# An Evaluation of Youth Care Health Program (PKPR) in Public Health Center in Jakarta, Indonesia

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Keywords: Youth, Health Promotion, Health Care, Indonesia.

Abstract: Indonesia government has facilitated youth care that was implemented in the Public Health Centre (PHC) called Youth Care Health Service (PKPR). This research aimed to evaluate the implementation of PKPR program in the Public Health Centre in Jakarta, Indonesia. This research employed qualitative approach. The data were collected from 10 Public Health Centre in Jakarta from August to October 2016. The informants consisted of head of PHC, PKPR program manager, visitors, and PKPR patients. We specifically explored the input and process of the implementation of PKPR program. Thematic content analysis was used to analyse the data. It was revealed that all PHC have implemented the PKPR Program. In term of facilitation, a PHC has a special room for implementing PKPR clinic, but others do not. Some PHCs did not have staffs that specifically manage the PKPR program. However, some staffs have not been trained for giving care for youth. Trained staffs are necessary to provide or the patients. Further, some of the PHC staffs did not use HEADSSS assessment.



## 1 INTRODUCTION

Youth is a critical stage in human development. Youths tend to develop risk-taking behaviours, sensation-seeking, novelty-seeking and increased focus on social status (Berenbaum, Beltz, & Corley, 2015; National Research Council, Institute of Medicine, & Transportation Research Board, 2007). Therefore, susceptibility to substantive abuse in that period increases (Berenbaum et al., 2015).

Indonesia Global Student Health Survey revealed that smoking and drinking alcohol, less fruit and vegetable intake, mental health, and violence become the main risk factors among Indonesian youth (Puslitbang, 2015). Based on the report, 13.6% of student were current smoker and 4.4% were alcohol user (World Health Organisation, 2015). Moreover, in dietary behaviour, Indonesia is facing double burden of malnutrition which is marked by the coexistence of under-nutrition along with overweight and obesity (Hanandita & Tampubolon, 2015).

Youth health becomes an important aspect that contributes to the national development. Investing in the health of youth will bring high benefits and significant progress towards achieving Sustainable Development Goals (Sheehan et al., 2017). World Health Organization stated that investing in adolescent health will bring benefits for themselves, their future lives, and their next generation (WHO, 2009).

Nevertheless, the importance of investing in adolescence health is facing challenges, especially in providing healthcare for adolescence in Indonesia. A research conducted in Semarang stated that 61.5% of youth still less participated in youth care program (Sari, Musthofa, & Widjanarko, 2017). Research in evaluating youth care program in Jakarta also revealed that there were still lack of facilities, manpower, and financial support in providing youth care, leading to a less standardized services. (Friskarini & Manalu, 2017).

In 2014, Ministry of Health of Indonesia developed a set of guidelines for Public Health Centre (PHC) to perform Youth Care Program (PKPR). PKPR program includes activities inside and outside



Barida, I., Nurmansyah, M. and Sabilla, M.
An Evaluation of Youth Care Health Program (PKPR) in Public Health Center in Jakarta, Indonesia.
DOI: 10.5220/0008380500560060
In *Proceedings of the 1st International Conference on Social Determinants of Health (ICSDH 2018)*, pages 56-60
ISBN: 978-989-758-362-9

PHC. The former includes disease prevention, health counselling, and treatment for youth, while the latter includes health screening and health education in school, youth society, orphanage, and youth prison (Ministry of Health Republic of Indonesia, 2014). Ministry of Health also developed Indonesia HEADSSS assessment, a guideline for psychosocial assessment in youth. HEADSSS stands for Home, Education (school), Activities/Employment, Drugs, Suicidality, Sex and eating, and Safety (Katzenellenbogen, 2005).

This research aimed to explore the performance and challenges of youth health service in 10 PHCs in Jakarta. This research is expected to enrich the literature regarding youth care performance in Public Health Centre, especially in using HEADSSS assessment guidelines.

# 2 METHOD

This qualitative research was conducted in 10 Public Health Centres in Jakarta. The data were collected in December 2016. The informants were chosen using purposive sampling method. They were involved in the Youth Care Program of the PHCs. The informants in each PHC were consisted of one Head of PHC, 2 staffs who managed the Youth Care Health Program, 2 staffs of PHC who were involved in PKPR Program, and 2 adolescents attending the care centre. Therefore, the total of number of informants in this study was 50.

The data were collected through in-depth interview. Semi-structured interview guidelines were made prior to the data collection. The interview guidelines were aimed to explore the adequacy of PKPR implementation program from 5Ms perspective (Manpower, Money, Material, Method, Machine) and functions of Management (Planning, Organizing, Actuating, Controlling and Evaluating). In managerial elements, we assessed the readiness, education, training, and skill adequacy of the staffs responsible for the adequacy of funding, adequacy of health promotion media, policy and standard operational procedure, adequate facilities for the program. We also assessed the managerial process of the program, such as the planning process of the program, organization of the program, implementation barriers and satisfaction of the patients, as well as monitoring and evaluating process of the program.

Informants who agreed to involve in this study signed the inform consent prior to the interview. No consequence was imposed on the informants who were unwilling to involve in this study. Six researchers from National Institute for Health Research and Development and Directorate of Child and Adolescent Health, Ministry of Health of Indonesia were assigned to do the interview for data collection. During the interview process, the researcher used voice recorder and notes to record the interview contents. After collecting the data, the researcher made an interview transcript and analysed the data. Thematic content analysis was used to analyse the data.

# 3 RESULTS AND DISCUSSIONS

Readiness for the implementation of PKPR was assessed by identifying the condition of the facilities, human resources, and funding of the program in PHC.

## 3.1 PHCs Facilities

Most of PHCs have had an adequate facility for implementing PKPR Program. It includes a special room, health equipment, and other facilities to support the program. The informants also stated that they already have PKPR guideline from the Ministry of Health as guidelines in implementing PKPR.

Yet, some PHCs still have not provided special room for PKPR Program, leading to the cancellation of the program because during the service, the rooms were used for other types of services. The unavailability of the room was caused by several reasons, such as small area of the PHC building. The unavailability of the room was caused by several reasons; one of which is the moving of the PHC to a new area that is smaller than the previous place. It results in the inability of the centre to provide a room for the program. A specific room is necessary for providing private care to the youth patients, allowing them to discuss their problems more deliberately.

*"...Because the PHC's building is small, a room for youth service in the other time is also used by another program so there is a lack of room..." (Public Health Centre Staff)*

The informants also said that the infrastructure (medical equipment and service room) was the biggest obstacle in implementing PKPR Program. For instance, stethoscope, thermometer and flashlight were not in good condition.

## 3.2 Human Resources

In the context of availability and competence of human resources, most informants stated that they already have adequate human resources to implement the PKPR Program. They also said that they already have sufficiently competent staffs for the service. They had been trained before the implementation of the program.

Nonetheless, other informants stated that they lacked human resources for the program, in terms of number and competence. The less competent staffs were unable to solve the problems faced by the youth, such as when they experienced a kind of violence. In terms of number, the staffs in PHC are not only responsible for the €PKPR program, but also responsible for other duties, leading to double their workload. Another consequence is the less routine service in the clinic, since the staffs are not available every day.

*"…Honestly, I feel that I still have forthcomings, because giving service for youth needs special skill in order to explore youth problems, for example there was a youth that experiencing bullying so there is a need more competence for giving youth service…" (Public Health Centre Staff)*

## 3.3 Implementation Of PKPR Program

All informants stated that PKPR Program has been implemented in their PHC. There were programs that were implemented inside and outside of the PHC. The program that is implemented in of the building includes health counselling for youth, while outside includes school visiting for health promotion and education.

## 3.4 Integrated Service

Previously, some PHCs integrated their service for youth and other patients, but currently, most PHCs have implemented youth health counselling program in separated room from other service. In addition, the program is available 6 days a week.

Most informants stated that they have a special procedure for their patient (client). It is not necessary for the youth to go the general clinic. Instead, they can go directly to the youth care clinic. However, youth with special cases, such as pregnancy and dental problem , have to visit a more particular clinic before they proceed to the youth care. All in all, some PHCs still allow patients of all ages to enter the general clinic.

## 3.5 Use Of Headsss Assessment And Counselling Process

In terms of diagnosis procedures, some PHCs have implemented the algorithm proposed by the Ministry of Health. In spite of that, some other has not used it because they were confused of it. In some cases, sometimes they could not find the disease in the algorithm, such as the infectious disease.

*"…There is some diagnosis that not included in this algorithm like smallpox. The algorithm is confusing because infection diseases is not included…" (Public Health Centre Staff)*

Another reason is caused by the high number of the clients. Therefore, to shorten the waiting time, the staffs should do the counselling faster. They stated that the algorithm should be made simpler to facilitate the diagnosis process as well as clear classification.

*"…If I did not use overall case for HEADSSS maybe the service just 10 minutes. But if we use overall HEADSSS algorithm, the service maybe reach one hour for one patient…" (Public Health Centre Staff)*

In giving the counselling, some informants found it difficult to build good rapport with the clients. Good relation helps the clients to be more open in counselling about their health problem. The staffs should work harder to make the clients trust them.

## 3.6 PKPR Program Outside Building

For youth program outside building, the program was varied among PHCs. Most of PHCs have implemented health education program in school that scoped in their area. Most of PHCs also have program for training peer as health counsellor. Some of PHCs have a program for training youth to be a volunteer in keeping environment free from mosquito larvae.

## 3.7 PKPR Monitoring And Evaluation

The results revealed that there were some kinds of monitoring and evaluation of the PKPR Program. Evaluation was performed by the head of

PHC and also Jakarta Subdistrict Health Office. It was performed in every month and every 3 months. The monthly evaluation is performed by the internal staffs of PHC, while the 3-month evaluation involves other sectors such as educational sector and other governmental sectors.

# 4 DISCUSSIONS

All PHCs in this research have implemented PKPR Program in their service. Not all PHCs used the algorithm for diagnosing the patient. Most of human resources responsible for the program are competent in giving the service. Only some PHCs have special room and specific procedure for giving service for the youth.

Some staffs stated that there was no special room for youth examination. World Health Organization (WHO) in the Global Standards for Quality Health-Care Services for Adolescents stated that the examining room plays an important role in ensuring the privacy of the patients, especially during clinical examination and treatment (World Health Organization, 2015). One study in Burundi revealed that designated exam rooms, educational materials in waiting rooms, privacy, and confidentiality are significantly associated with adolescents' use of youth health service (Moise, Verity, & Kangmennaang, 2017).

In the aspect of human resources, some informants stated that they were not sufficiently competent in helping the clients' problem. Health-care knowledge, attitude, and skills are essentials element in quality service provision (Ambresin, Bennett, Patton, Sanci, & Sawyer, 2013). Health providers also need to create a comfortable atmosphere that allows the youth to talk about their health issues (Grant, Elliott, Di Meglio, Lane, & Norris, 2008). Some PHCs staff stated that they have not yet used the diagnosis procedure algorithm from the Ministry of Health. Some informants stated the length of the diagnosis process using the algorithm causes them unwilling to use it. Grant in her paper agreed that addressing psychosocial risks was time consuming, therefore, when short on time, a strategy is to address one or two psychosocial domains at each visit (Grant et al., 2008).

# 5 CONCLUSIONS

All PHCs have implemented PKPR inside and outside the building. There were several challenges that were faced by the PHCs in performing PKPR: lack of competence and number of human resources as well as lack of facilities, such as room and medical equipment. Adolescent is a critical period when health/unhealthy behaviours are established and therefore it is necessary to counsel and educate them in order to develop healthy lifestyle early (National Research Council and Insttitue of Medicine, 2009).

In order to provide better performance in the youth health care, training for PHC staffs is needed. Besides, it increases their competence in performing the counselling and treatment for youth in the PKPR program. Nevertheless, the government should also increase the number of the staffs in PHCs to avoid any workload and to ensure quality service.

# ACKNOWLEDGEMENTS

We would like to extend our gratitude to all of staff in Public Health Centres in Jakarta who have involved and assisted for data collection process of this research.

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