



**JOURNAL OF PUBLIC HEALTH FOR TROPICAL AND COASTAL
REGION (JPHTCR)**

Journal homepage: <http://ejournal2.undip.ac.id/index.php/jphtr/index>

ISSN : 2597-4378

The Influence of Organizational Factors on Compliance With The Standard Planning Process in Primary Health Care

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Abstract

Background: Planning becomes the most important management function because it arranges all management activities. Non-compliance with the standards of the planning process has an impact on the quality of planning that is unable to bridge needs which ultimately lead to dissatisfaction. PHC as public organizations must meet public service standards. Organizational factors are determinants of organizational performance as they relate to the provision and arrangement of various resources. The purpose of study was to determine affect of organizational factors on compliance with the standards of PHC planning process.

Methods: An observational study with cross sectional design. All 56 PHC in the 2 districts in Central Java province (Semarang and Kudus) became the samples. The respondents are officer in charge of the PHC planning programme.. Data collection by interviews using questionnaires and observations. Data were analyzed descriptively and statistically.

Results: Only 55.4% of PHCs comply with standard planning process. Weaknesses and inconsistencies still occur at every stage, especially with regard to inaccuracy of time, incomplete and inappropriate data, and low understanding of members of the team. Study shows that the aspect of manpower, infrastructure, organizing and monitoring-evaluation function are positively correlated with adherence to standard planning processes, where monitoring-evaluation factors are the dominant factor.

Conclusion: All the gaps identified as the cause of puskesmas non-compliance to the standard planning process can be overcome through increasing staff commitment and competency by providing structured managerial training and routine socialization. Strengthening the monitoring-evaluation function needs to be pursued consistently to ensure the quality of the puskesmas planning process and the implementation of the work plan produced.

Keywords: planning of PHC; compliance of standards; organizational factors

Article history : Received: 6th March 2020 , Revised : 14th April 2020 , Accepted: 17th April 2020

Background

As a basic health facility with wide access and reaching all corners of the region, Primary Health Care (PHC) are required to be able to carry out their activities and managerial functions in quality, especially in arrangement of limited resources.[1] It is recognized that the quality of health services is currently low because of resources limitation.[2] PHC be accredited as an effort to ensure the quality of their services, although it is recognized that not all PHCs are ready for accreditation.[3, 4] There for Puskesmas must meet certain quality standards in every managerial activities.[5]

The right planning mechanism through the good governance's principles in the decision-making process becomes the first step towards achieving quality of performance of the PHC. Planning as the most important management function because all management activities are always directed by planning [6], including the monitoring and evaluation functions.[7] The PHC planning activities look very complicated because of the large number of programs that have to be done and the overlapping of existing data. Preparation of program plans and activities of PHC tends to be routinely and without innovation. Programmes only based on the activities of previous years.[8] The study of the quality of the evidence-based health center planning process is still very minimal.

Minister of Health Regulation No.44 of 2016 concerning "PHC Management Guidelines" divides the PHC planning process in 4 stages, namely the Preparation stage, the Situation Analysis stage, the stage of preparing the Activity Propose Plan (APP) and the stage of preparing an Activity Implementation Plan (AIP). The compliance of the PHC towards meeting the standards of planning process is still weak. Most PHC in Jepara district of Central Java province did not carry out community satisfaction surveys as a first

step in PHC planning.[5] Study in Jayapura Papua province shows there is no PHC whose planning mechanism refers appropriately to the "PHC Level Planning (PLP)" guideline. Only the AIP stage is carried out well, whereas the previous stage was not.[9] Non-compliance with managerial process standards has implications for the quality of decisions and weak program implementation. Overlapping and the rest of the budget prove the inability of PHC to manage their finances.[10] This proves there is a problem in the execution process between planning and implementation. Obviously not all PHC carried out a good planning process.[10, 11].

Organizational factors influence performance related to the determination and allocation of organizational resources, including resources, leadership, incentives, work structure and job design.[12] Organizational factors also represent the effectiveness of leadership and coordination,[13] including organizational culture.[14] The purpose of the study was to determine the influence of organizational factors on compliance with the standard PHC planning process.

Methods

An observational study with quantitative approach and cross-sectional design. The locations at 2 districts in Central Java province, namely Semarang City and Kudus District. The population were all PHC and sample was total population, which totally 56 PHC, consisting of 37 PHC in Semarang City and 19 PHC in Kudus District. The officers in charge of the planning activities of PHC as respondents of this study.

Primary data was collected through interviews using a structured questionnaire and observation using a check-list. All data were analyzed with frequency distribution, crosstab analysis and correlation statistics test. To analyze the effect of all

independent variables on the dependent variable using *multiple logistic regression test* with the *enter* method.

Results and Discussion

Based on its characteristics, 80.4% were in the category of urban PHC and 57.1% have status as a non-hospitalized PHC. There are 51.8% of PHC with 1-5 villages area targets and 46.4% with 6-10 villages areas. As many as 60.7% are PHC with a population target of 30,000-60,000 people and 23.2% PHC have a population target more than 60,000 people. As many as 64.3% of PHC have 25-50 staffs and only 14.3% have <25 staffs.

Only 55.4% of PHC have a high level of adherence to the standard of planning process. There were several weaknesses and inconsistencies that occurred at each stage of this process. In the Preparation Phase, the PHC was constrained by the absenteeism of the PHC planning team members in the coordination meeting to schedule annual planning, the postponed of the Letter of Decree (LoD) for team and even many PHC whose have not the LoD. The PHC planning mechanism was not properly understood by the team. There were discrepancies in the documents of supporting data available with expected information needs, both the type and year time of data. Also inconsistencies often occur in the implementation of agreed procedures, misperceptions and unclear planning procedures because they contain multiple interpretations. PHC also tend not to periodically review all manual procedures.

At the Situation Analysis stage, the procedures for conducting the Self-Assessment Survey (SAS) and Community Satisfaction Survey are not accordance with the provisions of the Community Satisfaction Survey Guidelines from The Minister of Bureaucratic Reform Affair. The community satisfaction survey also does not use the instrument standards

for measuring Community Satisfaction Index and the minimum number of respondents is also less than standards 150 people. The schedule for implementation of SAS is often delayed and no prior notification regarding the survey to the regional government officer (Head of Villages). The implementation of Village Community Deliberation as a form of coordination and community consultation based on the results of the SAS also tends to not be on schedule and agreement with community groups and local officials. As many as 67.8% of PHC have teams that never been trained in PHC planning mechanisms and the process of health problem resolution.

The phase of APP also constrained by the problem of time inaccuracy, both during its preparation in the PHC, submission to the Regional Government through the Health Office and submission to the Legislative Council. The discussion of APP and its submission to the Regional Government is not in accordance with the time standard at around March-April of the current year, so that submission to the Legislative Council for get approval is also automatically late. This condition was caused by the delay of PHC submitting the draft APP to the Health Office. The ability of PHC developing indicators and instruments of monitoring-evaluation is also still weak. The micro planning activities of PHC are often not on schedule, and many operational plans also not according to plan. The PHC also does not involve the community and stakeholders as a control function in evaluating the quality of programs and services.

This study shows a greater proportion of good categories in all research variables. However, the proportion of less categories is also still large enough that to be need a special attention. In Table 1, it can be seen that manpower, facilities, organizing and monitoring-evaluation are significantly

correlated with the level of PHC compliance to planning standards with p value < 0.05. While the regulatory and leadership aspects do not correlate. With the value of r (*rho*) 0.430 proving the strength of the correlation between aspects of manpower, facilities, and organizing

aspect with PHC compliance to planning standards is quite strong. The power correlation between monitoring-evaluation aspects and compliance with planning standards is weak because the *rho* value is 0.271.

Table 1. The Frequency Distribution of Relationships between Variables

Variables	Compliance with Standards Process of Planning				Amount		Value of r (<i>rho</i>)	Sign.
	Less		Good		n	%		
	n	%	n	%				
Manpower								
1. Less	14	58.3	10	41.7	24	42.9	0.430	0.001*
2. Good	11	34.4	21	65.6	32	57.1		
Facilities								
1. Less	13	56.5	10	43.5	23	41.1	0.430	0.001*
2. Good	12	36.4	21	63.6	33	58.9		
Regulation								
1. Less	10	40.0	15	60.0	25	44.6	0.085	0.534
2. Good	15	48.4	16	51.6	31	55.4		
Leadership								
1. Less	12	44.4	15	55.6	27	48.2	0.246	0.068
2. Good	13	44.8	16	55.2	29	51.8		
Organizing								
1. Less	13	52.0	12	48.0	25	44.6	0.434	0.001*
2. Good	12	38.7	19	61.3	31	55.4		
Monitoring-Valuation								
1. Less	9	75.0	3	25.0	12	21.4	0.271	0.043*
2. Good	16	36.4	28	63.6	44	78.6		

* Significancy with p value < 0,05

Furthermore, the variables of workforce, facilities, leadership, organizing and monitoring-evaluation were included in multivariate modeling using multiple logistic regression tests using *enter* method. The final results showed the monitoring-evaluation aspects proved significantly affect compliance to the PHC planning standard with p value=0.038 and the Exp (β)=4.723. Increasing monitoring-evaluation activities has probability of increasing compliance with planning standards of 4.7 times greater.

In its roles and responsibilities as a public service unit, there is a tendency that service performance orientation of current PHC to be more oriented to achieve the target of Minimal Services Standards as an output rather than as a process. PHC has focused more on how targets are met

without seeing how the "process" is carried out in target achievement. Measures performance including process expectations (how work will be done) and expected process.[15] Performance that does not respect the process and only results oriented will lead to poor processes and poor outcomes.[16] A similar situation will also occur if PHC planning performance prioritizes results and not processes. Health planning is generally regarded as the technical subject and domain of health officials with a minimum involvement of community representatives[17].

Community involvement in priority setting is also very small. The low level of PHC compliance to planning standards is due to the obstacles and weaknesses in the planning process of the PHC and

become a gap in planning performance. These results also prove that ensuring the quality of planning process has not been a priority in the management of PHC. This study is inline with Mebri's study in Jayapura and Dhewi & Hedy in Medan which stated that PHC management activities were only considered routine activities, including planning activities, so that many officers were principled as long as activities could be carried out and could provide services to the community.[8, 9]

Non-compliance with planning standards relates to problems that can actually be controlled by the PHC as an organizational structure, among others: the schedule of activities that often retreats, the team members absenteeism in technical coordination meetings, incompatibility of documents and data supports, misperceptions and unclear procedures, and no review for manuals procedures periodically. The condition becomes increasingly severe when an understanding of the planning mechanism is not properly understood by members of PHC team because of lack of information and socialization. The impact occurring was the inconsistency in the implementation of agreed procedures because they were confused with interpretations that were different from the team members themselves. This is resulting in chronic management problems. Lawn et al's study in Australia shows a strategy to overcome chronic management conditions in PHC, namely by open and effective communication between multidisciplinary teams and with the community as a consumers through information sharing, setting the right time or schedule and providing adequate resources.[18]

The variables of workforce, infrastructure, organizing and monitoring-evaluation are related to compliance with PHC planning standards. In system approach, it is proved that the PHC performance is determined by its ability to

manage all elements effectively. This study inline with previous research which stated that resources, especially human resources are the key success of PHC management activities.[1, 2, 6] All organizational managerial activities are driven by human power which is also the controller and manager of system. The work system will not operate if it is not supported by sufficient resources and facilities.[19] Facilities will support the continuity of PHC work system. The work system runs well if the aspects of training, development, education, motivation and employee expectations are considered.[19]

The aspect of health workforce is a crucial problem especially in developing countries, which has implications for the low quality of human resources and competitiveness. Barber et al in Handayani stated that the quality of health services is highly dependent on the availability, type and number of health workers. The PHC performance is inseparable from the aspects of employment, especially the existence of health workers,[19] and competence.[20] To improve service quality, various problems relating to employees and job satisfaction must be considered, including maintaining work motivation and commitment. PHC need skilled staff, so all factors that can improve individual or PHC performance must be considered, including the adequacy of infrastructure. Skills and competencies to address performance gaps can be obtained through a measurable and sustainable process of education and training.[20] Relational learning and skills are accumulations of a continuous learning process.[19]

Mills stated the success factors to the health planning process (including PHC) are knowledge, attitudes and motivations that lead to aspects of job satisfaction. Various studies show there is dissatisfaction of health workers in PHC for their work. In Saudi Arabia, almost 40% of

nurses intend to leave their current jobs as a result of their dissatisfaction. The desire to retreat or turnover is related to commitment and motivation at work.[21] Staff motivation and workplace conditions are proven to improve service performance carried out in primary health services in Ghana.[22] Research in Pakistan proves that organizational factors (including low salary and lack of opportunities careers) determine demotivating factors.[23] There is dissatisfaction which has an impact on the low motivation of work by health workers in the PHC, mainly due to a lack support for infrastructure facilities.[19] Motivation and work competency have a strong influence on the PHC performance in Palu City.[24]

Research shows there is a correlation between organizing aspects and monitoring-evaluation to compliance with planning standards. The action plans as the planning output is guaranteed to be more successful when the resources needed are properly organized and routinely monitored for implementation and continuously evaluated. In organizing function there are principles of division of labor, specialization and coordination in order to achieve synergy in the organizational structure. It will explain who does what, with what, and how to do it. The organizing aspect also explain the communication channels that take place in order to focus resources on the target. The challenge of accountability is a key success factor of the organizing function. According to Frenk and Moon, the challenge of accountability relates to the legitimacy of every element and the vagueness of the working mechanism.[25] Accountability also related to resource allocation and priority setting.[26]

Research shows that PHC non-compliance to standards that must be carried out in the planning process is influenced by the weaknesses of PHC

management in carrying out management-evaluation functions regularly. It takes the ability of managers to guarantee the success of organizational performance through the elaboration and implementation of the monitoring-evaluation functions carried out. Managers play an important role in the smooth running of the organization and at the same time are responsible for the existence and sustainability of all personnel, facilities, materials and equipment to achieve the quality of health services held.

Strong monitoring and evaluation systems can provide information needed to assess the progress, generate information for program management and decision making, while producing evidence of impacts and health outcomes that are useful for informing various replications and increasing expected performance targets.[27] Milicevic stated that assessing performance remains a relatively high weakness among managers, so structured managerial training is needed as an effort to reduce this gap.[20] Planning and implementation programs are inextricably linked to monitoring and evaluation.[27] Community involvement in the community-based monitoring process is one of the strategies that can be carried out to ensure the success of the planning process and increase community participation in the planning process, in addition to efforts to increase the capacity of stakeholders and local advocacy.[17] Research in Kenya also shows that the level of community involvement and regional accountability structures increases planning capacity.[26]

Conclusion

Compliance with standard planning process affects the quality of planning. The factors of monitoring-evaluation, staffing, facilities and organizing affect the compliance with planning standards of PHC. Performance barriers occur in

aspects of time management, human resource management and management of supporting infrastructure. These gaps can be reduced through structured managerial training and routine socialization. Strengthening the monitoring-evaluation function needs to be carried out consistently to ensure the quality of the PHC planning process and implementation of work plans. The PHC increase commitment, work motivation and competency of its staff intensively through structured training on the topic of prioritizing process and problem solving cycles as well as topic of PHC accreditation. PHC gradually completes facilities and infrastructure, including completing manual documents and procedures while simultaneously revising expired manual procedures.

Acknowledgements

Thank you for Institute for Research and Community Services Diponegoro University for the funding this research through scheme other than APBN DPA SUKPA 2016-2017

Conflict of Interest

The authors do not have any conflict of interest regarding the process and results of this research.

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