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TB HIV Control Program Problem Analysis in Gresik District Health Office

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ABSTRACT

Introduction. Health problems in Gresik district were diverse. Ideally, all existing problems must be solved, but because of limited resources, not all problems can be resolved at once. The purpose of problem analysis was to determine the problem considered as the most priority and can be used as a basis for effective and efficient program planning and evaluation. **Methods** used in determining priority problem were Urgency, Seriousness, and Growth (USG) and root cause analysis by fishbone diagram. Whereas to determine the root priority of the problem, the Rienke method was used. Health problem analysis activities at Gresik District Health Office was executed on January 3 to February 3, 2017. The data used for this analysis came from secondary data. **Results** shows that the low number of TB-HIV patients receiving ARVs was a priority issues in Gresik District Health Office. Based on the fishbone diagram, the patient's lack of understanding about the importance of ARVs causes low number of TB-HIV patients receiving ARVs. **Conclusion.** Utilizing peer support group as a medium for counseling and training was needed to increase understanding about ARVs importance to TB-HIV patients.

Keywords: TB-HIV, Urgency, Seriousness, Growth, TB-HIV

INTRODUCTION

Background

Health development is one of national development efforts that aims to increase awareness, willingness and ability to live healthy. This development aims to realize an optimal degree of health for the community. The implementation of health efforts can be in the form of promotive, preventive, curative, and rehabilitative activities that were carried continuously⁽¹⁾.

Health is one aspect that is regulated and managed by local government, which at first was a top-downsystem (from central government to regional government) and now become a bottom-upsystem (from local government to central government). Regional autonomy in health sector provides many opportunities for local governments to explore the ability of the region to build health, regional health systems, regional health management, funds, facilities and infrastructure that are adequate, so the communities health in the regions can get better⁽²⁾.

Gresik District Health Office is responsible for regulating the running of health system in Gresik District. Health problems in Gresik Regency were diverse. Ideally, all existing problems must be solved, but due to limited resources and time, not all health problems can be resolved at once. For this reason, it was necessary to conduct a health problem analysis in Gresik District. We expected to find the health problem that are considered as the priority issue and formulating a problem solving, so that it can be used as a basis for effective and efficient program planning and evaluation.

Purpose

The purpose of problem analysis was to determine the problem considered as the most priority and can be used as a basis for effective and efficient program planning and evaluation.

METHODS

Health problem analysis at the Gresik District Health Office were held on January 3 to February 3, 2017. The data used for the analysis were secondary data obtained through document study and primary data obtained from interviews with respondents. Data came from the Gresik District Health Profile 2013–2015^{(3),(4),(5)}, Population Profile and Employment of Gresik District Statistics Indonesia (BPS) 2013-2016, East Java Provincial Health Office Profile 2014-2015⁽⁶⁾, monthly and annual immunization coverage data reports, annual report on Universal Child Immunization (UCI) by village, monthly and annual reports on infectious disease data, monthly and annual reports on Non-Communicable Diseases data, monthly and annual reports of Gresik District Health Office Surveillance Data 2013-2016. Then the collected data will be analyzed to identify existing problems.

Respondents involved in this study were head of Disease Control and Prevention (P2P) of Gresik District Health Office, head sections and staffs of infectious diseases prevention and control program, head sections and staffs of non-communicable disease prevention and control program, head sections and staffs of surveillance and immunization program of Gresik District Health Office. The total respondents involved in this study were 15.

The steps taken in analyzing health problems at the Gresik District Health Office referred to Newman's problem solving cycle techniques⁽⁷⁾. Stages started from situation analysis, identify problems, compare current achievements with objectives or previous achievements, and determine priority issues, root problems, and priority root problems.

In determining the priority of the problems, the methods used were urgency, seriousness, and growth (USG). Urgency was related to the importunateness of the time needed to resolve the problem. The more pressing a problem to be resolved the higher the urgency of the problem. Seriousness was related to the impact of the problem on health problems. The higher the impact of the problem on the community, the more serious the problem became. Growth was related to the expansion of problems. The faster the problem develops the higher the growth rate. A problem that is rapidly developing, certainly became a priority to overcome.

After the priority of the problem determined, then we determined the root cause of the problem using a fishbone diagram. The next step, we determined the root problem priority using the Reinke method. The result of the root priority of the problem chosen as an alternative solution for the problem.

RESULTS

Identification of Problems and Priority Problems

Based on the data collected, several problems were found in the Gresik District Health Office. List of identified problems can be seen in Table 1 below.

Table 1. Health problems identification in Gresik District Health Office 2017

No	Health Problem	Indicator	Year				Target
			2013	2014	2015	2016	
1	DHF	DHF incidence per 100.000 people	50.20	21.10	45.69	65.24	51/100.000 people
		DHF Case Fatality Rate (%)	1.30	2.29	0.70	0.12	< 1%
2	Pneumonia	Coverage of under five years found and treated (%)	9.55	8.99	5.45	5.63	60 %
3	Diarrhea	Coverage of all cases found and treated (%)	Not valid	158.53	120.74	205.24	100%
		Diarrhea incidence per 1000 people	Not valid	33.92	25.84	43.92	Decreasing IR trend by each year
4	TB HIV	Number of TB patient with HIV (%)	Not valid	Not valid	28.18	55.16	60 %
		TB HIV patient receiving ARVs (%)	Not valid	Not valid	26.31	40.42	100 %
5	Hypertension	Number of hypertension	0.51	1.80	4.09	Data not ready	100%

No	Health Problem	Indicator	Year				Target
			2013	2014	2015	2016	
		patients getting standard treatment (%)					
6	Diabetes Mellitus	Number of DM patients getting standard treatment (%)	0.49	3.60	8.75	Data not ready	100%
7	Ca. Cerviks	Proportion of Woman of Childbearing Age getting Ca. Cerviks early detection	0.24	4.63	4.88	Data not ready	50 %
8	Measles	Measles Incidence per 100.000 people	Not valid	2.98	3.74	12.91	Decreasing IR trend by each year
9	Diphtheria	Diphtheria Incidence per 100.000 people	Not valid	1.29	1.03	2.83	Decreasing IR trend by each year

On the results of the identification of health problems, we found nine problems that needed to find a solution, but the respondent agreed that only four were considered to be a problem because the data of five other problems were less valid. Based on identification of the selected problem, then we tried to determine the priority problem using the USG method to find alternative solutions. The results of determining the problem prioritization based on USG method can be seen in Table 2 below.

Table 2. List of priority health problems in Gresik DHO using USG method

Health Problem	Urgency	Seriousness	Growth	Total	Priority
The low number of TB-HIV patients getting ARVs	42	43	38	123	I
Increasing Trend of Measles Incidence Rate	41	39	34	114	II
Increasing Trend of Diphtheria Incidence Rate	39	39	33	111	III
Increasing Trend of DHF Incidence Rate	37	39	33	109	IV

The priority problems taken for further analysis, namely the highest USG results, was the low number of TB-HIV patients who receive ARVs.

Root Problems and Priority Root Problems

To determine the root cause of the low number of TB-HIV patients who receive ARVs, we made the fishbone diagram. Whereas to determine the priority root of the problem, we used the Rienke method. The results of determining the root cause of the problem can be seen in Table 3 below.

Tabel 3. List of priority root problem of the low number of TB-HIV patients who receive ARVs using Rienke method

No	Root Problem	Score	Priority
1	Lack understanding of TB-HIV patients regarding the importance of ARVs	205	I
2	The separation between TB services and HIV services so that patients are lazy to queue	54.33	VIII
3	Lack of counseling officers competence	117.5	V
4	Patients cannot afford the ARVs	68	VI
5	Refusal of TB-HIV patients to consume more than one type of drug and for a long duration	154	II
6	The patient has not felt any clinical symptoms of complications yet	118	IV
7	Lack of social support from family or close relatives	58	VII
8	Patient Mentality Crisis	131	III
9	Lack of information about the importance of ARV	38	IX

The results of the analysis using Rienke method showed that the root priority of the problem that considered as the most important was the lack understanding of TB-HIV patients regarding the importance of ARVs. An alternative solution that can be formulated for the problem was to improve understanding of TB patients with HIV regarding the importance of ARVs.

DISCUSSION

Based on the results of the problem analysis, the priority of the problem chosen was the low number of TB-HIV patients who receive ARVs. Whereas the priority of the root problem chosen to find alternative solutions was the lack understanding of TB-HIV patients regarding the importance of ARVs.

Lack understanding of TB-HIV patients regarding the importance of ARVs was very important and need to be handled immediately. In accordance with Ministry of Health Regulation Number 87/2014 concerning ARVs treatment, patients with TB-HIV coinfection must receive ARVs. By giving ARVs it was expected to reduce morbidity and mortality. In addition, because both TB and HIV are contagious diseases. If this was not handled optimally it would make a bigger impact and burden.

According to data from Indonesia Ministry of Health, until the end of December 2010, the cumulative number of AIDS cases in Indonesia reported was 24,131 cases with the highest number of co-infection with 11,835 cases (49%). Whereas HIV infection in TB patients in Indonesia was estimated at around 3%. The high-risk population was in Papua Province, but the population in prisons / remand centers estimated to be higher. Based on the results of seroprevalence studies, HIV prevalence rates among TB patients in several provinces such as Yogyakarta were 2% in 2006, while in 2008 East Java province was 0.8%, Bali was 3.8% and 14% in Papua⁽⁸⁾.

The Ministry of Health's data and information center said that the presentation of TB patients who knew of HIV status increased from 2012-2014, but was inversely proportional to the percentage of TB-HIV patients receiving ARVs drugs that experienced a decline from 2012-2014 (Table 4).

Table 4. TB-HIV coinfection in Indonesia 2012-2014

No	Variable	2012	2013	2014
1	Number of TB patients who knows their HIV status	6.317	10.497	16.133
2	Number of TB-HIV patients	2.089	2.438	2.399
3	Number of TB-HIV patients receiving ARVs	1.063	1.149	441

Source: Directorate General of Disease Prevention and Control, Ministry of Health RI, 2016.

Factors that can influencing the lack understanding of TB-HIV patients about the importance of ARVs were the level of patient's education, media (information), counseling techniques, the ability of officers to provide counseling, patient's utilization of peer support group, and patient's mentality conditions.

One method that can be used to improve understanding of patients about ARVs was by optimally utilizing peer support groups. This method was in line with Khairun Nisa's (2015)⁽⁹⁾ research which shown that peer support group was very effective, especially for psychological support, reward support, and information support.

Peer support group was a place of support for and by people in the same situation. Through this forum, patients will get information related to basic knowledge of TB-HIV. The existence of this group was expected to help patient pass the psychological crisis, how to open their health status to others, receiving ARV treatment, monitor adherence to treatment therapy, and development of other knowledge that supports the improvement of quality of life. The usefulness of this group was in line with Diatmi's (2014)⁽¹⁰⁾ study that there was a positive relationship between social peer support group and quality of life in people with HIV and AIDS. A study conducted by Sugiharti (2014)⁽¹¹⁾ showed that the obstacles in taking ARV drugs were boredom, long duration taking medication, side effects of drugs, and community stigma. But within the peer support group, it was less likely to occur.

Peer support group can be used by patients, but can also be used by health workers. Government support can be provided through this group in the form of various positive activities, such as coaching and supervision of TB-HIV awareness about the importance of ARVs, open counseling practices, meeting psychologists and psychiatrists, or religious refresher on international AIDS Day.

CONCLUSION

The priority of health problems at the Gresik District Health Office based on the USG method was the low number of TB-HIV patients who receive ARVs. Priority root problem based on Rienke's method was

the lack of understanding of TB-HIV patients about the importance of ARVs. The alternative solution chosen to improve patients' understanding of ARVs was to use peer support group optimally.

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