center is considered the best in carrying out Posbindu NCD indicated by the activeness of the implementation of Posbindu NCD, kader activeness, complete equipment, and training of cadres.

Puskesmas Pasir Mulya builds 3 urban villages with 31 Posbindu NCD and since 2015 has integrated with posyandu for elderly, so that health examination of elderly become health examination with target group age 15 years and above.

During the period of March 2016 to January 2017, the highest number of visits by Posbindu NCD Kelurahan Gunung Batu was NA of 1 while the lowest was NA of 7. The difference in the number of visits which far enough encouraged the researcher to study deeper the factors of innovation, communication, management, in the implementation of Posbindu NCD in Gunung Batu Village and know the factors that determine the results of the evaluation of the implementation of Posbindu NCD at Pasir Mulya Health Center Year 2017.

METHOD

This is a qualitative study. We conducted in-depth interviews, focus group discussion, document review, and observation. Qualitative data collection techniques are more suitable in obtaining useful information for decision making to intervene public health programs by looking at the components needed in the implementation. The research was conducted in Pasir Mulya Bogor Public Health Center, in two Posbindu with the lowest and most visited visit, in NA (RW, neighborhood association) of 1 and NA of 7 of Gunung Batu respectively. We interviewed 15 people, consisted of NCD Officers in Puskesmas Pasir Mulya, supervisor of Posbindu NCD, Kader, Community Leaders, Participants Posbindu NCD in NA of 1 and NA of 7 Gunung Batu Village.

RESULT AND DISCUSSION

Management Factor in Implementation of Posbindu NCD
From in-depth interviews and focus group discussions we found differences in personnel management in both Posbindu NCD NA of 1 and NA of 7 as presented in Table 1.

Table 1. Differences in HR Management Posbindu NCD NA of 1 and of 7

<table>
<thead>
<tr>
<th>Dimension</th>
<th>NA of 1</th>
<th>NA of 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment</td>
<td>- based on voluntary and NA recommendations from Neighborhood</td>
<td>- volunteer</td>
</tr>
<tr>
<td></td>
<td>- there was a cadre regeneration process</td>
<td>- driven by a sense of responsibility and time-lapse factor for not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>having a baby.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- difficulty finding new cadres.</td>
</tr>
<tr>
<td>Processes</td>
<td>- activity in Posbindu NCD, FWM, family Welfare Movement, and Posbindu.</td>
<td>- active in Posbindu and Posyandu, only 1 cadre active in FWM.</td>
</tr>
<tr>
<td></td>
<td>- supported by a respected and experienced senior cadre.</td>
<td>- new cadres and not yet have a big influence in the community.</td>
</tr>
<tr>
<td></td>
<td>- a lot number of cadres (10)</td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>- 3 cadres have been trained</td>
<td>- 3 cadres have been trained</td>
</tr>
<tr>
<td>Job description</td>
<td>- Clear with a 5 table system</td>
<td>- situational</td>
</tr>
<tr>
<td></td>
<td>- compact: completing joint reports, shared meals, and uniforms.</td>
<td></td>
</tr>
</tbody>
</table>

The presence of good human resources management, in this case the cadres of Posbindu NCD supported implementation of the program. It began with voluntary recruitment. In its implementation in NA of 1 the recruitment of cadres was supported by the role of NA chairman in recruiting good cadres in the community. Recruitment in NA of 7 was done with self awareness and was influenced by how they care toddler, both as children and grandchildren. Cadre in NA of 1 were one lifelong cadre plus new cadres who become the successor in addition to an experienced cadre so there were transfer of knowledge.

There were various reasons for being a cadre. Some were children or wives of NA (RT, neighborhood association) heads, that became as NA representatives in mobilizing the community. Some were children of previous cadres that became old. The results of this study are in line with Rahmawaty's (2014) research which found that some cadres thought that they became cadres because their husbands became heads of NA, some were willing to help Posbindu activities, some also wanted to socialize with the community, and others wanted become a cadre because of his own will or initiative. This is a challenge in managing volunteer people to carry out its role. Nevertheless, empowerment-oriented development provided an opportunity for every member of the community to participate in the development process by obtaining equal opportunity and enjoying such development results in their capacity (Fauzia, 2013).

Posbindu NCD NA of 7 with the lowest number of visits has problems in recruiting cadres so the number of cadres in charge is often less than five people. This is in line with Thomas Frieden's suggestion that HR management is one of the challenges in the health program. Management is often difficult to recruit, train and retain qualified human resources to implement effective health programs. Limited budget becomes one of the problems. Good human resource management can be achieved through continuous training and awards (Frieden, 2014).

Sufficient number of human resources supports a clear division of roles. Kader as a team of managers of human resources through several efforts in order to increase cohesiveness and cooperation. Posbindu NCD NA of 1 performs several ways including, using uniform every time Posbindu NCD, making Posbindu NCD place as a means to gather and complete report together, and hold meal together every time finished Posbindu NCD.

Although voluntary, existing human resources must have the ability to perform tasks in the community. This is supported by various trainings conducted by Puskesmas or Dinas Kesehatan. Training is provided by inviting cadre representatives in turn. The monitoring function of the Posbindu NCD Coach supports the alignment of the HR work direction in turn. The monitoring function of the Posbindu NCD Coach supports the alignment of the HR work direction in accordance with the objectives to be achieved from the implementation of Posbindu NCD. Ongoing analysis to improve every aspect of program and management implementation is critical to program innovation and progress (Frieden, 2014).

In addition to human resources management, funds are one of the elements of management in the implementation of Posbindu NCD. Source of funds Posbindu NCD obtained from puskesmas, but in this
case Posbindu NCD with the most visits have self-help funds obtained from the help of NA and donors. Public participation in funding Posbindu NCD with the most visited is NA of 1 as much as 80% while in NA of 7 only 30%.

**Table 2. Funding Differences between Posbindu NCD NA of 1 and of 7**

<table>
<thead>
<tr>
<th>Aspek</th>
<th>NA of 1</th>
<th>NA of 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source of fund</td>
<td>Posyandu revitalization fund</td>
<td>Posyandu</td>
</tr>
<tr>
<td></td>
<td>Self rising fund – NA assistance</td>
<td>Self rising fund –</td>
</tr>
<tr>
<td></td>
<td>Sponsor</td>
<td></td>
</tr>
<tr>
<td>Proportion of fund</td>
<td>Community 80% and puskesmas 20%</td>
<td>Community 30% and puskesmas 70%</td>
</tr>
</tbody>
</table>

Posbindu NCD cadre NA of 1 manages Posyandu revitalization fund and community self-help outcomes to support the implementation of Posbindu NCD. Posyandu revitalization fund specifically used for stationery, photocopying and transportation of supporting activities. While at Posbindu NCD NA of 7 has few donor so most of fund come from fund of Posyandu revitalization. Non-governmental funds in NA of 7 are not sufficient for the development of other Posbindu activities. Another element in the implementation of Posbindu NCD is the means and infrastructure. Observations have been made of the building as a venue for the implementation of Posbindu NCD in both NA of 1 and NA of 7. Information obtained from the coach and community leaders states that NA of 1 has a relief building from the National Community Empowerment Program (PNPM) and NA of 7 assistance from kelurahan through local NA.

Observations indicate that the building or facility of Posbindu NCD execution in NA of 1 contained sufficient space as a waiting room, neatly decorated with inside wall information, and the exterior of the building surrounded by family medicinal plants carefully groomed. Green walls and floors blend with the color of plants.

Building Posbindu NA of 7 consists of one room with a size that can be filled by 4 cadres and 2 participants. Because there is no waiting room then the participants who wait their turn are seated outside waiting at the stalls or standing on the street. MOST room and mossy walls make the impression less comfortable and the air circulation was not good because it is too dense and feels hot.

About the Posbindu NCD facility, the result of interview with the NCD's Posbindu trainer in NA of 7 is available Card Go to Health (KMS) from Puskesmas. KMS stock runs out prompting cadres to create their own KMS. Sarana Posbindu NCD is managed jointly by cadres in NA of 1. The existence of family medicinal plants around Posbindu NCD and other complete supporting equipment become the attraction of the community to visit and provide a sense of comfort while waiting.

**Innovation Factor in the Implementation of NCD Posbindu**

According to the guideline, Posbindu NCD was implemented with a five-table system. In Posbindu NCD NA of 1, a five-table system was added with additional medication and food for participants. While in Posbindu NCD NA of 7, to increase the number of visits then the implementation along with the activity of recitation of mothers in the mosque near Posbindu NCD.

Innovation increased the attendances both in NA of 1 and NA of 7. Supplementary feeding activity becomes one of the strategy to attract the participants, although the distributed food is not much, but gives the impression for the society. Innovation in implementation can facilitate program improvement and improvement in accordance with real experience. Further innovations in program evaluation can build evidence-based interventions with better identification of what is not in accordance with what is planned and what is already effective and ready for development. When program holders want to improve creativity and innovation, the decision of the coach must stimulate and support creative and innovative ways of thinking. Instead, it will inhibit the development of creativity and innovation when cadres are separated or sequestered from the program participation section, when focused only on short-term outcomes and when funds and rewards do not support innovation (Longest, 2015).

Innovation that has been done in NA of 1 is supported by the participating donors and the unity of cadres and village officials in succeeding the implementation of Posbindu NCD. While the NA of 7 still has not received support from donors in an effort to run innovations that can increase the number of community visits. Innovation is vital in enabling ASEAN nations to successfully address the growing crisis of NCDs (Lim, Chan, Alsagoff, & Ha, 2014).
Communication Factors in Posbindu NCD Implementation

Communication of NA of 1 cadres and NA of 7 with Puskesmas was conducted through monthly routine meetings consisting of mini lokmin (lokmin) conducted by Puskesmas and presenting all representatives of Pasir Mulya Puskesmas area consisting of three urban villages: Pasir Mulya, Loji and Gunung Batu. The application of communication elements in Puskesmas management can be reviewed in routine meetings held at least once a month with two-way nature (Muninjaya, 2004). Before Lokmin is done, a meeting of cadres of Gunung Batu urban village with a coach is conducted to discuss matters related to the implementation of Posbindu NCD. This activity is done with two-way communication so that cadres and coaches can discuss, other than through WA or phone.

Table 3. Posbindu NCD Communication NA of 1 and of 7 in 2017.

<table>
<thead>
<tr>
<th>Aspect</th>
<th>NA of 1</th>
<th>NA of 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puskesmas to cadre</td>
<td>Communication using mobile-phone electronic media.</td>
<td>Communication for information delivery</td>
</tr>
<tr>
<td></td>
<td>Cadre forum in mini workshop of Pasir Mulya Health Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Column special cadres of Gunung Batu urban village</td>
<td></td>
</tr>
<tr>
<td>Community leader to cadre</td>
<td>Communication is good</td>
<td>Communication for information delivery</td>
</tr>
<tr>
<td></td>
<td>-from mouth to mouth</td>
<td>-from mouth to mouth</td>
</tr>
<tr>
<td></td>
<td>-the announcement in the mosque</td>
<td>-the announcement in the mosque</td>
</tr>
<tr>
<td></td>
<td>-sweeping</td>
<td>-sweeping</td>
</tr>
<tr>
<td>Cadre to community</td>
<td>in daily social activities</td>
<td>in daily social activities</td>
</tr>
<tr>
<td></td>
<td>such as recitation and social gathering</td>
<td>such as recitation and social gathering</td>
</tr>
</tbody>
</table>

Communication cadres NA of 1 and NA of 7 with the community conducted through word of mouth through chat activities. There are also announcements directly through mosque loudspeakers and home-based methods by bringing door to door. In addition, the cadre at NA of 7 also sent a short message in communicating. This is in line with Ivancevich (2007) assertion that in an organization, the flow of communication from individual to individual varies in various aspects, from face to face and in group order to short message form.

Effective communication can lead to behavioral change, but more important is the emergence of political commitment and program effectiveness by involving various community actors. New communication and technological tools facilitate interactive conversations, allowing health practitioners to be able to engage in dialogue with representatives of affected communities and other stakeholders (Frieden, 2014).

Communication enhances the visit of Posbindu NCD. NA of 1 established good communication with the community and local community leaders in supporting the implementation of Posbindu NCD. The results of in-depth interviews and FGDs indicate that there are variations of responses related to factors affecting the implementation of NCD Posbindu, but communication is the answer given by most informants. This indicates that communication is an important part of the success of NCD's Posbindu in NA of 1. While in NA of 7, communication has been built with community leaders but has not shown intense and reciprocal communication causing the participation of community and community leaders themselves not yet optimal.

Rahmawaty's research indicates that there is no constraint in delivering information from cadres to public figures as seen from the involvement of community leaders such as NA or NA chairman in community activities such as recitation, arisan, PKK meetings, in the delivery of information on elderly posbindu activities (Rahmawaty, 2014). Implementation of NCD Posbindu in NA of 1 shows that the role of community leaders in the delivery of information activities Posbindu NCD by community leaders through pengajian activities, arisan, PKK meetings and other activities. While the implementation of NCD Posbindu in NA of 7 is not optimal because of the lack of participation of community leaders such as NA's mother in community activities.

Good communication not only communicates understand the meaning of the message, but also emotionally motivated to implement or comply the message it receives (Sulaeman, 2011). In the implementation of Posbindu NCD NA of 1 and NA of 7 coaches to communicate by using everyday language that is Sundanese language so that (a) cadres and participants are able to understand and even encouraged to obey messages from the coach as a health worker from puskesmas and (b) a familial bond that encourages the community to respond to the call to attend the NCD Posbindu activities.

Partnership Factors in the Implementation of Posbindu NCD

In-depth interviews informants conveyed that formally there is no form of partnership in the implementation of Posbindu NCD in the built area of Pasir Mulya Community Health Center. The partnership in Posbindu NCD in Pasir Mulya region (including NA of
1 and NA of 7 urban villages of Gunung Batu) is done by cross-program cooperation in Puskesmas itself, between NCD, Promkes and Nutrition. The informant stated that NA of 1 had a partner in completing the need for the implementation of Posbindu NCD through the acquaintance of a relative or community of cadre acquaintances, but the same was not found in NA of 7.

In addition to partners in supporting financially, support from several parties became partners in improving the success of the NCD Posbindu implementation. NA of 1 in conducting socialization and invitation to the community in partnership with urban village heads and wives, head of NA and community leaders.

The results of in-depth interviews on NA of 7 reveal partnerships conducted in the form of encouragement of community leaders and scholars and some communities who want to contribute in the form of beverages, but still need to be improved. The statement was supported by the FGD results of NA of 7 cadres stating the support of NA, community and ulama leaders in the form of attendance and announcement to the residents. While partners in the implementation of Posbindu NCD in NA of 1 is village leader, religious leaders and donors. Related innovations in non-communicable diseases management in ASEAN diabetes community in Indonesia strengthen partnerships with government as one of the main strategies for continuous advocacy at all levels of government (Lim et al., 2014). The implementation of the partnership in NA of 1 encourages the participation of various parties in contributing not only in the form of positive responses but also in contributing. It is formed because the cadres who have been considered senior and have the power in mobilizing the community.

The implementation of Posbindu NCD

Innovation in NA of 1 is supported by partners who can contribute morally and materially. The presence of partners enabled Posbindu NCD to innovate. Collaboration depends on individual and community understanding of well-being that is influenced by social, environmental, and economic factors of health services. As long as health promotion and management belong to not just a single profession or sector, broad partnerships built through the advocacy process will narrow the health gap and maintain or improve the health of the population. Lim's (2014) study finds partnerships as an important tool in improving public health outcomes due to shared intelligence of information that increases understanding of the needs and desires of local communities.

Potential partnerships in supporting the implementation of Posbindu NCD include Corporate Social Responsibility (CSR), which is conducting health programs independently, universities that can supply experts, private practices, and other potentials. Posbindu NCD NA of 1 and NA of 7 need to partner with government agencies, community organizations, companies, foundations, donors, patients and volunteers. Partnerships are crucial to keep the program running, especially during times of budgetary difficulties. Partners can complement human and financial needs. This is supported by the location of Kelurahan Gunung Batu located in urban areas.

Implementation of Posbindu NCD

The results of recording and reporting become the material in conducting analysis and evaluation of the program in accordance with the objective of the implementation of NCD Posbindu is to prevent and control NCD risk factors from an early age. Risk factors that have been monitored regularly can always be maintained under normal conditions or do not fall into the bad category (Rahajeng et al., 2014). The evaluation of the implementation of NCD Posbindu in NA of 1 and NA of 7 shows the largest number of visits as an indicator of the ability to perform the function of preventing non-communicable diseases through control of risk factors that have been discovered at an early stage. Thus NCD risk factors can be controlled through controlling risk factors and healthy lifestyle such as smoking cessation, balanced diet, diligent physical activity, stress management and others. Counseling and education is conducted by Posbindu NCD officers to improve community knowledge and ability to control NCD risk factors. Then the results of the examination will be followed up with counseling from the coach. In certain cases, when there are participants of Posbindu NCD who can not attend due to illness, cadres and builders NA of 1 and NA of 7 will make a home visit which then provide a referral if health conditions require handling in the health center or hospital.

The proportion of NCD risk factors was calculated by comparing NCD risk PosBindu participants with NCD risk compared to the number of posbindu participants examined by the NCD Posbindu juknis. Based on the number of visits a year Posbindu NCD NA of 1 is known from 592 visits 16% of participants
receive education and recommendation therapy in lowering blood pressure, 47% with normal blood pressure should have received education to keep blood pressure normal, and 16% with low blood pressure obtain education and therapeutic recommendations to normalize blood pressure. Within a year of activity Posbindu NCD found (39 people) 7% of participants who have been diagnosed with diabetes. Risk factors that have been recorded were then followed up with treatment (20%) or referred (2%).

During the visit of Posbindu NCD NA of 7 it was found that from 285 visits 40% of the participants received education and recommendation therapy in lowering blood pressure, 55% normal blood pressure received education to keep blood pressure normal, and 9% received education and therapeutic recommendations to normalize blood pressure. Activities Posbindu NCD found 10% of participants who have been diagnosed with diabetes within a year. Risk factors that have been recorded were then followed up treated (29%) or referred (1%). The implementation of Posbindu NCD becomes gate keeper in preventing the occurrence of disease or complication through early detection. In NA of 7 more participants had more risk factors for body mass index, high blood pressure, and diabetes. This indicates that attendees are participants with risk factors and have been diagnosed with illness.

Communication factors play an important role in delivering health messages and follow-up results of medical examinations. Innovation is driving the emergence of new ideas that are able to develop the integrated implementation of Posbindu NCD (food supplement, drug distribution, religious citation) and impact on changes in community behavior in improving health efforts that is to manage risk factors that have been detected so as not to worsen and maintain the continuity of healthy lifestyle (the result of education and consultation with health workers every month). Partnership is important for all elements to be a part of achieving the objectives of Posbindu NCD (Role of Village Head, NA head, community leaders, religious leaders, the wife of NA head and the community).

Management, communication, partnership, and innovation factors are mutually related to each other in supporting the implementation of NCD Posbindu that is appropriate for the purpose. Implementation of Posbindu NCD in NA of 1 and NA of 7 indicates that good human resources management supports optimal role of cadres as a driving force that fosters a sense of belonging to the successful implementation of NCD Posbindu program so that unpaid cadres are ready to work fulfilling joint responsibility. Good fund management supports innovation in enhancing participant visits. In addition to being supported by funding, innovation is also supported by sustainable partnerships so that the cadres are able to develop other activities as a community attraction. Partnerships can work with good communication. The most important communication is the communication between the coach and the cadres so that there is a unity of purpose between the cadres and the puskemas. Communications with community cadres also support the increase in the number of visits. Poscindu NCD cadres NA of 1 has good communication with local area or community leaders and able to convey urgency and purpose of Posbindu NCD implementation resulting in shared vision between cadres with community leaders. This supports the participation of various parties in implementing NCD Posbindu in NA of 1.

CONCLUSION

The successful implementation of Posbindu NCD is influenced by management (human resources, funds, and facilities), innovation, communication and partnership. The existence of these four factors is more optimal in Posbindu NCD with good performance (most visited indicator) compared with Posbindu with poor performance (lowest indicator of visit). Management / human resources management, funds and facilities support the implementation of Posbindu NCD. Voluntary cadres, ownership of Posbindu own building, the existence of fixed funds, good communication, and the existence of partnership and innovation in the implementation of NCD Posbindu in NA of 1 has increased the visit of Posbindu NCD to be the highest. Intense communication also ensures the implementation of Posbindu NCD. Posbindu NCD NA of 1 with the most number of visits has advantages in partnership factors that support the innovation in the implementation of Posbindu NCD. This research can be continued by exploring other elements that can become new insights in improving the effectiveness of Posbindu NCD program.

Based on the result of the research, it is recommended to optimize the management factor, innovation, communication and partnership so that the potential in society can be developed for the sake of public health development. Stakeholder Posbindu NCD is able to facilitate the program well through instrument optimization, Posbindu clear measurement of success.
optimization of follow-up of recording results, and building partnerships (especially in Puskesmas that are close to industrial areas) with universities in community service.

RECOMMENDATION

The implementation of Posbindu NCD is supported by a more complete guide and a clear measurement tool to be able to be applied to Puskesmas in conducting the evaluation. The encouragement from government nationally can be realized through advertisement and socialization by adjusting to the current technological developments both through social media and printed media. The implementation of Posbindu NCD is one of the programs that is able to become an evidence based data which can be analyzed and followed up by Dinas Kesehatan, hence, a complete data is needed to be used as the evidence in determining a policy. The role of Puskesmas becomes a direct intermediary in encouraging the optimization of management, communication, partnership and innovation factors. Appreciation towards Puskesmas officers who directly involved in the field must be done. Inadequate innovation and partnership factors need to be pushed by Puskesmas through several ways as a trigger for cadres (through CSR, private practice, local people who work as health workers, health community). Therefore, it is also necessary for the officers to be creative and good at communicating with the community, so they can easily mobilize the community. Universities become partners in developing new ideas, on the other hand, Posbindu NCD itself can also be a learning tool for the students.

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