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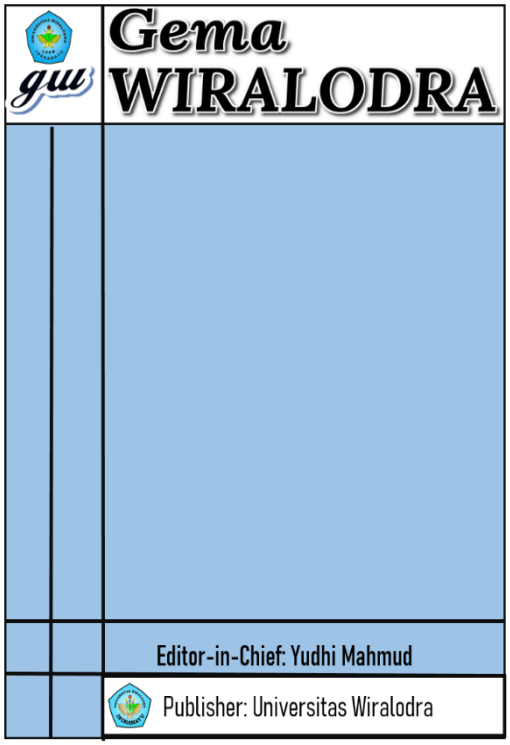

Implementation of The Clean and Healthy Living Behavior (PHBS) Fostering Program in Indramayu Regency : Case Study in The Work Area of UPTD Puskesmas Jatibarang

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Orginal Article

Implementation of The Clean and Healthy Living Behavior (PHBS) Fostering Program in Indramayu Regency : Case Study in The Work Area of UPTD Puskesmas Jatibarang

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Abstract
This study was conducted to determine the implementation of the household PHBS development program in the working area of UPTD Puskesmas Jatibarang. The research focused on motivating, facilitating, directing, communicating, and controlling aspects carried out by UPTD Puskesmas leaders and PHBS program managers in the UPTD Puskesmas Jatibarang working area, Indramayu Regency. In addition, identifying and analyzing the constraining factors in the implementation of the PHBS coaching program. This study used a qualitative method with a descriptive phenomenological approach. Samples were selected purposively, with key informants being the head of the UPTD Puskesmas Jatibarang and the PHBS program manager. Research informants were PHBS cadres, housewives, and community leaders. Data collection techniques through in-depth interviews and observations of PHBS management informants at the puskesmas level, PHBS cadres, housewives, and community leaders, as well as documentation techniques. Data analysis techniques through qualitative data analysis techniques, through data reduction, data display, and conclusion drawing/verification. The results showed that the achievement of 10 indicators of PHBS in the work area of the UPTD Puskesmas Jastibarang in 2011 had reached 82.1%, while in 2012 the program achievement was seen to increase to 90.3% or an average of 86.2% per year. However, judging from the achievement of the total percentage of healthy households in 2012 only reached 36.4% or decreased compared to 2011 which had reached 56.3% of healthy households, so that the PHBS program in the family setting has not been fully effective. There are still internal and external constraints in the management of the PHBS program, as well as the need for coordination and synergistic cooperation with cross-program, cross-sector and other related.

Keywords: Policy Implementation, Fostering Program, PHBS, Households, UPTD Puskesmas

1. Introduction

Clean and Healthy Living Behavior (PHBS) is still an interesting topic to study until now. Health development aims to increase awareness, willingness and ability to live a healthy life for everyone in order to realize the highest degree of public health, as an investment for the development of socially and economically productive human resources. Health itself is a state of well-being of the body, soul and social that allows everyone to live a socially and economically productive life (Central Bureau of Statistics, 2011). Meanwhile, the degree of health is not only determined by health services, but more dominant are environmental conditions and community behavior (Ministry of Health of the Republic Indonesia, 2011).

One of the efforts of the Government of Indonesia to change people's behavior to support the improvement of health status is through the Clean and Healthy Living Behavior (PHBS) development program implemented by the Ministry of Health since 1996. PHBS is any behavior that is carried out on awareness of the results of learning, which makes a person, family, group or community able to help themselves (independently) in the field of health and play an active role in realizing public health (Ministry of Health RI, 2011). PHBS has 5 (five) scopes, namely

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PHBS in household settings, workplaces, health facilities, educational institutions, and public places.

Household PHBS is one of the indicators to assess the performance of district/city governments in the health sector, namely the achievement of 70% healthy households. Based on the results of the Basic Health Research (2013) shows that the national proportion of households with good PHBS is 32.3%, with the highest proportion in DKI Jakarta (56.8%) and the lowest in Papua (16.4%). There are 20 out of 33 provinces that still have good PHBS households below the national proportion.

Services and guidance in the health sector are one of the mandatory government affairs that are the responsibility of the District / City Health Office. In the context of equitable distribution of health services and public health guidance, basic health service facilities have been built, namely the Technical Implementation Unit (UPTD) of the Community Health Center, hereinafter referred to as UPTD Puskesmas. In Indramayu Regency, the UPTD Puskesmas is currently formed based on Indramayu Regent Regulation Number 7 of 2009 concerning the Establishment of Service Technical Implementation Units (UPTD) and Agency Technical Implementation Units (UPTB) within the Indramayu Regency Government, with an organizational structure and work procedures based on Indramayu Regent Regulation Number 15 of 2009 concerning Organization and Work Procedures of UPTD Puskesmas at the Indramayu Regency Health Office. UPTD Puskesmas has the task of carrying out technical operations and technical support at the Service in the health sector led by the head of UPTD and is under and responsible to the head of the Service. UPTD Puskesmas has functions, including the implementation of guidance on community-sourced health efforts (UKBM) and efforts to empower individuals, families, and communities to play an active role in every health effort.

In the context of implementing the UKBM coaching function as well as efforts to empower individuals, families, and communities to play an active role in every health effort, in this case including at the UPTD Puskesmas Jatibarang, a PHBS coaching program at the Household level has been prepared and implemented. One evaluation of the success of PHBS coaching is done by looking at PHBS indicators in the household setting (Ministry of Health RI, 2011). Based on the results of data collection of 10 indicators of PHBS in households in the working area of UPTD Puskesmas Jatibarang in 2011 and 2012, it is known that in 2011 it has reached 82.1%, while in 2012 the program achievement increased to 90.3% or an average of 86.2% per year. However, judging from the achievement of household status, it shows a decrease in the percentage of healthy households in 2012, which only reached 36.4% compared to 2011 which had reached 56.3%. Thus it can be said that the implementation of the PHBS coaching program in the household has not been fully achieved effectively.

For this reason, it is necessary to conduct research with a focus on the implementation of the PHBS coaching program in Households, especially in the aspects of motivating, facilitating, directing, communicating, and controlling carried out by UPTD Puskesmas leaders and PHBS program managers in the working area of UPTD Puskesmas Jatibarang, Indramayu Regency. In addition, identifying and analyzing the constraining factors in the implementation of the PHBS coaching program. The purpose of this study was to determine the implementation of the PHBS coaching program in households in the working area of the UPTD Puskesmas Jatibarang, Indramayu Regency, identify obstacle factors in the implementation of the PHBS coaching program and efforts to overcome them.

2. Theoretical Basis

The State Administration Agency of the Republic Indonesia (2003) defines a program as a collection of systematic and integrated activities to obtain results carried out by one or several

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government agencies or in the context of cooperation with the community, in order to achieve certain goals. The success of the program carried out by the UPTD Puskesmas is closely related to the policies of government agencies, both the Central Government, Regional Government and related agencies. In that framework, it is also necessary to identify the relationship between policies that have been determined with programs and activities before they are implemented. The policy needs to be reviewed in advance to ensure that the policies that have been set can actually be implemented.

Based on the PHBS guidelines issued by the Indonesian Ministry of Health (2011), PHBS in Households is an effort to empower household members to know, want and be able to implement clean and healthy living behaviors, and play an active role in the health movement in the community. The purpose of PHBS in Households is carried out to achieve healthy households. Healthy households are households that practice 10 (ten) PHBS in Households, namely: (1) childbirth assisted by health personnel, (2) exclusive breastfeeding, (3) weighing babies and toddlers, (4) using clean water, (5) washing hands with clean water and soap, (6) using healthy latrines, (7) eradicating larvae at home, (8) eating fruits and vegetables every day, (9) doing physical activity every day, and (10) not smoking in the house.

The benefits of healthy households, especially for households include: (1) Every family member becomes healthy and does not get sick easily, (2) Children grow up healthy and smart, (3) Family members are active at work, (4) Household expenses can be aimed at meeting family nutrition, education and business capital to increase family income. Meanwhile, the benefits for the community include: (1) The community is able to strive for a healthy environment, (2) The community is able to prevent and overcome health problems, (3) The community utilizes existing health services, and (4) The community is able to develop community-sourced health efforts (UKBM), such as Posyandu, maternity savings, arisan latrines, village ambulances, and others.

According to Blum (Notoatmodjo, 1993), health status is influenced by 4 (four) factors, where the environment and behavior have an important role in influencing health status, in addition to health service factors and heredity. According to Lawrence W. Green (1991), behavior and lifestyle are influenced by three factors, namely predisposing, enabling, and reinforcing factors. Predisposing factors concern a person's knowledge, attitudes, beliefs, beliefs, values and perceptions which form the basis of individual or group motivation to act. Enabling factors are manifested in the physical environment, resources needed to support behavior, such as the availability of health care facilities, officers, affordability and distance. While reinforcing factors are factors that determine whether health actions get support or not and can be realized through the attitude and behavior of officers in a service. He added, besides being influenced by these three factors, behavior and lifestyle can be influenced by the surrounding environment, economy, income, and others to create PHBS. All these factors must support each other in order to realize clean and healthy living behavior.

The existence of the work implementation (program) itself, according to George R. Terry (Syafiie, 2011) states that: Actuating is setting all members of the group to want to achieve and to strike to achieve the objective willingly ang keeping with the mangerial planning ang organizing efforts. Thus, for a UPTD Puskesmas leader, the implementation of the work program is the pinnacle of his administrative managerial. According to Syafiie (2011), in implementing the work program, there are functions, namely: (1) Motivating (providing encouragement of work enthusiasm); (2) Facilitating (providing facilities and infrastructure to be able to work); (3) Directing (providing direction to subordinates to be able to work); (4) Communicating (providing a clear explanation of what is done); (5) Controlling (providing supervision so that it is not wrong to work). Therefore, the successful implementation of the PHBS coaching program in households can be determined by motivating, facilitating, directing,

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communicating, and controlling factors carried out by UPTD Puskesmas leaders and effective PHBS program managers according to their authority, main tasks and functions.

3. Method

This study used a qualitative method with a descriptive phenomenological approach. Samples were selected purposively, with key informants being the head of UPTD Puskesmas Jatibarang and the PHBS program manager. Meanwhile, the research informants were PHBS cadres, housewives, and community leaders. Data collection techniques were conducted through in-depth interviews and observations of PHBS management informants at the puskesmas level, PHBS cadres, housewives, and community leaders (Cassell & Symon, 1994), as well as documentation. Data analysis techniques were carried out with qualitative data analysis techniques (Sugiyono, 2011). Activities in data analysis, namely data reduction, data display, and conclusion drawing / verification. The location of this research was carried out in the work area of UPTD Puskesmas Jatibarang at the Indramayu Regency Health Office. This research was conducted in 2013.

4. Results and Discussion

General Description of Research Objects

a) Geographical Conditions

The working area of UPTD Puskesmas Jatibarang has an area of 2,281.77 Km2, which includes 8 (eight) villages, namely Sukalila, Pilangsari, Jatibarang Baru, Bulak, Bulak Lor, Jatibarang, Kebulen, and Pawidean Villages. The distance from the farthest village to the Puskesmas location is about half an hour, while the distance from the Puskesmas to the capital of Indramayu Regency is about 17 Km or about 1 (one) hour. The distance to the Indramayu Regency General Hospital is about 17 Km, and the distance to Zam Zam General Hospital is about 3 Km. Geographical situation by village in the working area of UPTD Puskesmas Jatibarang as shown in Table 1.

Table 1.
Geographical Situation

No.	Village	Area (Km2)	Number of RT/RW	Travel Distance to Health Center	Average Travel Time
1.	Sukalila	5,50	27/8	6 Km	30 Minute
2.	Pilangsari	3,69	33/8	3 Km	15 Minute
3.	Jatibarang Baru	1,40	32/11	3 Km	25 Minute
4.	Bulak	2,79	19/6	5 Km	30 Minute
5.	Bulak lor	5,50	27/8	6 Km	30 Minute
6.	Jatibarang	3,69	33/8	3 Km	15 Minute
7.	Kebulen	1,40	32/11	3 Km	25 Minute
8.	Pawidean	2,79	19/6	5 Km	30 Minute

Source: UPTD Puskesmas Jatibarang (2013)

b) Demographic Conditions.

The total population in the working area of UPTD Puskesmas Jatibarang in 2011 reached 44,443 people, consisting of 22,090 men and 22,353 women, with an average population density of 4 people per Km2. The total population based on age groups, recorded age 0-12 months as many as 1,047 babies, age 12-35 months as many as 860 children, age 36-59 months

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as many as 2,049 toddlers. While the age of 5-44 years is 27,160 people, the age of 49-59 years is 9,131 people, while the age above 60 years is 4,196 people.

Based on the comparison of the 2011 population by age group, the productive age ranks first, so that the number of vulnerable groups for the next year will increase, due to the increase in pre-elderly, elderly and elderly. Meanwhile, the number of poor people in the working area of UPTD Puskesmas Jatibarang in 2011 (table 2) was recorded at 22,747 people with 2,901 families.

Table 2.
Number of Poor People in the Jatibarang Distric

No.	Villges	2011	
		Jiwa	KK
1	Sukalila	3.294	841
2	Pilangsari	4.114	1.339
3	Jatibarang Baru	3.187	883
4	Bulak	2.492	792
5	Bulaklor	3.168	1.007
6	Jatibarang	1.129	365
7	Kebulen	2.419	668
8	Pawidean	2.945	861
	Total	22.747	2.901

Source: UPTD Puskesmas Jatibarang (2013)

The number of residents based on the level of education completed, it can be seen that there are still many people who do not finish elementary school and finish elementary school as much as 32%. However, the community members easily understand what the officers convey in counseling, and the community still cares about health because of the amount of information they receive either through print media, television or any media, including cooperation between the health sector and other sectors related to the health sector. As for the livelihoods of the population, there are still people who do not have a fixed income. With the policy that all services at the Puskesmas are free or at no cost, the community can get health services easily and is not too burdened.

c) Condition of Health Workers and Supporting Infrastructure UPTD Puskesmas

1) Health Workers

The number of employees at UPTD Puskesmas Jatibarang, both civil servants and employees, can be seen in the table below.

Table 3.
Number of Health Workers at UPTD Puskesmas Jatibarang

No.	Type of Health Personnel	Total
a.	**Civil servants / PTT**	
1	Doctor	1
2	Dentists	1
3	Community Health Center Midwives	4
4	Village Midwives	4
5	Nurses	14

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No.	Type of Health Personnel	Total
6	Dental Nurse	1
7	Nutrition	1
8	Community Healt	1
9	Laboratory	1
10	Pharmacy	1
11	Health Crafts	1
12	Administration	2
	Total	33
b. PTT Power:		
1.	Doktor	0
2.	Village Midwife	5
	Total	5
c. Sukwan Power:		
1.	Nurses	2
2.	Dental Nurse	-
3.	Administration	1
4.	Driver	0
5.	Cleaning Service	1
6.	Office Guard	1
	Total	5
Total		**43**

Source: UPTD Puskesmas Jatibarang (2013)

From the table above, the health workers at the UPTD Puskesmas Jatibarang are still quite limited, especially the number of nurses available, so they have not been able to carry out activities optimally with other activities and programs.

2) Supporting Facilities and Infrastructure

Supporting facilities and infrastructure at the UPTD Puskesmas Jatibarang include the Puskesmas building as the main facility, as well as other facilities and infrastructure. Puskesmas Jatibarang has 1 Main Puskesmas building located in Jatibarang Village, including outpatient rooms (BP Dental Set Dental Unit, KIA, BP General, MTBM / MTBS, Usila, DIDTK, Simple Lab, Counseling, PKRET, General ER, 1 Blangkar, 2 Bad Action, Furniture and Archive Cabinets), Obstetrics ER (Partus Set 1 Set, 2 Bad Obgyne, 2 Bad Genikolog), 2 Pustu, 2 Poskesdes Building, 3 computers. 1 four-wheeled vehicle, 5 two-wheeled vehicles, data board and medicine cabinet.

The number of Posyandu in UPTD Puskesmas Jatibarang is 58. All Posyandu have Posyandu buildings with each Posyandu having 5 active cadres. Posyandu cadres have a cadre forum formed by the UPTD Puskesmas Jatibarang. The formation of the cadre forum is expected to accommodate difficulties and share experiences with existing cadres. The number of cadres is sufficient even though the ability is not optimal, due to the frequent turnover of cadres. The development or addition of cadres' knowledge about the tasks they perform at the posyandu is carried out every 2 times a year and the activities are carried out by the cadre forum accompanied and facilitated by UPTD Puskesmas officers.

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Orginal Article

Implementation of PHBS Development Program in Households at UPTD Puskesmas Jatibarang

The discussion of the implementation of the PHBS development program in this study will first describe the achievement of 10 indicators of PHBS based on the results of data collection in target households in the working area of UPTD Puskesmas Jatibarang which includes 8 (eight) villages, namely Sukalila Village, Pilangsari, Jatibarang Baru, Bulak, Bulak Lor, Jatibarang, Kebulen and Pawidean in 2011 and 2012. The achievement of PHBS indicators in these households is shown in Table 4 below.

Table 4
Results of Data Collection in Households according to PHBS Indicators in the Working Area of UPTD Puskesmas Jatibarang in 2011 and 2012

No.	Description of PHBS Indicators	2011	%	2012	%	Means (%)
1.	Childbirth	13	100	56	100	100
2.	Providing exclusive breast milk	11	53,4	76	91,5	69,7
3.	Considering	107	90,6	616	98,7	87,5
4.	Use clean water	399	99,7	1327	94,7	93,6
5.	Wash your hands with clean water and soap	388	97,0	1357	96,9	96,9
6.	Use a healthy toilet	295	73,7	1372	98,0	85,9
7.	Eradicating larvae at home	321	80,2	1305	93,2	86,7
8.	Eat fruit and vegetables every day	374	93,5	1383	98,8	96,2
9.	Carry out physical activity every day	343	85,7	1306	93,2	89,2
10	No smoking in the house	181	47,2	533	38,1	42,65
	Total	**-**	**82,1**	**-**	**90,3**	**86,2**

Source: UPTD Puskesmas Jatibarang (2013)

Table 4 shows that the success of the PHBS program from the achievement of 10 PHBS indicators shows that the average achievement of program implementation has only reached 86.2%. While seen based on the budget year, that in 2011 only reached 82.1%, while in 2012 the program achievement was seen to increase to 90.3%. In addition to being seen from the achievement of the PHBS indicators mentioned above, the achievement of the PHBS program in households can also be seen from the aspect of achieving household status in Table 5.

Table 5.

Status of Households according to the Results of Data Collection in Households at UPTD Puskesmas Jatibarang Fiscal Year 2011 and 2012

No.	Household Status	Fiscal year				Means
		2011	%	2012	%	(%)
1.	Healthy	225	56,3	509	36,4	**46,35**
2.	Not Healty	175	43,7	891	63,6	**53,65**

Source: UPTD Puskesmas Jatibarang (2013)

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Table 5 shows that the average achievement of household status based on the results of household data collection in the 8 (eight) villages mentioned above, in terms of household status, is an average of 46.35% classified as healthy households, while the remaining 53.65% are classified as unhealthy households. Even in quantity, based on the available data, this shows a decrease in the quality of the program's achievements, because on the other hand there was a decrease in the percentage of healthy households in 2012, which was only 36.4% compared to 2011, which had reached 56.3%.

Furthermore, to analyze the implementation of the PHBS development program at the household level at the UPTD Puskesmas Jatibarang in this study, the discussion can be described based on the dimensions of the research variables as follows:

1) Motivating

The motivating function in the implementation of the PHBS coaching program in households seems to have gone well. This function is carried out through providing motivation and work enthusiasm by the head of the UPTD Puskesmas to subordinate elements. The encouragement of work enthusiasm can be seen from indicators in providing work motivation to subordinates, encouraging comfort at work, and giving awards.

a) Providing work motivation to subordinates.

Providing work motivation to subordinates by UPTD leaders in implementing the PHBS development program in Households, it seems that this indicator is a fairly important working capital. This effort, in addition to being able to provide a fairly good working spirit to subordinates (implementing employees) at UPTD Puskesmas, also seems to provide its own motivation to other parties involved in the implementation of the PHBS program. The results of interviews with implementing elements and several PHBS cadres in several villages in general, stated: “In several meetings conducted by the UPTD Puskesmas Jatibarang, the head of UPTD Puskesmas always motivates all of us so that each implementing element and PHBS cadres can work well, so that the goals and objectives of PHBS can be realized effectively.”

From the description above, the head of the UPTD Puskesmas always makes efforts to encourage the spirit of work, especially in the implementation of the PHBS program at the household level both to his subordinates and to other parties involved. This includes the PHBS Cadres in the villages in his working area. These efforts are made by utilizing meetings and other activities, both held at the UPTD Puskesmas level and at the village level, both held at the UPTD Puskesmas level and at the village level so as to support every effort to implement the PHBS program. Efforts to provide motivation and enthusiasm are in line with the concept of service leaders whose main focus is to appreciate and develop employees according to their talents, ... the results cause employees to give their best efforts and efforts for the organization. Employees will serve consumers wholeheartedly, as if employees are the owners of the organization (Rewansyah, 2011).

b) Encouraging comfort at work.

In addition to encouraging motivation at work, it can also be seen that the head of the UPTD Puskesmas in implementing the PHBS program in Households also encourages comfort at work. Thus it can be said that in the implementation of the PHBS program in Households at the UPTD Puskesmas Jatibarang, as the leader or Head of UPTD always encourages comfort at work, so that the program can be realized as previously expected.

c) Awarding.

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Another important indicator in the implementation of the PHBS program in Households, namely the provision of awards by UPTD leaders. It can be seen that the awarding, although limited to giving praise for good work and sincere dedication to PHBS cadres, it seems that such awarding efforts are still quite effective in encouraging and providing work enthusiasm, especially to PHBS cadres in the villages. Meanwhile, the awarding of awards by UPTD leaders to employees does not appear to be a real effort to give awards. In addition, they also make efforts in the form of giving reprimands to employees to their subordinates, if they are seen to be unable to carry out their duties and responsibilities properly.

Providing motivation in the form of support from health workers is one of the predisposing factors of the formation of a person's behavior, where people who get support from health workers continuously will tend to behave in accordance with the information received (Notoatmodjo, 2010). Meanwhile, support by the Puskesmas for adequate programs and training to cadres can improve the empowerment process by cadres, so as to increase the coverage of households with PHBS in the Puskesmas area (Aslichah, N. (2011). According to the Ministry of Health of the Republic of Indonesia (1999), household PHBS indicators are indicators related to clean and healthy living behavior in households, prioritized in 5 (five) programs, namely maternal and child health (MCH), nutrition, environmental health, lifestyle and participation in health efforts, especially JPKM (community health maintenance insurance).

This is in line with the main tasks and functions of the UPTD Puskesmas which is expected to support the implementation of the PHBS development program optimally. Efforts to improve PHBS are carried out through meetings, health counseling, and community empowerment in improving the implementation of 10 indicators of PHBS in the family setting, although in general the results are still not optimal, including seen from the achievement of the number of healthy households in 2012 (36.4%), even decreased from the achievement in 2011 (56.3%). These efforts have various challenges or obstacles, because they are closely related to behavioral problems, while behavioral problems are complex problems.

2) Facilitating

The implementation of the PHBS coaching program in Households is also inseparable from the existence of facilities and infrastructure that support the implementation of the program (facilitating), including other UPTD Puskesmas Jatibarang work programs, including being supported by adequate work facilities and work facilities and infrastructure that are sufficiently supportive.

a) Work facilities

Among the work facilities of the UPTD Jatibarang as described earlier, which is also a supporter in the implementation of the Household PHBS program at the UPTD Puskesmas Jatibarang, among others, is the UPTD Puskesmas building with all its supporting equipment. The Jatibarang Main Puskesmas, which is located in Jatibarang Village, has rooms such as for outpatient services, consisting of BP dental room, dental unit, KIA, BP general, MTBM / MTBS, Usila, DIDTK, simple lab, counseling, PKRET, general ER, with the support of 1 Blangkar, 2 bad actions, furniture and filing cabinets). In addition, there is an Obstetric ER, which includes 1 Partus Set, 2 bad Obgyne 2 bad Genicologist), supported by 2 Pustu, 2 Poskesdes building, 3 computers, as well as 1 four-wheeled vehicle, 5 two-wheeled vehicles, and other equipment such as data boards and medicine cabinets.

b) Work facilities and infrastructure

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To support the implementation of the PHBS program in Households, it seems that it has also been supported by adequate work facilities and infrastructure. These working facilities and infrastructure include institutional aspects, funding, and other aspects. In terms of institutions in the implementation of the PHBS program in Households, in addition to the existence of institutions that handle the program, namely elements of the UPTD Puskesmas Jatibarang, especially UPTD Puskesmas elements that are incorporated in the implementation of community-sourced health efforts (UKBM), as well as efforts to empower individuals, families, and communities.

Meanwhile, at the Jatibarang Sub-district level, the implementation of the Household PHBS program has been supported institutionally, namely by the issuance of the Decree of the Jatibarang Sub-district Head of Indramayu Regency Number 440/606/Kec.Jtb/2012 concerning the Establishment of the Healthy Village/Kelurahan Communication Forum on November 20, 2012. The communication forum is a forum for the community that has the main task of channeling aspirations and participation, as well as determining the direction, priorities, planning of the Jatibarang Sub-district area, and integrating various aspects so as to realize safe, comfortable, clean and healthy conditions.

The tasks of the Healthy Village Communication Forum are: (a) Forming and fostering healthy village working groups at the village/kelurahan level; (b) Formulating proposals, priorities, targets, planning and evaluating the development of healthy villages; (c) Seeking and channeling sources of financing that cannot be covered by the forum and working groups, so other sources are sought, such as from NGOs, the private sector, and the government; (d) Coordinating the implementation of activities to be carried out by the community, government and non-government elements so that they can be carried out effectively and efficiently; (e) Socializing, promoting and disseminating the Healthy Indramayu District program; (f) Carry out other activity efforts in order to realize the Distric as a healthy area.

The membership structure of the Jatibarang Sub-district Healthy Village Communication Forum consists of a supervisor (Jatibarang Sub-district Head), steering committee (Jatibarang Sub-district Muspika, Head of KUA Jatibarang Sub-district, Chairman of MUI Jatibarang Sub-district, Secretary Jatibarang Sub-district, Head of UPTD Puskesmas Jatibarang, and Head of UPTD Puskesmas Jatisawit), chairman (Head of UPTD Puskesmas Jatibarang) vice chairman (Head of UPTD Puskesmas Jatisawit), secretary and treasurer. In addition, there are elements of the Field, namely the health sector, the field of counseling and fostering community participation, the field of environmental development, the field of order development, the field of evaluation and development, and the field of fundraising, each of which consists of a chairman, vice chairman, and three members.

The existence of local-level community organizations reflects the dynamics of society in an area. The variety of activities and dynamic roles played by local organizations shows the dynamics of the problems faced by the community (Muluk, 2007). However, the role of other community organizations, such as village community empowerment institutions (LPMD), PKK, neighborhood associations (RT), neighborhood associations (RW) in supporting the implementation of the PHBS development program is still not fully effective, so it needs to be facilitated by the village government, sub-district, and UPT Puskesmas.

From the aspect of funding in the implementation of the PHBS program in the household, so far it is still quite limited, which is only supported by the Indramayu District Budget. However, in its operation, not every fiscal year, the PHBS coaching

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program in the Household receives a budget. Meanwhile, funding for the UPTD Puskesmas Jatibarang itself comes from the APBN, Provincial APBD, District APBD, Askes, Jamsostek and Jamkesmas. In supporting PHBS operations at the community level, the need for organizational resources derived from donations, dues, levies and so on that are designed by its members according to the activities and interests of the group (Muluk, 2012).

In other aspects, especially to mobilize community participation in the implementation of the PHBS program in the household, there is a PHBS cadre forum. As is known, until now in each village in the working area of UPTD Puskesmas Jatibarang has had an average of 5 (five) active cadres. The duties of these cadres include collecting data, conducting socialization, and making other efforts so that community members have a clean and healthy lifestyle according to their respective working areas.

3) Directing

Aspects of the directing function in the implementation of the PHBS coaching program in Households are seen that the leader / Head of UPTD Puskesmas continues to provide guidance and instructions to subordinates which are quite effective, in addition to seeking unity of interest.

a) Providing guidance and instructions to subordinates.

Providing guidance and instructions to subordinates by UPTD Puskesmas leaders, including in the implementation of the PHBS program in Households is an important indicator, so that the PHBS program can be implemented. From the interview, it is clear that to achieve the implementation of the PHBS program in Households, the UPTD Puskesmas leaders make efforts to provide guidance and instructions to subordinates. Meanwhile, the same thing has also been done by providing guidance, especially to PHBS cadres who are scattered in villages in the working area of the UPTD Puskesmas Jatibarang.

Thus, the achievement of the implementation of the PHBS program in the Household, it appears that one of them is determined by the efforts to provide guidance and instructions to subordinates, including to PHBS cadres in the villages from the UPTD Puskesmas leadership element as well as by the PHBS program management element at the UPTD Puskesmas level.

b) Striving for unity of interest.

Another important indicator in the implementation of the PHBS program in Households is trying to ensure that there is unity of interest by the Head of UPTD Puskesmas Jatibarang. This condition can be seen from the efforts of the UPTD Puskesmas leadership starting from planning activities, implementation and evaluation of the program. In planning activities, UPTD leaders always direct especially to subordinate employees to always be guided by applicable regulations, for example according to the joint regulation of the Minister of Home Affairs and the Minister of Health Number 34 of 2005, and Number 1138/Menkes/PB/viii/2005 concerning the Implementation of Healthy Districts / Cities, activities need to be carried out by empowering the community, and carried out through healthy village / kelurahan communication forums or functioning existing community institutions. This means that the UPTD leadership has focused on the unity of interest so that the PHBS program can support the existence of healthy villages.

In relation to the implementation and evaluation of activities, it appears that the Head of UPTD Puskesmas also continues to strive for unity of interest, namely the achievement of the PHBS program by including the vision and mission of UPTD

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Puskesmas Jatibarang, one of whose missions is to realize healthy living behavior in the community.

4) Communicating

The Communicating aspect in the implementation of the PHBS coaching program in Households has several indicators, such as the division of tasks and the delegation of authority, which looks quite good.

a) Division of tasks

Division of tasks is an important aspect in any organizational activity, including at the UPTD Puskesmas Jatibarang. With the division of tasks, the position of the elements involved will be seen, especially regarding their main duties and functions, including in supporting the success of the PHBS development program. Based on existing information from elements of the UPTD Puskesmas Jatibarang, a description of the division of tasks in the implementation of the PHBS program in Households can be described as the main tasks and functions of the relevant elements, namely:

a) The Head of the UPTD Puskesmas has the task of leading, coordinating, and controlling programs at the UPTD Puskesmas according to his authority, especially in implementing comprehensive health services to the community in his working area. The Head of UPTD Puskesmas Jatibarang, has functions, among others:
   - preparation of UPTD Puskesmas work plans and programs according to their working area;
   - formulation of technical policies in the field of health;
   - organizing guidance and counseling in the health sector;
   - organizing services in the health sector;
   - organizing operational technical activities in the health sector;
   - organizing functional technical in the health sector;
   - organizing administrative guidance for UPTD Puskesmas;
   - organizing communication, coordination, consultation and cooperation in the Health sector.

b) Sub Division of Administration.

The Sub Division of Administration has the task of implementing, coordinating, and controlling tasks in the field of management, secretarial services which include coordinating program planning, managing general affairs, equipment, staffing and financial management. The Head of Administration Subdivision has functions, among others:
   - preparation of plans, and operational work programs for financial management activities, and general administrative services, housekeeping, and equipment as well as management of personnel administration;
   - implementation of management, and administration of official correspondence;
   - preparation of materials for fostering organization and management;
   - implementation of management and control of official travel administration;
   - implementation of protocol services, public relations and organizing UPTD Puskesmas meetings.

c) Administrative Executive.

The Administrative Executive has the main task of assisting the task of the Administration Subdivision to carry out administrative activities, program

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planning, management of public affairs, personnel administration, finance and equipment. The Administrative Executive has functions:

- implementation of the preparation of work programs and activity schedules;
- implementation of correspondence management, official travel, household, public relations and protocol;
- implementation of management of personnel administration, finance, equipment and maintenance;
- implementation of other official duties in accordance with the field of duties and functions.

d) The Operational Executive has the task of supporting the implementation of health services in accordance with the work program and schedule of activities that have been determined. Operational Executives have functions, among others:

- Implementation of mandatory health effort services consisting of: health promotion efforts, environmental health efforts, maternal and child health efforts and family planning, community nutrition improvement efforts, efforts to prevent and eradicate infectious diseases and treatment efforts.
- Implementation of development health effort services consisting of: school health efforts, sports health efforts, community health care efforts, occupational health efforts, dental and oral health efforts, mental health efforts, eye health efforts, elderly health efforts, and traditional medicine development efforts.
- Implementation of supporting services, namely: laboratory efforts (medical and public health), and implementation of the Puskesmas recording and reporting system (SP3).
- Implementation of community-sourced health coaching (UKBM) and efforts to empower individuals, families and communities to play an active role in every health effort.
- Implementation of referrals for individual health and public health efforts.

b) Delegation of authority.

The implementation of the PHBS program in Households in the work area of the UPTD Puskesmas Jatibarang also shows good delegation of authority. This can be seen from the work procedures that have been established at the UPTD Puskesmas Jatibarang. Delegation of authority is reflected in the implementation of tasks by implementing the principles of coordination, integration, synchronization and simplification vertically and horizontally. The Head of UPTD Puskesmas leads and coordinates his subordinates and provides guidance, control, instructions for the implementation of his duties.

The Head of UPTD Puskesmas conducts functional cooperative relationships in accordance with the structure and level of positions that apply vertically and horizontally. In addition, follow and comply with instructions, and be responsible to the Head of the Health Office and submit reports on time. Every report received by the Head of the UPTD Puskesmas from his subordinates is processed and used as the preparation of further reports, and to provide instructions to his subordinates. In submitting reports, copies are submitted to the Head of the Sub-District in their working area, and other organizational units that have a functional working relationship. In the event that the Head of the UPTD Puskesmas is unable to carry out his duties, he can appoint the Head of the Administration Section or one of the Non-

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Structural Staff or Functional Position Groups in accordance with the field of duty by taking into account the seniority of his rank.

5) Controlling

The implementation of the controlling function in the implementation of the PHBS coaching program in Households, the indicators can be seen from the efforts of the UPTD Puskesmas leadership in striving for activities to be carried out according to plan, evaluating plans with implementation, and making corrective efforts.

a) Striving for activities to be carried out according to plan.

To achieve the goals and objectives of the implementation of the PHBS guidance program in Households, it appears that the leadership of the UPTD Puskesmas Jatibarang always strives for these activities/programs to be carried out according to the original plan. Program/activity planning has been carried out before an activity is carried out according to the main tasks and functions of the UPTD Puskesmas. Planning should be the basis for plan implementation as well as a tool for evaluation. However, when associated with the concept of participatory development planning, which is a model of development planning that includes the community (Nurcholis, 2009), it has not yet been realized. Ideally, the community should be actively involved in identifying problems, formulating problems, finding alternative solutions to problems, developing a solution agenda, engaging in the process of conversion, monitoring implementation, and actively participating in evaluation. Meanwhile, the conditions and practices in the field, including planning in the PHBS development program, still do not support the participatory planning. On the other hand, the involvement and participation of the community in the planning of PHBS programs, it is expected that the community will be responsible for the implementation of the plan and its evaluation (Cokroamidjojo, 1995).

Based on the general data of UPTD Puskesmas Jatibarang in 2012, the target population of PHBS program in 2012 included poor families and community members in general spread across 8 (eight) villages in the working area of UPTD Puskesmas Jatibarang. Meanwhile, the main health service targets include pregnant women as many as 1320 people, maternity/postpartum as many as 1201 people, neonatal and infants as many as 2553 infants, and toddlers as many as 5623 children under five. From the data, it is known that the implementation of the PHBS development program plan that conducts 10 PHBS has been quite good, which on average reaches 86.2% per year, where in 2011 it has reached 82.1%, while in 2012 the achievement of the program rose to 90.3%.

Based on the results of interviews with several community leaders and housewives who became the target group in general explained that in the implementation of the PHBS guidance program in Households in the working area of the UPTD Puskesmas Jatibarang, in general, the Puskesmas leadership has strived for the activities/programs to be carried out according to the original plan, although in its implementation there are still obstacles, including the lack of public awareness that needs to be fostered, and developed continuously by related parties, in addition to limited personnel and budget.

b) Evaluating plans with implementation.

In the implementation of the PHBS coaching program in Households, there are also efforts to evaluate the plan in its implementation. The implementation of the evaluation of the PHBS program in Households in the working area of the UPTD Puskesmas Jatibarang is carried out at the time of planning and at the end of program implementation in the current fiscal year. The evaluation, in addition to aiming to

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determine the extent of the success and failure of existing programs/activities, is also to determine feedback for further planning. However, it appears that the evaluation has not involved all existing stakeholders, one of which is due to budget constraints.

c) In the implementation of the PHBS guidance program in Households in the working area of the UPTD Puskesmas Jatibarang, efforts have also been made to improve, both planning, implementation, and evaluation. However, the improvement efforts made adjust to the existing conditions. Every program in the UPTD Puskesmas Jatibarang has made continuous improvement efforts, especially related to aspects of human resources as the implementer, in addition to human resources (community) who are the targets and objectives of the PHBS coaching program that has been implemented.

Obstacle Factors for the Implementation of the PHBS Guidance Program in Household Settings

The constraining factors for the implementation of the PHBS coaching program in the Household setting at the UPTD Puskesmas Jatibarang can be identified as follows:

1) There are still limited health workers in the UPTD Puskesmas Jatibarang. Based on current data, the UPTD Puskesmas Jatibarang has 33 civil servants, 5 PTT staff, and 5 sukwan staff. In terms of quantity, the condition of the implementing staff looks sufficient, but when viewed in terms of quality there is still a gap, because not all implementing staff can carry out their duties and functions optimally, especially with the existence of programs that come quite a lot, both from the central government, provincial government, and district government.
   From the results of interviews with informants, it is known that knowledge related to community participation in health efforts is still low. Meanwhile, to foster community participation in order to grow the need for the importance of PHBS, there is a need for mobilizers, both formal and informal personnel in the community (Gelberding, (2004). The classic obstacle raised from the PHBS manager informants at the Puskesmas level is that they work concurrently not only managing PHBS activities. The lack of staff who have health promotion education is a separate problem that hampers the process of implementing PHBS. Meanwhile, support from cross-programs and cross-sectors, both at the Puskesmas and district levels, is also still lacking.
2) The implementation of PHBS program socialization activities by the UPTD Puskesmas Jatibarang is still limited, so that it does not reach all existing target groups. This condition can be seen from the fact that there are still target groups of the program that have not been reached due to various factors, such as the lack of awareness of the target family members of the program to participate in socialization activities and other activities that are a series of PHBS activities at the household level. Meanwhile, there are limitations from health implementers to conduct socialization continuously and continuously.
   On the other hand, there is a need for health promotion that can provide learning to the community in order to have knowledge or understanding, ability and willingness starting from the individual, family, group or community level to carry out PHBS. These conditions can affect the effectiveness of increasing the role of health education, changing community attitudes, as well as efforts to increase community participation, and community empowerment in the implementation of PHBS programs that are still less than optimal. While health education on clean and healthy living behavior in household settings has a positive effect on the knowledge of housewives (Artanti, 2013).
   The results of interviews with informants from several village community leaders showed that community attitudes basically support the implementation of the PHBS development program which is a program of the Government and Puskesmas. Therefore, it is

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necessary to improve the family's attitude towards the implementation of PHBS in real actions in the household. However, there is still a community attitude that is less supportive of the implementation of PHBS. This can be related to information that is less up to the community about PHBS, so that their knowledge is also lacking, because a person's attitude is formed after someone gets information or knowledge about something. Because attitude is a person's willingness or response to an object in an environment (Notoatmodjo, 2010). Among the factors that influence attitude formation are personal experience, culture, other people who are considered important, mass media, educational institutions or institutions and religious institutions as well as emotional factors within the individual. These factors will be the basis for the formation of attitudes, whether positive or negative (Notoatmodjo, 2010). In addition, there is a positive influence on the level of knowledge and attitudes about PHBS with the implementation of PHBS in households (Azrimaidaliza et al., 2012).

The results of interviews with PHBS cadre informants, that to foster community participation in PHBS activities in households, it is necessary to mobilize the community in addition to PHBS cadres, such as from community leaders, RT heads, in addition to the need for special officers in the field. So far, efforts to mobilize and increase community participation have not grown optimally, because they are only incidental meetings or there are certain activities, but there has been no effort to empower and institutionalize effective activities. The results of interviews with key informants from PHBS managers, that there is still a limited number and quality of active PHBS cadres in the program target villages, which until now only 290 people. However, not all active cadres can carry out their duties and obligations regularly. Ideally, the number of active cadres should increase, in addition to the increasing role and function of cadres that can support the implementation of the PHBS program.

On the other hand, community empowerment is the ability of individuals who are members of the community in question. A community with a society with high empowerment is one in which most of its members are physically and mentally healthy, educated and strong, and have values, are physically and mentally healthy, educated and strong, and have intrinsic values that are also a source of empowerment, such as kinship and empowerment instrinsic values that are also a source of empowerment, such as kinship, mutual cooperation, and for our society is diversity (Sumodingrat,1997). However, empowerment efforts in the implementation of PHBS are still limited to meetings. Community empowerment in PHBS has not been implemented in real due to internal and external constraints. This requires good governance, which is a condition that guarantees the existence of an alignment, similarity, cohesion carried out by three a process of alignment, equality, cohesion carried out by three components, namely the government, citizen or civil society, and the private sector (Taschereau & Compagnieu, 2012; UNDP, 1997 (Thoha, 2012). The civil society component must have a leading role in the implementation of PHBS, so that it can support the achievement of the goals and objectives of the PHBS program in the family setting.

3) There is still weak support for PHBS activities from cross-sectors and cross-programs at the Puskesmas level. So far, it seems that PHBS activities in the field only belong to health, whereas sectoral involvement in order to succeed the PHBS development program plays a very large role. Therefore, partnerships between cross-program, cross-sectoral and other institutions related to PHBS activities need to be fostered, both at the puskesmas and district levels (Gelberding, (2004). This is in line with the healthy paradigm which is a holistic perspective, mindset, or model of health development, seeing health problems

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that are influenced by many factors that are cross-sectoral in nature (Ministry of Health RI, (1999).

The results of interviews with key informants from the UPTD leadership found that there was still a lack of optimal coordination and cooperation in the implementation of the PHBS program, especially with cross-program and cross-sectoral, as well as other related parties. There are still overlapping programs from across sectors that should be combined in their implementation, so that they support and strengthen each other. To be able to coordinate well, an official must understand exactly what is the main task and function, but also understand the tasks and functions of other agencies. With this understanding, it will be understood that the relationship between agencies as a larger system is mutually influencing and interdependent (Suhendra, 2006). Factors related to and available in the PHBS program itself need to be analyzed to answer whether there is a relationship between sociodemographic factors (population density, poverty level, education level), environmental factors (availability of health service facilities) with Clean and Healthy Living Behavior and being able to identify vulnerabilities that exist in the puskesmas working area (Effendy & Mubasysyir, 2009).

4) Limited budget/financing support in the implementation of the PHBS program. In its operation, the PHBS program has so far only been sourced from the Indramayu Regency APBD, and in each year it has not been budgeted with certainty. Meanwhile, financial support and participation from community members and non-government parties is still very limited.

Some efforts to overcome the obstacles to the implementation of the PHBS coaching program at the household level include: Fist, increasing the quantity and quality of health workers. This effort was taken, among others, by coordinating with the BKD of Indramayu Regency so that the recruitment of employees in the health sector should pay attention to their educational background. On the other hand, the UPTD Puskesmas appointed sukwan personnel according to the needs of the UPTD. Secondly, increasing efforts to socialize the PHBS program with the increasing number of residents, especially to poor families. This effort is carried out, for example, by conducting visits to Puskesmas Pembantu and to villages as needed. Other efforts are made by strengthening the role and function of active PHBS cadres through coaching during each visit. Meanwhile, increasing the quantity of existing PHBS cadres is done by continuing to provide opportunities for community members to join cadres in the village according to community needs.

Third, in an effort to improve the synergy and support of PHBS activities from cross-sector and cross-program at the Puskesmas level, coordination and communication with related parties, such as with other Departments, Agencies / Institutions and UPTDs in the UPTD work area so that programs planned and carried out can support each other, so that they can be optimal in their implementation. Fourth, to increase budget support for financing the implementation of the PHBS coaching program, the UPTD always proposes a budget to the Indramayu District Government in each fiscal year. Meanwhile, to increase community participation in the implementation of the program, including participating in providing assistance in the form of funds or other material as appropriate, especially in supporting activities related to PHBS development at the Posyandu level and in the village concerned.

5. Conclusion

Based on the entire research process and discussion, it can be concluded that the implementation of the Clean and Healthy Living Behavior (PHBS) coaching program at the Household level at the UPTD Puskesmas Jatibarang, Indramayu Regency as seen from the

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aspects of motivating, directing, communicating, and controlling in its implementation is quite optimal, but not yet fully effective.

The success of the PHBS development program based on data on the achievement of 10 indicators of PHBS in 2011 has reached 82.1%, while in 2012 the program achievement was seen to increase to 90.3% or an average of 86.2% per year. However, the achievement of the percentage of healthy households in 2012 only reached 36.4% or decreased compared to 2011 which had reached 56.3% of healthy households. There are still internal and external constraining factors in the implementation of the PHBS development program/activity, but in general it can be overcome by the UPTD leadership and PHBS program managers at the Puskesmas level.

For this reason, the Head of UPTD Puskesmas Jatibarang needs to continue to make efforts to improve coordination and carry out effective cooperation with parties and those involved in the implementation of the PHBS development program in Households, in addition to improving the quality of organizational resources in supporting the sustainability of PHBS program implementation, especially for the realization of Healthy Indramayu Regency. These efforts can be made by optimally planning and budgeting, implementing, monitoring and evaluating, and supervising more effective programs/activities in each running budget year, taking into account the resource capabilities of the UPTD Puskesmas and the condition of the community as the target of the PHBS coaching program.

The limitation of this research is that it was only conducted on the implementation of the PHBS coaching program in the Household setting at the UPTD Puskesmas Jatibarang, Indramayu Regency. Future research is expected to be conducted on the evaluation of the implementation of the PHBS coaching program on a broader scope, namely in addition to PHBS in the household setting, also PHBS in the workplace setting, health facilities, educational institutions, and public places with the research locus of Indramayu Regency.

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