



การควบคุมโรคผ่านการมีส่วนร่วมของชุมชนในหน่วยบริการปฐมภูมิ

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บทคัดย่อ

การเจ็บป่วยของประชาชนในประเทศอินโดนีเซีย มีการเปลี่ยนแปลงรูปแบบของการเจ็บป่วยที่มาจากโรคต่างๆ ที่ซับซ้อนเพิ่มมากขึ้น ส่งผลให้หน่วยบริการสุขภาพระดับปฐมภูมิต้องมีการปรับปรุงคุณภาพการให้บริการด้านสุขภาพแก่ผู้รับบริการเพื่อตอบสนองต่อปัญหาและความต้องการการดูแล การศึกษานี้เป็นการวิจัยเชิงชาติพันธุ์วรรณาแบบวิพากษ์ (Critical Ethnography) เพื่อศึกษาวิธีการให้บริการของหน่วยบริการสุขภาพระดับปฐมภูมิ โดยการมีส่วนร่วมของชุมชนที่สอดคล้องกับบริบทสังคมและวัฒนธรรมของชุมชนจากผู้ให้ข้อมูลหลัก ได้แก่ เจ้าหน้าที่ในหน่วยบริการสุขภาพระดับปฐมภูมิ 13 คน และผู้ให้ข้อมูลรอง ได้แก่ ผู้มีส่วนได้ส่วนเสียที่มีประสบการณ์เกี่ยวกับบริการสุขภาพในชุมชน 23 คน รวบรวมข้อมูลโดยการสังเกต การสัมภาษณ์เชิงลึก และการสนทนากลุ่ม ตรวจสอบความน่าเชื่อถือของข้อมูลโดยการตรวจสอบแบบสามเส้า วิเคราะห์ข้อมูลโดยการวิเคราะห์เชิงเนื้อหา

ผลการศึกษาพบว่า หน่วยบริการสุขภาพระดับปฐมภูมิมีการควบคุมโรคผ่านการมีส่วนร่วมของชุมชน ใน 2 รูปแบบ ได้แก่ 1) การปรับรูปแบบการให้บริการให้สอดคล้องกับภาวะสุขภาพของบุคคล พฤติกรรม วิถีชีวิตและสิ่งแวดล้อมของชุมชน 2) การควบคุมโรคการพัฒนาบริการสุขภาพ การสร้างเสริมสุขภาพและการเสริมความเข้มแข็งให้ทุนทางสังคมในชุมชน โดยใช้ยุทธศาสตร์การสร้างการมีส่วนร่วมขององค์กรที่เกี่ยวข้องและทุนทางสังคมในชุมชน ชุมชนได้รับการผลักดันให้ร่วมมือในการควบคุมโรคโดยเฉพาะการป้องกันการคั่นหาระยะเริ่มต้นและการส่งเสริมสุขภาพประชากรกลุ่มเสี่ยง

คำสำคัญ : บริการสุขภาพระดับปฐมภูมิ การมีส่วนร่วมของชุมชน

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Disease control through community involvement at the primary care services

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Abstract

There are changes in the disease patterns of people in Indonesia as the diseases are more complex. As a result, primary care units are required to improve the quality of their health services in order to respond to problems and care needs. This Critical Ethnography study aimed to investigate the service delivery of primary care units by community participation consistent with the social and cultural context of the community from thirteen primary participants, the staff, and twenty-three secondary participants, the stakeholders. The data were collected by observation, in-depth interviews and group discussion. Triangulation was employed to verify data reliability and content analysis was used to analyze the data.

The study indicated that the primary care units operate the disease control by community participation in two forms: 1) adjusting the services to be consistent with the health status of the people, the behaviors, the way of life and the environment of the community, and 2) controlling diseases by developing health service, operating health promotion and strengthening social capital in the community by using participatory strategies of relevant organizations and social capital in the community. The communities are encouraged to engage in disease control, especially in preventive measures, early detection and health maintenance of people who are at risk to those non communicable diseases.

Keywords : Primary Care, Disease Control, Community Participation

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Introduction

Through the vision of Healthy Indonesia 2010, Ministry of Health states that, the people of Indonesia in the future will be a community, a nation and a country that is characterized by its peoples living in the environment and healthy behavior, have the ability to reach the quality of health services fairly and equitably, and have a good health state¹. Currently in Indonesia, communicable diseases (CDs) still exist as one of the health problems among the community. At the same time, non-communicable diseases (NCDs) morbidity and mortality are increasing. The proportion of mortality due to NCDs increased from 41.7% in 1995 to 49.9% in 2001 and 59.5% in 2007².

Disease control program has been run by the primary care unit-PC with six basic programs namely; health promotion, mother's health, child and family planning, improving nutrition, environmental health, communicable disease control and basic medical services. The disease control program is carried out from preventive in prevention and mitigation of risk factors, improvement of immunization; promotive in improvement of communication, information and education (KIE) disease control and prevention; and curative in case finding and management of patients, epidemiological surveillance and epidemic measures⁴.

However, compared to other countries, Indonesia is still lacking of disease control and prevention program. For instance, HIV / AIDS cases increase fastest in Southeast Asian countries. Dengue hemorrhagic fever is still an endemic and its case is always found throughout the year, especially in big cities. Coronary heart disease is still a major killer. Also, the incidence of obesity and Diabetes Mellitus continue to move up⁴. Most of diseases both communicable diseases (CDs) and non communicable diseases (NCDs) are preventable. NCDs are related to the lifestyles of our changing society so that degenerative diseases are more common at younger ages. Increased degenerative

disease is associated with urban lifestyles that tend to consume foods high in fat and less exercise activities.

Right now, there are various community-based health programs, such as the *jemantik* program, *desa SIAGA*, sanitation clinic and *Posyandu*. These community-based programs are stimulants and learning materials for the community to participate in and take responsibility for health issues in their region. The community-based health efforts are usually under the supervision of the PC. These efforts relatively fluctuate with attention availability and community resources. The role of PC is to look at the community ability and changes in disease patterns, and to be the main actor of sustainable health development.

The Government recognized how community participation play importance role. From the experience so far, it shows that community participation can lead to significant achievement of public health. So far, people are able to show their participation in maintaining a healthy environment, so the disease caused by the environment can be relatively controlled. How about the changing of diseases pattern, in term of the PC role, does it require development especially in disease control program? Also, for community participation, what can be done by the community in suppressing the incidence of disease, especially NCDs?

Research Methodology

Design: Critical Ethnography, a qualitative research approach that focuses on the nature of primary care coming up with existing work performance and situation surrounding was employed in the study.

Setting: The study was conducted at a Bukateja PC, Bukateja sub-district, Purbalingga District Central Java Province of Indonesia. The Bukateja PC with 12 beds capacity, supports the health program, especially in providing more accessible healthcare facilities and health services to people in the village, there are two sub-Puskesmas and community-based health efforts;



40 Integrated Service Posts (*Posyandu*), 6 village health posts (*Poskesdes*), and 2 posts of integrated development (*Posbindu*).

Participants: The key informants provided detailed information on the PC daily activity. The key informants were the PC staffs; minimum 2 years work experience, and willing to participate. In this study, there were 13 key informants whose age ranged from 30 to 50 years old and most of them were female. The average work experience was 12 years.

In term of triangulation, the general informants were needed. The general informants were selected to give reliability checks and validate the information given by the key informants. The general informants were the PC stakeholders; a) the patients, b) the community leaders both formal and informal, c) a group of people with specific conditions including elder people, disabled people, maternal, community health voluntary, and willing to participate in the study.

Data Collection: Observations were made against the PC daily work activities, including the health care personnel and how they run the PC program. Primary care service perform could reflect as well under participant observation.

Instruments: Semi-structured questions were used as an interview guide developed by researchers. Face validity were conducted in other health centers by interviewing the informants with the same qualifications as the samples to ensure that the instrument can be applied in real life situations. Other instruments, including tapes, tape recorders, and field notes were also used. Interview guidelines were based on the context of the nature of primary care in term of answering the need of health care from the community and what health care services should be provided by the primary care.

Informed consent was obtained and individual face-to-face interviews were scheduled according to the informants' convenience. Interviews were

conducted among the key and general informants. The interviews took place in a private room in PC for about 30-60 minutes. To interview the general informants, the researcher contacted them prior to the actual interview. The times of the interview were arranged for the general informant's convenience. The key informants introduced the general informants to the researcher and arranged the interviewing room. All interviews were recorded with the permission from the participants.

Focus Group Discussion (FGD) with the PC staff as a participant was performed several times, conducted in the PC meeting room. The FGD was conducted to clarify that the topics were relevant to the objectives of this research. Meanwhile, the FGDs with the community as a participant were performed after they had finished *Posyandu / Posbindu* activities in the community. Each FGD session consisted of 5-10 people and it was performed for not more than 90 minutes. After every FGD had been done, the researcher made summary and reflection. It aimed to provide a clearer an idea of the participants during the discussion and the things that might be required for further clarification.

Data Analysis: Data consisted of recorded field notes, artifacts, and transcripts of taped interviews in the form of Microsoft Word document. Constant comparative analysis was employed for data analysis and data processing. Constant comparative analysis techniques are the analysts who use an approach to contrasts between elements. Data processing included; a) data reduction, b) data display, and c) conclusions and data verification.

Rigor and Ethics: Ethical clearance for the study was obtained from the ethics committees of Khon Kaen University (number HE592158). The participants were given an information sheet and asked to sign the consent form. They were assured of anonymity and confidentiality. The study ensured that data were



presented in such a way that comments could not be linked to specific key informants. Rigor was ensured by observing key principles of qualitative interviewing consistent with ethnography, such as, follow-up on participants' comments, and asking for confirmation of understanding derived from the comments. Transcripts and emerging themes were shared with participants to ensure that comments had been captured accurately (member checking). Detailed field notes were written up during data collection and analysis to ensure auditability of the study. Prolonged field work also ensured that all relevant key informants were interviewed and emerging themes were fully investigated.

Result

Resetting the Priority

Health service demands were based on the need for health and projected through the gap in the health status of a community. Currently, Indonesia is facing complex health problems, through the vision of Healthy Indonesia 2010. Ministry of Health states that the people of Indonesia in the future through the development of health will be a community, a nation and a country that is characterized by its peoples living in the environment and healthy behavior, have the ability to reach the quality of health services fairly and equitably, and have a good health state.

A lot of health problems in the community that now there are so many... precisely, people talked about healthy Indonesia 2010-2015, but right now has not been reached yet, do not know how much longer this healthy Indonesia...

From observations, interviews and FGDs, the participants described that there is a change in diseases pattern. Meanwhile, the PC health profile, 2015 was recorded. The outpatient visit with NCDs symptoms was 26.06 %. Although the outpatient was still dominated by CDs such as Acute Respiratory Infection, dermatitis, diarrhea, typhoid fever, in recent

years the NCDs have increased significantly. Other data show the incidence of hypertension among the population aged 18 years and above as of 50.00%, and obesity as of 23.33%⁵.

One of the participants said:

...in Bukateja PC, there are usually 10 diseases. Yes, but the highest are usually acute respiratory infections. Even though it is not close, the possibility of non-communicable diseases is now already rising...

In the 1990s, the biggest causes of death and illness were infectious diseases such as acute respiratory infection, tuberculosis, and diarrhea. Nevertheless since 2010, NCDs such as stroke, heart, and diabetes (catastrophic disease) have had a larger proportion in health care. This is triggered by changes in community lifestyle patterns towards unhealthy lifestyles such as lack of physical activity, less consumption of vegetables and fruits, smoking and alcohol consumption⁶.

One of the participants mentioned: ... To do with diet, there are stress, hypertension, diabetes, that lifestyle... on the other hand now there is lot of fast food which does not support health. Eventually, the diseases such as hypertension, diabetes mellitus are more increased ...

The rising prevalence of chronic diseases and the multiple burdens caused by diseases is making healthcare delivery increasingly complicated. The PC availability should be able to answer the community health needs that are currently slightly shifted. The Indonesian PC gives considerable contribution to health development. The PC functions are originally more oriented to curative and rehabilitative efforts. Right now, the trends put more attention on preventive and promotive aspects.

patients who visit the PC dominant are usually for personal health, but now the government has started many programs to implement community health ... especially for the prevention ... a lot of programs in the



community, one of them; integrated health post (Indonesian acronym; *posyandu*), now usually at PC. There are also infectious disease educational programs, NCDs counseling then ... maternal nutrition, supplementary food for pregnant women. The government starts thinking to develop more community health at PC...

Actually, the PC is responsible for health care services not only for the individual health but also community health. According to the Ministry of Health, decree number 75, in the year 2014, it was stated that the PC is a health care facility that organizes the community health effort (CHE) and individual health effort (IHE) to achieve the degree of public health. The implementation of health efforts; preventive, promotive, curative and rehabilitative in the context of primary health care does not stop at the individual only. This effort will be more efficient if it involves the family and society and the environment, as an aspect that cannot be separated from the vicious cycle of health problems.

Involving the Community

Implementation of the PC program is closely related to community participation. During this time, PC establishes good communication with the community as the subject of health development. There is a forum for community participation in the health sector, namely *Posyandu*. *Posyandu* is an independent activity conducted by the community through health volunteers, implemented in the community and intended for the local community. Health volunteers are local residents who are voluntarily or designated by the village apparatus to be responsible for the *Posyandu* program.

One of the participants stated:

... almost every day, we go to the community to supervise, *Posyandu* for both children under-five and elderly... although there are already health volunteers,

people expect our arrival, sometimes there are programs such as immunizations that cannot be given by health volunteers...

Posyandu as a community-based health effort is a tangible form of community participation. The PC as a formal institution responsible for regional health development acts as facilitator and supervisor. Synchronization of community health program implementation is always done by the PC and the community. Community empowerment is also directed towards preventive and promotive efforts. Currently, the PC is trying the program called NCDs *Posbindu* (Non Communicable Diseases - Development of Integrated Post). The NCDs *Posbindu* is one of the efforts that is community based health promotion and prevention of the NCDs.

The NCDs *Posbindu* activity is actually the activity carried out by the community and for the community. The NCDs *Posbindu* is newly formed. The PC is still handling the responsibility in term of supporting them.

... *Posbindu* ...for early detection of diseases that are now developed in the community, especially for NCDs. The community has already formed *Posbindu* in each village. PC for employees began in October (2016) also began in the form of *Posbindu* ...

... because it is a pretty good NCDs program, which now the number is rising little high enough compared with their CDs. Even now, NCDs was first ranked, so to *Posbindu*. It is actually one of the factors to prevent the risk of NCDs...

The activities usually done by *Posbindu* in society are physical examination; urine test, blood test, a person's weight and height. When somebody reports bad feeling condition of their body, they will be referred to PC. Usually, the *Posbindu* will assist by PC officer even though *Posbindu* is community participation on health. The PC plays a role in terms of coaching and receiving referral service of NCDs *Posbindu* because



in principle, NCDs *Posbindu* activities include promotive and preventive efforts. However, the activities do not include treatment and rehabilitation services. NCDs *Posbindu* will refer any NCDs cases found to the PC or other health services to obtain further services.

Discussion

The epidemiologic transition comes with two groups of disease cases, CDs and NCDs. The third transition occurs in the nutritional sector. On the one hand, we are dealing with a case of the population overweight, while cases of malnutrition are still going on. The fourth transition is the pattern of behavior or lifestyle. Behavior “modern”, or rather “sedentary” starts to become second nature to society. Instant paced lifestyle, including choosing food, and less concerned about the health aspects, while others still believe the myths that are passed relating to the person’s health-illness⁷.

The diseases are preventable, and a preventive approach is the main choice to deal with. The policy of disease prevention and control at the PC is local government policy execution. District health office through the PC is the driving force and facilitator on prevention and control of NCDs risk factors that hold together the public, including civil society organizations, to make people avoid risk factors⁸. The significant role of government presented by Bongani showed the evidence of a rise in mortality and morbidity from non-communicable diseases in all strata of South African. Bongani argues the creation of a national initiative to establish sites of service excellence in urban and rural settings across South Africa⁹. According to the Regulation No. 32 2014, pertaining to Regional Government is right, authority, and duties of the autonomous regions to set up and manage with their own way and community’s interests. The region’s autonomy is directed to accelerate the realization of public welfare by improving services, empowerment and community participation. The Indonesian

constitution 1945, article 34, paragraph 3 mandates that the state is responsible for the provision of health care facilities and public service facilities¹⁰. Article number 10 explained the highest level of public health, organized integrated health efforts and comprehensive through individual and community health. The activities approach; promotive, preventive, curative and rehabilitative services are implemented in an integrated, holistic, and sustainable setting. The health care service provider is prepared by the government. One of the public services delivering in the health sector is PC.¹⁰

The term of primary care was used to describe first line health services, while the term of primary health care was used to describe a wider construct of social justice based on Alma-Ata philosophy. Alma-Ata stated that a comprehensive primary health care system “addresses the main health problem in the community, providing promotive, preventive, curative and rehabilitative services accordingly.”¹¹ Community Health Effort (CHE) becomes the main task of PC that focuses on prevention and promotion. The CHE encourages public participation involved in improving public health. Some activities cannot be separated from the mobilization and empowerment. PC together with the community, mutual synergy will ultimately result in the independence of community health. Mobilization and community empowerment is a process, while community independence is the main result.⁶

Independence of the community on health can be defined as the ability to be able to identify health problems. Community participation in health development can be measured by the increasing number of community members who want to take advantage of health services, such as health centers, sub, village health clinic, attending health education activities and willing to be a voluntary health care. Active community participation in the development process occupies a very important position. The



perception of society as “an object of development” should be replaced by the community as “a subject of development”. Communities should participate in the development process. The situation and conditions of the society should objectively determine the level of the position of its participation in the development process, not a unilateral decision of bureaucracy that always tends to forget the potential of community.

The strategic approaches to achieve a healthy society are as follow; 1) mobilizing and empowering communities in the prevention and control of risk factors for NCDs, 2) improving public access to services, early detection and prevention (treatment) of risk factors for NCDs, 3) developing and strengthening epidemiological surveillance disease risk factors, monitoring and information systems and 4) improving financing for prevention and control of the NCDs risk factors⁷. The NCDs *Posbindu* target is people with good health status, society and communities with NCDs risk. For communities with health conditions, NCDs *Posbindu* aims to provide health education and efforts in order to prevent the NCDs. For the risk people, NCDs *Posbindu* aims to recognize existing NCDs risk factors and reducing the number and intensity of these risk factors. For people with NCDs, NCDs *Posbindu* aims to control and maintain optimal health, through preventive measures such as counseling and curative treatment through a referral system to the PC.

References

1. Ministry of Health Republic of Indonesia, A Ministry Strategic Planning 2010-2014, Jakarta; 2010.
2. Ministry of Health Republic of Indonesia, 2015, Healthy Indonesia Program to Address Health Issues, Public Communication Center, The Secretary General Republic Indonesia Ministry of Health retrieved from <http://www.depkes.go.id/article/view/15020400002/program-indonesia-sehat-untuk-atasi-masalah-kesehatan.html#sthash.6hcrOqDL.dpuf>, at Januari 3, 2016
3. Rahajeng E, Noncommunicable Disease Control Efforts in Indonesia, Buletin Jendela Data dan Informasi Kesehatan, 2nd semester of 2012, ISSN 208-270X, Ministry of Health of Indonesia, Jakarta; 2012.
4. Syam AF , 2017, Disease Prevention Concept for Healthier Indonesia, retrieved from http://www.pbpapdi.org/papdi.php?pb=detil_berita&kd_berita=181, at January 2, 2017.
5. Bukateja PC, 2016, Bukateja Health Profile 2015, Bukateja Purbalingga
6. Ministry of Health Republic of Indonesia, 2011, Implementasi Primary Health Care in Indonesia retrieved December 12, 2015 from <http://www.depkes.go.id/article/view/1558/implementasi-primary-health-care-di-indonesia.html>
7. Ministry of Health Republic of Indonesia, Primary Health Care Reformation, <http://www.depkes.go.id/article/print/1382/reformasi-primary-health-care.html>, Center for Public Communication, Secretariat General of the Ministry of Health, Jakarta; 2011.
8. Government decides Healthy Living Society Movement (November 15, 2016), retrieved March 30, 2017, from <http://www.depkes.go.id/article/view/16111600003/pemerintah-canangkan-gerakan-masyarakat-hidup-sehat-germas-.html#sthash.u3F4JGML.dpuf>
9. Bongani M Mayosi, Alan J Flisher, Umesh G Lalloo, Freddy Sitas, Stephen M Tollman, Debbie Bradshaw, The burden of non-communicable diseases in South Africa, *Lancet* 2009; 374: 934–47, Published Online August 25, 2009, DOI:10.1016/S0140-6736(09)61087-4, This is the fourth in a Series of six papers on health in South Africa; 2009.
10. Hoedijono S, Suharniati, Develop Model of Independent Primary Health Center in a Decentralized Era, *Buletin Penelitian Sistem Kesehatan* 2003; Vol 6 No 2
11. Lawn Joy E, Rohde Jon, Rifkin Susan, Were Miriam, Paul Vinod K, Chopra Mickey, 2008, Alma-Ata: Rebirth and Revision 1: Alma-Ata 30 years on: revolutionary, relevant, and time to revitalize, *The Lancet*; Sep 13-Sep 19, 2008; 372, 9642; Nursing & Allied Health Database