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Research

Implementation of Context Input Process Product Model on Healthy Indonesia Program Policy with a Family Approach

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ABSTRACT

Background: The Healthy Indonesia Program with a Family Approach started in 2017, has now reached the first visit coverage rate of 26.80% as of October 3, 2018, with a Healthy Family Index (IKS) value of 0.165. This figure is still far below the expected target, namely in 2019 it is expected that the visit coverage rate has reached >90% so that in 2019 an intervention plan at the community health center (puskesmas) level can be carried out in accordance with the roadmap of the Ministry of Health. This study aimed to investigate the implementation of the context input process product (CIPP) model in the healthy Indonesia program policy with a family approach.
Subjects and Method: This research is a qualitative descriptive study using a sample of policy makers and implementers of the Healthy Indonesia program with a Family Approach (PIS – PK), namely: Head of Public Health Center, Head of Health Service Division of Karanganyar District Health Office, Person in Charge of Healthy Indonesia Program, implementer of PIS – PK visits, and the surrounding community. The research was conducted in August 2021. Data were collected by means of document review, in-depth interviews, focus group discussions (FGD), and participatory observations. Data is presented in analytical descriptive form.
Results: Data were collected from 16 research respondents. In the input aspect, the implementation of PIS PK is supported by sufficient human resources, although there are still gaps in the fulfillment of types of positions. Financial support, infrastructure, methods, implementation time and cross-sectoral support look very good and in accordance with the mandate of the Minister of Health 39 of 2019 concerning PIS PK. There are still problems in the application of healthy families, making the PIS PK output results not in accordance with manual calculations, so that family interventions both individually and in groups cannot be carried out optimally. Not all puskesmas have also implemented total coverage in the implementation of PIS PK, nor have all puskesmas used IKS value data as one of the inputs in planning puskesmas in the form of RUK and RPK.
Conclusion: The Healthy Indonesia Program (PIS PK) in Karanganyar Regency can be implemented well in terms of context, input and process, but it is still not optimal in the aspect of output because of obstacles in the application of healthy families and the output of PIS PK has not been fully used as a basis for planning at the puskesmas level.

Keywords: : context, input, process, product, Healthy Indonesia Program

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BACKGROUND

Based on the results of the Basic Health Research (Riskesdas) in 2018 showed that the Maternal Mortality Rate (MMR) decreased from 359 per 100,000 live births (KH) in 2013, to 305 per 100,000 KH in 2015. A significant decrease also occurred in the proportion of malnutrition cases from 5.7 in 2013 to 3.9 in 2018, and the proportion of cases of malnutrition less than 13.9 in 2013 decreased to 13.8 in 2018. However, this figure is still above the expected target according to the 2019 RPJMN, which is 17%, while the results of Riskesdas in 2018 were 17.7%.

Health problems also still occur in the proportion of short and very short nutritional status of children aged two years (baduta) of 29.9% even though the expected target in the 2019 RPJMN is below 28%. This shows that there is a need for a targeted and planned program to be able to improve the health status of the community. The Healthy Indonesia Program at least provides new hope for health development towards the Sustainable Development Goals (SDGs), by changing the health conditions of the Indonesian people for the better, although the challenges are also increasingly complex.

The Healthy Indonesia Program with a Family Approach started in 2017, has now reached the first visit coverage rate of 26.80% as of October 3, 2018, with a Healthy Family Index (IKS) value of 0.165. This figure is still far below the expected target, namely in 2019 it is expected that the visit coverage rate has reached >90% so that in 2019 an intervention plan at the puskesmas level can be carried out in accordance with the roadmap of the Ministry of Health. This roadmap provides clusters at the Puskesmas to be able to trigger the Puskesmas to increase the coverage rate of family visits to 100%. For Puskesmas with a coverage rate of <30%, it is necessary to conduct acceleration development so that the coverage rate can increase to 100%, for Puskesmas with a coverage of >30% can carry out intervention development, namely continuing to reach 100% coverage and using the IKS achievement rate as the basic data in planning for the year. – the coming year (Trihono, 2018). For this reason, it is necessary to periodically monitor and evaluate the increase in data collection coverage and the value of the Healthy Family Index (IKS).

Based on the description above, the authors conducted research on the implementation of the Healthy Indonesia Program with a Family Approach (PIS – PK) from the context, input, process and product aspects at the Karanganyar District Health Center.

SUBJECTS AND METHOD

1. Study Design

This was a descriptive qualitative study.

2. Sample

Policy makers and implementers of the Healthy Indonesia program with a Family Approach (PIS – PK), namely: Head of Puskesmas, Head of Health Services at the Karanganyar District Health Office, Person in Charge of the Healthy Indonesia Program, executors of PIS – PK visits, and the surrounding community.

3. Operational Definition

The Healthy Indonesia Program with a Family Approach is a health visit program carried out by puskesmas with the aim of bringing puskesmas access closer to the community, recognizing health problems in the work area and making the family the focus of empowerment.

Context evaluation is an attempt to describe and detail the needs for program implementation and the objectives to be achieved.

Input Evaluation is an effort made to assess and determine the available resources to support the success of the program, including 7M+1I (Man, Material, Money, Machine, Method, Market, Minute, Information).

Process Evaluation is an effort made in describing the procedures for implementing the Healthy Indonesia program in accordance with Permenkes 39 of 2016, the extent to

which the program has been implemented, identifying barriers to program implementation and what components need to be improved.

Product evaluation is an effort made in assessing the success of the program, program outputs that can be used to make decisions related to puskesmas level planning (making RUK and RPK of Health Center).

4. Instruments

Data collection was carried out using interview guidelines, participatory observation guidelines and field notes.

The following are the achievements of PIS PK at the Karanganyar Regency level until the end of 2019.

No	District	Score of IKS
1.	Jatipuro	0.18
2.	Jumapolo	0.09
3.	Matesih	0.29
4.	Ngargoyoso	0.18
5.	Karanganyar	0.28
6.	Jaten	0.29
7.	Gondangrejo	0.21
8.	Mojogedang	0.23
9.	Jenawi	0.25
10.	Jatiyoso	0.11
11.	Jumantono	0.22
12.	Tawangmangu	0.07
13.	Karangpandan	0.29
14.	Tasikmadu	0.24
15.	Colomadu	0.30
16.	Kebakramat	0.25
17.	Kerjo	0.25

RESULTS

1. Characteristics of Study Subjects

The respondents in this study were 16 people, consisting of: 4 heads of puskesmas (TA, BM, SP, and SL), 4 PIS PK coordinators at the puskesmas level (RR, OK, AJ and HN), 4 PIS PK implementers at puskesmas (SR, DW , ND and IS), district level PIS PK supervisors (WN and FD), and 2 general public (SP and PR).

2. Overview of PIS PK Achievements

Karanganyar Regency

Based on the results of observations of healthy family application outcomes in August 2020, the highest IKS value was in Colomadu sub-district (0.30) and the sub-district with the lowest IKS was Jumapolo sub-district (0.09).

From the data above, the indicator with the highest achievement is access to healthy latrines (98.18) and the lowest indicator is in patients with hypertension taking treatment regularly (17.19).

3. Indonesian Program Implementation

Healthy in terms of input

a. Human resources

The readiness of human resources in implementing PIS PK begins with training which is attended by 5 people from each puskesmas. From 5 people, they were chosen to conduct training of trainers (TOT) for all personnel who will be involved in PIS PK. In this case, there are differences between nursing and non-maintenance health centers in their involvement in the PIS PK program. Health centers with more human resources do not include human resources who carry out guard duties. This causes the number of human resources to carry out PIS PK is still lacking.

The lack of human resources is also triggered by the disproportionate number of personnel in the puskesmas, because it is not in accordance with the manpower pattern of the puskesmas.

b. Money/budget

Most of the PIS PK budget for puskesmas comes from BOK (Health Operational Assistance) funds, which are fully allocated for transporting officers during data collection. The allocation of the BOK budget for PIS PK is carried out in stages because it must also be allocated to other activities. Since the implementation of the financial management pattern of the Regional Public Service Agency (PPK – BLUD) in 2017, the income of the puskesmas has been partially used for the procurement of facilities and

infrastructure in the implementation of PIS PK, especially during the pandemic. In providing the budget, the puskesmas feels that it is sufficient to be able to finance all PIS PK activities, so that the puskesmas no longer receives a budget subsidy from the District Health Office (DKK).

c. Material / facilities and infrastructure

Facilities and infrastructure for the implementation of PIS PK such as data collection forms, educational media, stationery, bags, uniforms, counseling flip sheets, and tensimeters. The Puskesmas also provides infrastructure that is used for data collection during a pandemic, so that data collection continues according to strict health protocols. There are 2 (two) puskesmas which in terms of procurement of facilities and infrastructure receive support from CSR and village funds. This shows that there is good support from across sectors for the implementation of PIS PK.

d. Machine / equipment and technology

The technology used in the implementation of PIS PK is a healthy family application that is accessed via a web service. All puskesmas use this web-based application, starting from recording, analyzing, reporting to program evaluation. Barriers in using this healthy family application are mainly in connection and application updates. Applications are often inaccessible during working hours, as well as application updates that make data entry difficult. In 2020, where there is a covid-19 pandemic, healthy family applications are even more difficult to access and minimal updates. Socialization regarding the update of the healthy family application feature is also still lacking, so that the PIS PK data manager is also difficult to analyze the output.

e. Method

The method used in collecting data on healthy families is door-to-door visits, while the method used in monitoring and evaluation is periodic evaluation meetings and mini-workshops at the puskesmas. The obstacle in carrying out door-to-door visits is that there are still residents/communities who refuse to be recorded, so the officers must re-collect the data the next day..

f. Market / cross-sectoral support

2 (two) of the 4 (four) puskesmas studied received sufficient cross-sectoral support for the implementation of PIS PK. The form of cross-sectoral support is the provision of facilities in the form of family/prokesga recording forms, and counseling sheets (pinkesga) from village funds. Support is also provided by health cadres in delivering and accompanying officers during family data collection.

g. Minute/ time

Scheduling family data collection is the main thing that is done in time efficiency of PIS PK implementation. Non-maintenance health centers take advantage of time outside of service hours in the building, while nursing health centers divide the team on duty into 2 teams, namely the team that carries out services in the building, and the team that carries out family data collection. Barriers are often found when the number of personnel is not sufficient so that the time required for data collection becomes longer.

h. Information and policies

The information component in supporting the implementation of PIS PK consists of policies and performance achievements. The only policy owned by the puskesmas in implementing PIS PK is the Decision Letter (SK) of the PIS PK Team. The absence of SOPs for the implementation of PIS PK has hampered the implementation of PIS PK, including in conducting health interventions. In terms of performance achievement, puskesmas have not synchronized the performance of MSS with the achieve-

ment of the 12 indicators of PIS PK, so that in terms of intervention, it is still not universal/overall.

3. Implementation of the Healthy Indonesia Program in terms of Process

a. Planning (P1)

The planning steps in implementing PIS PK consist of socialization, financing and preparation of family data collection. The socialization aims to build commitment in supporting the successful implementation of PIS PK, for that internal and external socialization of the puskesmas is carried out. Internal socialization was carried out by the PIS PK team to all employees after receiving training, and material refreshing was carried out during the monthly mini-workshop of the puskesmas. External socialization is carried out through meetings with community leaders, health cadres, and regional officials, and this is only done 1 (one) time at the beginning of data collection.

Another component related to PIS PK planning is financing. In terms of financing, the puskesmas uses BOK funds for data collection, while specifically in the procurement of facilities and infrastructure, funds are sourced from the BLUD. The Puskesmas anticipates the shortage of PIS PK operational funds by allocating it for the year in stages.

b. Mobilization and implementation (P2)

The movement in the implementation of PIS PK begins with forming a team, then the team will schedule family data collection. In terms of scheduling, the team coordinated with local health cadres and village midwives. In the implementation of health data collection, there were still residents who refused to be visited, or people were not at home when the data collection was conducted. Another problem at the time of data collection is the invalidity of population data, so that the families to be met do not exist de facto.

The PIS PK database management is carried out by the coordinator by taking from the healthy family application. The problem of healthy family applications that cannot be accessed during working hours, as well as application updates which make it more difficult to make the IKS results from the application output invalid, so that officers still make reports manually.

The implementation of data analysis, formulation of health problem interventions was carried out by the puskesmas individually or in groups. Not all puskesmas have implemented further PIS PK interventions, because there are still puskesmas that have not fully covered total. Not all puskesmas have also implemented group interventions, so that the follow-up intervention is still in the form of individual interventions such as direct counseling and education on the spot, or providing internal referrals to services within the puskesmas building. Given that follow-up interventions in groups require community participation in one or more forms of community empowerment.

The data from the PIS PK implementation in the form of the IKS value is used as a basis for determining the planning of the puskesmas for N+1. The forms of planning for the puskesmas include RUK (Proposed Activity Plan) and RPK (Activity Implementation Plan). Based on the results of observations on planning documents, not all puskesmas use the IKS value as a basis for planning puskesmas.

The implementation of promotive and preventive efforts to overcome health problems from the results of PIS PK has been carried out by the puskesmas. The forms of promotive and preventive efforts carried out by the puskesmas include: pre-health visits, on-the-spot counseling with

pinkesga and flipcharts, family visits in the context of community health and individual visits with health risks. Regarding the implementation of curative and rehabilitative efforts, not all puskesmas have been able to implement it because not all puskesmas have completed family data collection, as well as puskesmas have not implemented integrated efforts between Community Health Efforts (UKM) and Individual Health Efforts (UKP).

The implementation of the PIS PK Health Information System (SIK) and puskesmas reporting is carried out through 1 (one) door, namely the healthy family application. At the end of 2018, puskesmas can download raw data from PIS PK visits. Puskesmas can download complete raw data by name by address for further intervention planning, real target data as MSS targets, and to complete program data analysis and link PIS PK achievements with program achievements.

c. Supervision, Control and Assessment (P3)

Supervision, Control and Assessment of the implementation of PIS PK is carried out by the Health Office through a meeting to evaluate the results of PIS PK and the overall puskesmas performance achievement desk called the PKP desk. In addition, the Health Office also supervises, controls, and evaluates the implementation of PIS PK in the field, namely visiting families in the work area of the puskesmas randomly / sampling. Supervision and assessment of puskesmas reporting is also carried out through monitoring in the healthy family application.

In addition to the supervision, control and assessment by the Health Office, the puskesmas themselves also carry out internally through evaluation meetings of PIS PK results and discussions in puskesmas mini workshops.

4. Implementation of the Healthy Indonesia Program in terms of Outputs

The output of PIS PK is the value of the Healthy Family Index (IKS) as a marker of family health status. The IKS score of Karanganyar Regency is included in the unhealthy category with the lowest achievement on the indicator of hypertension sufferers who seek treatment regularly at 17.93%. These results are not much different from the IKS scores at the provincial and national levels. The low IKS output achievement is influenced by the entry process that is less than optimal and the application of healthy families which is difficult to access during working hours. One of the puskesmas stated that the IKS value reported to the Health Office did not match the real data collection results because not all data had been successfully entered into the healthy family application. Another thing that affects the PIS PK output which is less than optimal is the absence of a definite and planned roadmap regarding the process of implementing data collection, so that the puskesmas adjusts to the availability of the budget and conditions in each region.

5. Integration of PIS PK Outcomes with Health Center Level Planning

In the case of puskesmas planning based on the results of PIS PK, the IKS value can be used as one of the inputs in analyzing health problems so as to produce planning outputs in the form of RUK and RPK for the puskesmas. The results showed that all puskesmas had integrated puskesmas planning with PIS PK, although the type of activity planning did not directly lead to problem solving from low IKS scores. From the results of the review of the puskesmas planning documents in the form of RUK and RPK, it showed that the puskesmas had integrated the results of PIS PK with the

planning of puskesmas activities, but the planning document did not include the IKS value as one of the inputs in the analysis of health problems. Other forms of planning for puskesmas activities are also indicated by the existence of innovation activities in alleviating the problem of low IKS scores. Some puskesmas that have not had total coverage have not been able to conclude activities that boost the IKS value, so activities are still limited to individual interventions.

DISCUSSION

1. Implementation of the Healthy Indonesia Program in terms of inputs

a. Human Resources

This study also shows that there is a gap in the fulfillment of human resources for health workers to carry out PIS PK, such as the disproportionate number of health workers with needs according to the Workload Analysis (ABK). This is in accordance with research by Rizcarachmakurnia, et al (2017) which states that the results of calculating ABK and the need for nurses at the puskesmas are still below the standard because the distribution and addition of nurses is only based on the criteria for the type of puskesmas. The solution offered is to use other sources of funds owned by the puskesmas.

b. Money/financial

Based on the results of the study, it was found that 3 (three) puskesmas stated that the existing budget was sufficient to meet the implementation of PIS PK, while 1 (one) puskesmas stated that the budget was not sufficient to make the roadmap for the implementation of PIS PK to be delayed in the following year.

The use of the BLUD budget can also be used to finance programs in public health efforts (UKM), for example to finance the program for giving blood tablets for teenagers (Purwati, 2016).

c. Material / facilities and infrastructure

Based on the results of the study, it is known that the tools used for implementation at the puskesmas are adequate and sufficient, but in the context of implementing PIS PK during the pandemic, the puskesmas cannot fully prepare them. This is because the implementation of PIS PK during the pandemic by paying attention to health protocols was not predicted by the previous puskesmas, so it had not been implemented by the puskesmas. The solution in this case is to follow existing procedures, namely the puskesmas adding data collection facilities and infrastructure to adjust to the pandemic period such as hand sanitizers, thermoguns, medical masks, level 1 Personal Protective Equipment (PPE) as a form of implementing standard precautions and transmission precautions (Ministry of Health, 2020).

d. Machine / equipment and technology

In the implementation of PIS PK in Karanganyar Regency, where there are still problems regarding the application of healthy families that are difficult to access. This is in accordance with research by Astuti (2020) which states that the low coverage of family visits and IKS in Depok is still low due to difficulties in inputting data in healthy family applications and technical management of data collection, and officers who master computers.

f. Market / cross-sectoral support

Cross-sectoral support is one of the external factors which are opportunities in the implementation of programs carried out by the Health Office and puskesmas (Ayuningtyas, 2020). The results of this study indicate that cross-sectoral support is very helpful in implementing PIS PK, especially in family data collection activities. Cross-sectoral support is also provided by the

village by providing an allocation of funds for the procurement of facilities and infrastructure for PIS PK data collection, as well as from health cadres when data collection is carried out.

h. Information and policies

The absence of this district level regulation shows the local government's lack of commitment that the City of Depok is ready to succeed in a program or policy (Astuti, 2020). This is also in line with the implementation of PIS PK in Karanganyar Regency, where there are no regulations or policies that specifically regulate technical instructions and roadmaps for the implementation of PIS PK, both at the district level and at the puskesmas level.

2. Implementation of the Healthy Indonesia Program in terms of Process

a. Planning (P1)

At the planning stage of PIS PK, socialization and budgeting are carried out. Socialization is carried out internally and externally. The budget planning process was carried out at the end of the previous year by utilizing various available funding sources. This is in accordance with the Minister of Health Regulation No. 39 regarding the Technical Guidelines for PIS PK, and in accordance with the Ministry of Health Decree (2016) concerning the Technical Guidelines for Strengthening Community Health Center Management with a Family Approach.

b. Mobilization and Implementation (P2)

The process of mobilizing and implementing PIS PK implementation is carried out through regular monthly mini-workshops at the puskesmas and tri-monthly mini-workshops at the puskesmas, as well as several incidental meetings. The mobilization-implementation function (P2) is not limited to the process of collecting family data, but also at the time of making puskesmas plans for family intervention and group intervention (Ministry of Health, 2016e). This study shows that the mobilization and implementation functions at the puskesmas have been running well, but the puskesmas which have not had total coverage, have not been able to carry out the mobilization function - implementation to the process of formulating health interventions and raising commitments with cross-sectors for further PIS PK interventions.

Mini workshops can also be used for supervision – control and assessment (P3) in addition to mobilization – implementation (P2) (Ministry of Health, 2006e). Based on the results of this study, the method used by the puskesmas in the P3 function is through an evaluation meeting for the implementation of PIS PK which is held at least 2 (two) times in 1 year. There is also a health center that conducts an evaluation meeting on the implementation of PIS PK after every healthy family data collection is completed.

c. Supervision, Control and Assessment (P3)

Health interventions in the form of programs that are implemented in communities facing various complex situations and limited resources. To overcome this, program monitoring and evaluation (monev) can ensure the use of resources and encourage the willingness of organizations or program implementers and other resources so that they can be directed to achieve outcomes (Mahendradata et al, 2019).

3. Implementation of the Healthy Indonesia Program in terms of Outputs

The results showed that health interventions could not be implemented optimally because not all puskesmas were able to carry out family data collection as a whole (total coverage). Problems are also expe-

rienced by the puskesmas where the PIS PK output has not been said to be valid, because not all family data collection results can be inputted into the healthy family application. This is in accordance with Sulaeman (2017) which states that the quality of policy analysis depends on the accuracy, completeness and relevance of the information that can be obtained.

The results of this study are in line with Fauzan, et al (2019) which stated that the results of the implementation of PIS PK at the Mulyaharja Health Center were good in accordance with the concept set by the puskesmas. However, in terms of output, there are still constraints in data input in healthy family applications and there is still a lack of facilities and infrastructure in family data collection.

4. Integration of PIS PK Outcomes with Health Center Level Planning

The results of this study indicate that the PIS PK intervention in the context of family empowerment has been quite well implemented, but in terms of community empowerment it is still not running. Interventions in the context of PIS PK can be demonstrated by encouraging UKBM to return to solving problems from the low PIS PK indicators. For example, in strengthening one UKBM, namely Posbindu for Non-Communicable Diseases (PTM), one of the benefits is being able to control the behavior of hypertension sufferers, so that hypertension sufferers are encouraged to take regular treatment. This is in line with Fredianto's research (2019) which states that the PTM posbindu has a contextual influence on the tertiary prevention behavior of hypertensive patients, where the goals of the posbindu tertiary prevention are to prevent disability, control blood pressure, minimize complications, and increase compliance with hypertension patients receiving treatment according to standards.

AUTHOR CONTRIBUTION

Ninawati, as the main researcher has role in collecting and processing research data; Endang Sutisna Sulaeman and Didik Tamtomo examine the conceptual framework and Research methodology.

CONFLICT OF INTEREST

There is no conflict of interest in this study.

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REFERENCE

Agustina SC, Trisnanto L, Handono D (2019). Implementasi Program Indonesia Sehat dengan Pendekatan Keluarga (PIS PK) Menggunakan Tenaga Kontrak di Kabupaten Kulon Progo Tahun 2018 (Implementation of the Healthy Indonesia Program with a Family Approach (PIS PK) Using Contract Workers in Kulon Progo Regency in 2018). Jurnal Kebijakan Kesehatan Indonesia. 08(03): 104-112. https://-journal.ugm.ac.id/jkki/article/download/45705/25695.

Agustino. 2014. Dasar – dasar Kebijakan Publik (Fundamentals of Public Policy). Bandung: Alfabeta.

Agustinova, DE (2015). Memahami Metode Penelitian Kualitatif : Teori &praktis (Understanding Qualitative Research

Methods: Theory & Practical), Yogyakarta: Calpulis.

Astuti TRS, Soewondo P (2020). Financing Readiness Analysis of Hypertension, Diabetes Mellitus and Mental Disorders for the Healthy Indonesia with Family Approach Program 2018 – 2020. Jurnal Ekonomi Kesehatan Indonesia. 3(1).

Ayuningtyas (2020). Manajemen Strategis Organisasi Pelayanan Kesehatan: Konsep dan Langkah Praktis (Strategic Management of Healthcare Organizations: Concepts and Practical Steps). Depok: Rajawali Pers.

Azwar A (2010). Pengantar administrasi Kesehatan Edisi Ketiga (Introduction to Health Administration Third Edition). Binarupa aksara: Tangerang.

Bungin B (2009). Analisis Penelitian Data Kualitatif (Qualitative Data Research Analysis). Jakarta: Raja Grafindo.

Darma S, Juanita, Rochadi RK (2018). BPJS Barrier to Strategic Purchasing of Primary Care Service at Public and Private Health Facilities in Sulubussalam, Aceh. Journal of Health Policy and Management. 3(2): 81-91. https://doi.org/10.26911/thejhpm.2018.03.02.03.

Dano JC, Inabangan AA. (2013). The CIPP Model in Evaluating the Affiliated Primary Health Care Centers of Cebu Norman University. CNU Journal of Higher Education. 7: 27-44. https://jhe.cnu.edu.ph/index.php/cnujhe/article/view/72.

Departemen Kesehatan RI (2009). Rancangan Final Rencana Pembangunan Jangka Panjang Bidang Kesehatan 2005 – 2025 (Final Draft of Health Sector Long Term Development Plan 2005 – 2025). Jakarta: Departemen Kesehatan RI.

Divayana, Dewa GH (2015). Evaluasi Program Penanggulangan HIV/AIDS dengan Model CIPP Berbantuan Komputer (Evaluation of HIV/AIDS Control Program with Computer Assisted CIPP Model). *Konferensi Nasional Sistem dan Informatika 2015*, *Denpasar, Indonesia*, *October, 2015*. STMIK STIKOM Bali. Dikutip 20 Oktober 2019 dari https://www.neliti.com-/publications/172612/evaluasi-program-penanggulangan-hivaids-dengan-model-cipp-berbantuan-komputer

Frediyanto A, Tamtomo DG, Sulaeman ES (2019). Does the integrated health post have contexual effect on tertiary behavior among hypertensive patients? A multilevel analysis evidence from Surakarta. Journal of Health Promotion and Behavior. 4(3): 224-234 https://doi.org/10.26911/thejhpb.2019.04.03.07.

Handayani L, Ma'ruf NA, Sopacua E (2009). Peran tenaga kesehatan sebagai pelasana pelayanan kesehatan masyarakat (The Role of Health Workers as Implementers of Public Health Services). Buletin Penelitian Sistem Kesehatan. 13(1): 12-20.

Hall D, Stella T, Lee N (2010). CIPP as a Model For Evaluating Learning Spaces. Dikutip 19 November 2019 dari https://researchbank.swinburne.edu.au/items/b9de5b45-1a28-4c23-ae20-4916498741b8/1/PDF%20%28Published%20version%29.pdf?.vi=save.

Kementerian Kesehatan RI (2014). Peraturan Menteri Kesehatan Republik Indonesia Nomor 75 Tahun 2014 tentang Pusat Kesehatan Masyarakat. Jakarta: Kementerian Kesehatan RI.

Kementerian Kesehatan RI (2016a). Pedoman Umum Program Indonesia Sehat dengan Pendekatan Keluarga. Jakarta: Kementerian Kesehatan RI.

Kementerian Kesehatan RI (2016b). Peraturan Menteri Kesehatan Republik Indo-

nesia Nomor 39 Tahun 2016 tentang Pedoman Penyelenggaraan Program Indonesia Sehat dengan Pendekatan Keluarga. Jakarta: Kementerian Kesehatan RI.

Kementerian Kesehatan RI (2016e). Petunjuk Teknis Penguatan Manajemen Puskesmas Dengan Pendekatan Keluarga (Technical Guidelines for Strengthening Community Health Center Management with a Family Approach). Jakarta: Kementerian Kesehatan RI.

Kementerian Kesehatan RI (2017). Pedoman Monitoring dan Evaluasi Pelaksanaan Program Indonesia Sehat dengan Pendekatan Keluarga (PIS – PK) (Guidelines for Monitoring and Evaluation of the Implementation of the Healthy Indonesia Program with a Family Approach (PIS – PK).). Jakarta: Kementerian Kesehatan RI.

Kementerian Kesehatan RI (2018). Pembinaan Teknis Program Indonesia Sehat dengan Pendekatan Keluarga (PIS PK) Tahun 2018. Dikutip 22 Oktober 2019 dari http://www.dinkes.kalteng.go.id/beritapembinaan-teknis-program-indonesia-sehat-dengan-pendekatan-keluarga-pis-pk-tahun-2018.html

Kementerian Kesehatan RI (2019a). Laporan Nasional Riskesdas 2018. Jakarta: Lembaga Penerbit Badan Penelitian dan Pengembangan Kesehatan Riset Kesehatan Dasar (Riskesdas) (2018). Hasil Utama Riskesdas 2018. Badan Penelitian dan Pengembangan Kementerian Kesehatan. http://labdata.litbang.kemkes.go.id/images/download/laporan/RKD/2018/Laporan_Nasional_RKD2018_FINAL.pdf

Kementrian Kesehatan RI (2020). Panduan Pelaksanaan Program Indonesia Sehat dengan Pendekatan Keluarga (PIS – PK) pada Masa Pandemi Covid-19 serta Adaptasi Kebiasaan Baru (Guidelines for the Implementation of the Healthy Indonesia Program with a Family Approach (PIS – PK) during the Covid-19 Pandemic and the Adaptation of New Habits). Jakarta: Kementerian Kesehatan

Kiberu VM, Mars M, Scott RE (2017). Barriers and Opportunities to Implementation of Sustainable e-Health Programmes in Uganda: A literature review. Afr J Prm Health Care Fam Med. 9(1): a1277. https://doi. org/10.-4102/phcfm.v9i1.1277.

Kitreerawutiwong N, Mekrungrengwong S, Phetphum C (2017). Assessing the implementation of the Family Care Team in the District Health System of Health Region 2, Thailand. Journal of the Family Medicine and Community Health.DOI:10.15212/FMCH.2017.0139.

Laelasari E, Anwar A, Soerachman R (2017). Evaluation of Preparedness of Healthy Indonesia Program Implementation through Family Approach. Journal of Health Ecology, 16(2): 57 – 52.

Lahdji A (2019). Overview of survey results of the healthy indonesia program with a family approach in the area of Penggaron Lor, Semarang. Medical Journal Faculty of Medicine Muhammadiyah Surabaya. 3(2). DOI: 10.30651/jqm.-v3i2.2612.

Marwandi D, Sulaeman ES, Pawito (2020). Effect of leadership style of the head of the community health center and other determinants on the health personnel performance in Boyolali, Central Java. J Health Policy and Manage. 5(1): 74 – 84. https://doi.org/10.26911/thejhpm-.2020.05.01.07.

Mahendradhata Y, Probandari AN, Danu SS, Wilastonegoro NN, Sebong PH (2019). Manajemen Pogram Kesehatan

(Health Program Management). Yogyakarta: Gadjah Mada University Press.

Nutley T, Reynolds HW (2013). Improving the use of health data for health system strengthening. Journal of Global Health Action. 6(1).

Purwati, Tamtomo D, Sulaeman ES (2016). Context, input, process, product analysis in the implementation of iron supplementation program in Banyumas, Central Java. Journal of Health Policy and Managemet. 1(2): 113-120 https://doi.org/10.26911/thejhpm.2016.01.02.06.

Rahardjo M (2010). Triangulasi dalam Penelitian Kualitatif. n.d. Dikutip tanggal 4 Desember 2019 dari http://mudjiarahardjo.com/artikel

Rojali, Darmawan W, Gunawan AT (2018). Survey on the Implementation of Indonesian Health Family Program in Cluwak District, Pati Regency, Central Java Province. Internasional Journal of Innovative Research in Science, Engineering and Technology. 7(3). DOI: 10.15680/IJIRSET.2018.07030-59.

Silalahi U (2015). Asas Asas Manajemen. Bandung: Refika Aditama.

Shivali S, Majra JP, Akshaya KM, Qadiri GJ (2015). Family centered approach in primary health care: Experience from urban area of Mangalore, India. The Scientific World Journal. 1 – 8.

Stufflebeam DL (2002). The CIPP Model For Evaluation, dalam Daniel L. Stufflebeam, dkk. (eds), Evaluation in Education and Human Service. Boston: Kluwer Academic Publisher.

Stufflebeam DL, Kellaghan T, Wingate LA (2003). International Handbook of Educational Evaluation. Chapter 2 The CIPP Model for Evaluation. Boston : Kluwer Academic Publisher.

Suhadi dan Rais MK (2018). Perencanaan Puskesmas – Edisi Revisi (Health Center Planning – Revised Edition). Jakarta: CV Trans Info Media.

Sulaeman ES (2014). Manajemen Kesehatan: Teori dan praktik di puskesmas (Health Management: Theory and practice in puskesmas). Edisi Revisi. Yogyakarta: Gadjah Mada University Press.

Sulaeman ES (2017). Kebijakan Kesehatan: Teori dan implementasi (Health Policy: Theory and implementation). Surakarta: UNS Press.

Usman H (2013). Manajemen Teori, Praktik, dan Riset Pendidikan (Management Theory, Practice and Educational Research). Edisi 4. Jakarta: Bumi Aksara.