

Policy Implementation of Hypertension Prevention and Control Program in Banjarmasin

Sally Pobas^{1,*}, Balqis Nazaruddin², Sukri Palutturi², Muhammad Alwy Arifin², Wahiduddin³, Syamsiar S. Russeng⁴, Anwar Mallongi⁵

Sally Pobas^{1,*}, Balqis Nazaruddin², Sukri Palutturi², Muhammad Alwy Arifin², Wahiduddin³, Syamsiar S. Russeng⁴, Anwar Mallongi⁵

¹Master Program in Health Policy Administration Department, Faculty of Public Health, Hasanuddin University, INDONESIA.

²Department of Health Policy Administration, Faculty of Public Health, Hasanuddin University, INDONESIA.

³Department of Epidemiology, Faculty of Public Health, Hasanuddin University, INDONESIA.

⁴Department of Occupational Health and Safety, Faculty of Public Health, Hasanuddin University, INDONESIA.

⁵Department of Environmental Health, Faculty of Public Health, Hasanuddin University, INDONESIA.

Correspondence

Sally Pobas

Master Program in Health Policy Administration Department, Faculty of Public Health, Hasanuddin University, INDONESIA.

E-mail: sallypobas@gmail.com

History

- Submission Date: 12-05-2023;
- Review completed: 14-06-2023;
- Accepted Date: 19-06-2023.

DOI : 10.5530/pj.2023.15.132

Article Available online

<http://www.phcogj.com/v15/i4>

Copyright

© 2023 Phcogj.Com. This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International license.

ABSTRACT

The Ministry of Health launched the Policy Implementation for the Prevention and Control of Hypertension Program with the goal of addressing the needs of national and regional public health development through minimal service standards. The goal of this study was to look at how hypertension prevention and control programs were implemented in the city of Banjarmasin.

This study uses a qualitative descriptive-explorative analysis method with multiple case study approaches. Data collection was carried out by in-depth interviews, observation, documentation and literature study to all research informants. Informant selection technique used purposeful sampling. Research variables included communication, resources, bureaucratic structure and dispositions/attitudes.

The research findings indicated that communication between policymakers, implementers, and program targets was effective. Despite the fact that human resources have reached the criterion for personnel, certain officers continue to have an excessive burden, and the number of health cadres was insufficient. Although facilities and infrastructure were available, several Public Health Centers were still having difficulty channeling demands and budgets. The bureaucratic structure had been implemented through SOPs and the delegation of authority, however numerous agencies still lacked complete documentation and archives. Even though the overall objectives were not attained, all parties exhibited a strong commitment and determination to continue the program. It can be concluded that the implementation of hypertension prevention and control policies in Banjarmasin had been quite successful, though there were still some challenges, such as differences in program target participation methods, the need for systematic equalization of authority tasks, and more equitable budget management in terms of resources. Furthermore, in terms of bureaucratic structure, it is vital to develop organized documentation standards in each agency.

Key words: Implementation, Policy, Program, Prevention, Control, Hypertension.

INTRODUCTION

The advancement of times and cultural transitions, such as instant/practical lives, have an impact on people's welfare and health concerns, particularly in Indonesia.^{1,2} This practical lifestyle comprises bad behavior and nutrition, which raises the risk of noncommunicable diseases.^{3,4} Noncommunicable illnesses are the leading cause of death worldwide. According to a World Health Organization (WHO) report from 2017, noncommunicable diseases kill 40 million people, accounting for roughly 70% of the world's 56 million deaths. This is also supported by the RI Strategic Plan for 2015-2019, which lists hypertension, diabetes mellitus, cancer, and chronic obstructive pulmonary disease as major causes of death. As a result, the global health community's focus on noncommunicable illnesses is critical.^{5,6}

According to the Institute for Health Metrics and Evaluation (IHME), the incidence of noncommunicable diseases had increased in 2017, accounting for 33.1% of the 53.3 million deaths worldwide caused by cardiovascular disease. In the same year, hypertension killed around 7.5 million people, which amounts to 12.8% of all fatalities globally. Hypertension was projected to affect approximately 22% of the world's adult population, or approximately 1.28 billion people. However, only 42% of adults were diagnosed and treated for hypertension, 46% were ignorant that they had it,

and only 21% were able to control it. As much as two-thirds of people with hypertension lived in middle-to-low-income nations.^{6,7} Because most hypertension patients are unaware that they have the disease, it is sometimes referred to as a "silent killer" because it does not display symptoms in most cases and is only discovered when complications emerge, which can lead to death.⁸

According to the World Health Organization, the African area has the highest incidence of hypertension at 27%, followed by Southeast Asia in third place with a prevalence of 25% of the total population in the world. The number of people with hypertension continues to rise year after year, and it is anticipated that by 2025, there will be around 1.56 billion adults with hypertension, with an estimated 10.44 million people dying each year from hypertension and its sequelae.⁹

In Indonesia at present, non-communicable disease, especially cases of hypertension, are increasing every year. This is supported by the 2018 Riskesdas data showing the prevalence of non-communicable disease has increased when compared to the 2013 Riskesdas. The prevalence of blood pressure measurement results, cases of hypertension increased from 25.8% to 34.1%.¹¹ In 2016, it was noted that hypertension was the cause of death in Indonesia, amounting to 23.7% of 1.7 million deaths. Data on causes of death in Indonesia in 2016 found a

Cite this article: Pobas S, Nazaruddin B, Palutturi S, Arifin MA, Wahiduddin, Russeng SS, et al. Policy Implementation of Hypertension Prevention and Control Program in Banjarmasin. Pharmacogn J. 2023;15(4): 641-649.

total of 1.5 million deaths with the most common cause of death being cardiovascular disease 36.9%. IHME also stated that out of a total of 1.7 million deaths in Indonesia, the risk factor that caused death was blood pressure (hypertension) of 23.7%. In line with cases of hypertension in Indonesia, the Ministry of Health stated that in the last three years, the prevalence of hypertension in Indonesia has increased significantly. This puts hypertension as one of the highest causes of death in Indonesia. Therefore, hypertension is a case of non-communicable disease that needs to be managed and controlled seriously, because it can cause chronic disease complications and even death if not treated properly.¹⁰ This is also supported by the results of the 2018 Riskesdas, the prevalence of hypertension in Indonesia showed that the province of South Kalimantan had the highest prevalence of 44.13% followed by West Java with 39.6%, and East Kalimantan with 39.3%. West Sumatra had the lowest hypertension prevalence, at 25.16%, North Maluku had 24.65%, and Papua had 22.2%.⁴ The implementation of holistic and comprehensive health services includes efforts to prevent, treat, and control hypertension through noncommunicable disease management programs. The Indonesian government established the Directorate of Noncommunicable Disease Control to empower people to live healthy lives by detecting and controlling hypertension risk factors early and prioritizing prevention activities. This program comprises characteristics that are promotional, preventive, curative, rehabilitative, and palliative (Regulation of the Minister of Health of the Republic of Indonesia No. 1575 of 2005).

In 2019, the expected number of hypertension patients aged 15 years was 1,097,850 people, with 342,709 people receiving health treatments, representing a percentage of 31.2% (South Kalimantan Health Profile, 2020). In conjunction with this information, the South Kalimantan Provincial Health Office reported 201,501 instances of hypertension in 2019 based on male and female gender. The capital city of Banjarmasin has the greatest prevalence of hypertension in South Kalimantan, with 57,257 persons suffering from the condition in 2019. According to the 2018 Riskesdas, the prevalence of hypertension in South Kalimantan has increased by 13.3%. In 2020, the number of hypertension cases in Banjarmasin climbed to 108,392 (data from the South Kalimantan Provincial Health Office, 2019-2020). This data point is consistent with the prevalence of hypertension cases and deaths reported by the Banjarmasin City Health Office for 2020. It was reported that hypertension ranked first in Banjarmasin in terms of the number of cases recorded, with a total of 36,143 old cases (second or more visits to health care facilities) and 16,834 new cases (first visit and not yet recorded at a health care facility), with a total death of 879 cases.

An increase in the prevalence of hypertension in each area has major consequences, including an increased burden on society and the government, as well as increased expenditures and technology for dealing with it. Hypertension can potentially lead to problems and mortality, particularly in young or productive patients. Many cases of hypertension go unreported, affecting the entire health system, including health, economic, and social development, health status, and community welfare. As a result, a collaborative strategy and commitment in health policy are required to limit the harmful impacts of hypertension through optimal hypertension prevention and control at all levels of policymakers and implementation. In this case, the South Kalimantan Provincial Health Office has succeeded in implementing a hypertension prevention and control program through the non-communicable disease prevention and control program with good performance indicators, namely the prevalence of high blood pressure of 23.79% and the percentage of Public Health Centers with implement integrated non-communicable disease by 50%. This achievement was based on socialization activities to the community through health education regarding non-communicable disease, especially hypertension, calls for prevention and control of risk factors, and the

importance of increasing awareness to carry out independent and periodic health checks to prevent complications and death.

The Banjarmasin Health Office administers a hypertension prevention and control program based on standard policy directions and techniques in the national health development system, with the goal of lowering the prevalence of hypertension cases and addressing public health issues. This policy emphasizes enhancing everyone's awareness, willingness, and ability to live a healthy life to create a healthy environment and to have access to quality health services in a fair and equitable manner. According to the head of the section for non-communicable disease prevention and control program of the Banjarmasin City Health Office, hypertension has become a major health problem in South Kalimantan Province, particularly in the city of Banjarmasin, where the prevalence of cases is highest. The pattern and behavior of public health is one of the risk factors that contribute to hypertension cases in Banjarmasin. Although the South Kalimantan City Health Office has implemented several hypertension management programs in the Healthy Living Community Movement such as the Integrated Development Post of Non-Communicable Disease hypertension program with prevention actions through the program of: regular health checks, get rid of cigarette smoke, be diligent in physical activity, have a balanced diet, get enough rest and manage stress. Also, hypertension control actions through the program of, optimal success has not been achieved.

According to the Banjarmasin City Health Service Strategic Plan 2016-2021 and the Banjarmasin Health Profile 2019, the results of the evaluation of health services for people with hypertension (estimated number of people with hypertension aged 15 years at the district/city level) with a target achievement of 100% and the number of targets is 111,325, with an achievement of 71.94%. This data has failed to meet service objectives. Following the evaluation of the report, it is required to optimize it to improve the quality of health professionals and increase oversight of program and field implementing officers. Cross-sector collaboration is also required to obtain better results in line with the goals specified. Activities must be assessed for a year to control implementation and provide material for the development of future health initiatives. Some of the challenges in attaining program effectiveness include data collection difficulties and the need for assistance from all parties, including stakeholders, managers, and community participation.

The Banjarmasin City Health Office implemented the Integrated Development Post of Non-Communicable Disease Hypertension program, which discover several problems, particularly in the limited number of Public Health Centers staff who are not always present for program management on a regular basis, resulting in program management that is less than optimal in most Public Health Centers. This program's execution includes assessing non-communicable disease risk factors, screening persons with hypertension, and coaching by health center employees. Some of the challenges in implementing the program include low operational costs, limited facilities and infrastructure, a lack of cadres, unskilled cadres, and a lack of community enthusiasm. Furthermore, there is still a lack of diversity in the target sex and age categories, which is one of the reasons for the lack of variety in Integrated Development Post of Non-Communicable Disease visitors. The cadres and the community do not fully understand the program's primary premise, resulting in conflicting perceptions among management, cadres, and the community.

According to Kusnadi in 2015,¹¹ several factors have a significant impact on the quality of health services in the implementation of health policies, including communication, bureaucratic structure, support for human resources with the ability, creativity, and skills in providing services, as well as implementers' attitudes and behavior. One that is professional. These factors have been used indirectly in the NCD

policy implementation plan to promote public health on a national and regional scale. To do this, community empowerment has been used to increase policy advocacy, popularize the Prevention and Control of Non-Communicable Diseases program, increase human resource capacity, and strengthen surveillance, networking, and collaboration mechanisms. All of this is indicated in the 2019 Prevention and Control of Non-Communicable Diseases Guidelines provided by the Indonesian Ministry of Health.⁷ As a result, hypertension management plays a vital role in the prevention, management, and control of hypertension, particularly in preserving stability, improving health status, and extending patients' life expectancy.¹² This is supported by the disposition of the health office as the manager and attitude maker who plays the main role in implementing the program in accordance with existing bureaucratic standards, namely implementing policies and regulations, advocacy and outreach, early detection of hypertension, surveillance, health promotion, and partnerships with cross-sectors that are finally realized in hypertension management.

The impact of implementing suboptimal program policies can result in a variety of problems and health risks for individuals, families, and communities in a holistic manner (biological, physiological, psychological, social, and spiritual), as well as threaten the health system, such as by increasing and the large socio-economic costs caused by the Management, care, and treatment of hypertension and its complications, lowering health status and life expectancy, particularly for young people. Consequently, all forms of policy implementation through various health programs so that control efforts are carried out with a comprehensive Health Care Service (Promotive, Preventive, Curative, and Rehabilitative) are always carried out on an ongoing basis to suppress and minimize the impact of threats that can arise for the continuity of the health system both for regional, national, state, and community areas, have become crucial today, particularly in Banjarmasin.¹³

Understanding the implementation process is important not only in terms of what was successful and what was not, but also in terms of how and why the implementation went right or incorrect and testing potential solutions.¹⁴ Data and sources indicate that the province of South Kalimantan has the highest prevalence of hypertension in Indonesia, with a recent increase in the number of sufferers in the capital city of Banjarmasin. This condition is of particular concern and necessitates comprehensive and ongoing monitoring through the implementation of hypertension prevention and control program policies, particularly in the province of South Kalimantan and its capital city, Banjarmasin.

METHODS

This study employed a qualitative descriptive-exploratory analytic method using multiple case study approaches, with data collected from all research informants *via* in-depth interviews, observation, documentation, and literature review.¹⁵ This study was carried out at a number of locations, including the Banjarmasin City Government Office, the Banjarmasin City Health Office, several Community Health Centers in Banjarmasin City, and other areas in Banjarmasin City. Communication, resources, bureaucratic structure, and dispositions/attitudes are all research variables. In this study, informants were chosen through purposeful sampling. The informants in this study consisted of key informants: Planning Staff Young Expert at the Regional Development Planning Agency, Research and Development of Banjarmasin (local government representative), Sub Coordinator for Non-Communicable Diseases and Mental Health, Non-Communicable Disease program management and planning staff (hypertension). The main informants consisted of stakeholders at the health center, and those who were in charge of the Terminal health center program, the person in charge of the Cempaka Health Center program and the person

in charge of the Pelambuan Health Center program, as well as health cadres in the working areas of each of the health centers. Supporting informants are residents of Banjarmasin. Data analysis techniques: data reduction, data presentation and drawing conclusions.

RESULT AND DISCUSSION

This research was conducted in several places, namely the Banjarmasin City Government Office, Banjarmasin City Health Office, several Community Health Centers in Banjarmasin City according to the needs and criteria of the researchers, namely the Terminal Health Center, Pelambuan Health Center and Cempaka Health Center, as well as several areas in the city of Banjarmasin which were designated as representatives areas to be studied, namely West Banjarmasin and East Banjarmasin.

Informants in this study involved 10 people, Planning Staff Young Expert at the Regional Development Planning Agency, Research and Development of Banjarmasin (local government representative), Sub Coordinator for Non-Communicable Diseases and Mental Health, Non-Communicable Disease program management and planning staff (hypertension). The main informants consisted of stakeholders at the health center, and those who were in charge of the Terminal health center program, the person in charge of the Cempaka Health Center program and the person in charge of the Pelambuan Health Center program, as well as health cadres in the working areas of each of the health centers. Then, supporting informants included community representatives in the city of Banjarmasin. The age of the informants was dominated by the average age of early adulthood and late adulthood, which ranged from 26 to 45 years. The sex of the informants was dominated by women with a total of 9 women and 1 man. Based on the level of education in this study, there were 1 informant with a Master's degree, 5 people with Bachelor degree, 1 person for Diploma degree, and 3 high school graduates. The characteristics of the informants' tenure in this study were dominated by an average tenure of 1-5 years. The research results have been analyzed and presented in the following description:

Implementation of hypertension prevention and control program policy in Banjarmasin

Based on Law no. 25 of 2004 concerning the national development system which also applies in South Kalimantan Province, the regional government is required to have a development planning document based on a study of regional health indicators, which is a combination of guidelines for the National Long Term Development Plan, National Health System, 2014 Public Health Development Index, as well as Regulation of the Minister of Home Affairs No. 86 of 2017 (South Kalimantan Province RPJMD 2016-2021). Where one of the focus indicators of health strategy issues in the province of South Kalimantan, especially the local government, is the problem of non-communicable diseases. Meanwhile, several program policies in noncommunicable disease management are being implemented, such as increasing policy advocacy, carrying out promotional, preventive, curative, rehabilitative, and palliative efforts, improving the quality of human resources, strengthening surveillance systems, and finally strengthening networks and partnerships through community empowerment.¹⁶ This is also supported by the Regulation of the Minister of Health of the Republic of Indonesia No. 71 of 2015 concerning the prevention of noncommunicable diseases, which are of particular concern as the cause of high morbidity, disability, and death, resulting in an increase in the burden of health financing, so that it is necessary to organize a comprehensive, efficient, effective, and sustainable, especially in the case of hypertension. As a way to deal with it, the community must be actively involved, both individually and in groups, in a variety of activities aimed at improving and empowering public health, such as Community-Based Health Efforts through the establishment and

development of Integrated Noncommunicable Disease Development Posts.¹⁷

The responsibility of the local government in executing the strategy for the prevention and control of hypertension cannot be separated, so that it can reach the target evenly, namely the people in each region. In accordance with this, Government Regulation No. 02 of 2018 established minimal service requirements that must be supplied by the government in the form of basic services to the public in order to meet the basic needs of every person, one of which is health care. In providing basic health care, it refers to unmet MDG targets, SDG 2030 targets, and minimum service requirements (BAPPENAS, 2018). As a result, it has been governed through government rules in Law 23/2014 article 18 paragraph 3 about policies regarding basic service requirements in order to promote the implementation of the health service system in the regions. Regulation of the Minister of Home Affairs 59/2021, in particular, contains general implementation instructions for the application of minimum service standards, which contain technical instructions for mechanisms and strategies for implementing minimum service standards beginning with data collection, calculating basic needs fulfillment, planning, implementation, and reporting.

The Regulation of the Minister of Health 4/2019 policy regarding technical standards for fulfilling the quality of fundamental services at minimum service standards in the health sector specifies the minimum service standards in the health sector. The indicators for MSS services in the health sector at the city level consist of 12 fundamental services that must be met, one of which is health services for persons with hypertension and at productive age for early detection of infectious diseases, for which the achievement target must reach 100 percent. This is supported by Regulation of the Minister of Health No. 43 of 2016, which consists of health screening for ages 15-59 years, health screening for ages > 60 years, and health services for people with hypertension. It is also supported by Ningrum's research from 2016 concerning an analysis of the implementation of Minister of Health Regulation No. 71 of 2015 related to non-communicable diseases states that activities for managing non-communicable diseases, namely the implementation of public health services, will be facilitated to actively participate in management programs for the prevention and control of non-communicable diseases with the knowledge and skills of early detection.

The technical standards for fulfilling the quality of basic services in the health sector state that people with hypertension have the right to receive health services in accordance with standards that include measuring blood pressure at least once a month in health care facilities, education on lifestyle changes, treatment efforts, and the need for further referrals (Regulation No. 04 of 2019 of the Minister of Health).

Based on data on the results of health development in Banjarmasin in 2021, the achievement of Minimum Service Standards for Health Services for Hypertension Sufferers was reported. The estimated number of hypertension sufferers aged ≥ 15 years based on the prevalence rate is 86.73% of the target achievement of 100%. This is a benchmark for the success of health development performance for the community and an indicator of the government's role in managing basic needs in the health sector. Thus, it can be concluded that the achievement of the hypertension health program in Banjarmasin has been achieved with quite good results. On the other hand, the implementation of a policy or program is an activity of distributing the output of a policy or program carried out by implementers to target groups to realize the objectives of the policy or program.¹⁴

According to Edward III's theory, the successful implementation of program policies is influenced by four main indicators, namely communication, resources, bureaucratic structure and dispositions/attitudes,¹⁹ which are then depicted in the following description:

Communication

In the communication indicator, there are 3 main things that determine its success, namely transmission (dissemination of information), clarity and consistency. Overall, the communication process had been carried out effectively, both the policy makers, namely the Mayor of Banjarmasin, the Head of the Banjarmasin City Health Service through the local government's Research and Development Planning Agency section to the Prevention and Control of Non-Communicable Diseases field of the Health Service, which then from the City Health Office was forwarded to all program implementers in all Banjarmasin City Health Centers, especially program holders in the field of non-communicable disease prevention and control services along with non-communicable disease health cadres, until finally they reached the program target, namely the community in the city of Banjarmasin.

In terms of transmission, as a whole, the communication process in implementing programs to prevent and control non-communicable diseases related to hypertension had been going well. Communication was conducted in stages in accordance with the regulations governing each agency and affiliated industry. There were meetings, discussions, and socialization to plan interventions for hypertension service programs in accordance with the vision and mission guidelines of regional leaders, the attainment of minimum service standards in the health sector for hypertension services, and program adoption by the Ministry of Health. All program implementers participated in determining program interventions, reporting, sharing, evaluating implementation results, and reaching hypertension service program success goals. As program targets, the city administration, the Banjarmasin City Health Office, stakeholders such as health centers and health cadres, and the community were involved in the information transmission process. Communication was two-way and democratic, including all important parties to acquire the necessary feedback, input, and output information. The information dissemination process was carried out through a variety of methods and approaches from the health office to Public Health Centers, health cadres, and the community, such as regularly scheduled meetings, Integrated Development Post of Non-Communicable Disease activities, mini workshops, health education with the program of: regular health checks, get rid of cigarette smoke, be diligent in physical activity, have a balanced diet, get enough rest and manage stress, check your health regularly and follow the doctor's recommendations. Overcome illnesses with proper and regular medication. Stick to a healthy diet with balanced nutrition. Strive for safe physical activity. Avoid smoking, alcohol and other carcinogenic substances, and community outreach about hypertension in general from management, prevention, and control. Leaflets, flyers, banners, and movies were examples of public outreach media. The socialization aims, messages, and strategies were tailored to the sort of program objectives. According to research findings from Ratnasari, 2020 and Fitri *et al*, 2021,^{20,21} the employment of diverse media, both electronic and print, can maximize the process of effectively, efficiently, and sustainably sharing and transmitting information. This can lead to an increase in one's health-related knowledge, attitudes, and beliefs.

Clarity in communication by all parties on the implementation of hypertension prevention and control programs, based on policies, strategies, and program implementation contained in the vision and mission, and based on 12 achievement targets for minimum service standards in the Non-Communicable Disease Health Sector, particularly in dealing with hypertension problems in Banjarmasin. The health office organized and delivered to the Public Health Centers and health cadres all training activities, health education, and health checks in the program to prevent and control hypertension. This is corroborated by the findings of Nugraheni's 2018 research,²² which argued that health cadres are members of the community who have specific knowledge and abilities in health concerns as a result of health

worker training. This will aid in the smooth execution of health-care services on the ground. Health education information on hypertension with regular health checks, get rid of cigarette smoke, be diligent in physical activity, have a balanced diet, get enough rest and manage stress. Check your health regularly and follow the doctor's recommendations. Overcome illnesses with proper and regular medication. Stick to a healthy diet with balanced nutrition. Strive for safe physical activity. Avoid smoking, alcohol and other carcinogenic substances. These programs also assist the community in adopting a healthy lifestyle, care, and treatment. According to Wardana *et al.*, 2020,²³ education can promote public knowledge in establishing healthy lifestyle, care, and treatment arrangements, as well as raise awareness to comply with care and treatment. The consistency of information in the execution of hypertension prevention and control programs by all parties concerned implies that program implementation efforts are being paid attention to, focused on, and synchronized from start to finish.

This consistency had been followed from prevention through control and was backed by regulations and organizations developed in each institution involved in this initiative. Through health promotion, medical examination/screening, treatment, reporting, and data gathering, the Community Health Center and health cadres were able to achieve routine and sustainable consistency in a single integrated hypertension service program. The community had also received consistent information through scheduled activities carried out on a regular basis by the Public Health Centers, such as health counseling activities, health checks, and consultations during Integrated Development Post of Non-Communicable Disease events, Integrated Healthcare Center for Elderly, outreach, and others. This is corroborated by research by Damayantie *et al.* (2018),²⁴ which argues that in terms of fulfilling health needs, both independent routine health checks and access to health services are necessary. The community may easily have access to services ranging from detection to monitoring of health concerns, one of which is hypertension, thanks to Integrated Development Post of Non-Communicable Disease activities.²³

Good communication is required for optimal policy program implementation.²⁵ In an organization, communication is the process of transferring information and ideas between members of the organization in order to fulfill the goals that have been established. message success is measured by the transmission, consistency, and clarity of message. A systematic and structured approach and procedure is required from the originator of the information to the recipient who receives the information in order to accomplish optimal communication. However, there are barriers in the communication process that make it difficult to reach all targets related to hypertension prevention and control, particularly those of productive age who are influenced by experience, perception, motivation, individual awareness in managing health independently, and the timing of program implementation that does not facilitate them. According to the findings of Hasanah *et al.*'s²⁶ research, 2022, a lack of public knowledge about adequate health information led to low participation in socialization programs, health counseling, and other health programs held independently and by health institutions. A person's positive or negative perspective of sickness can influence their behavior, attitudes, and behaviors, as well as their decision making when it comes to managing and overcoming the disease. As a result, efforts must be made to raise public awareness in order to modify their ideas, beliefs, and motives about the importance of health care and management by participating in health programs established by health workers and the nearby health service facility.

The challenge is a lack of cross-sector support and coordination, which interferes with the program's effectiveness and efficiency, particularly for persons who already have hypertension. This issue is related to erroneous experiences, perceptions, comprehension, knowledge, and stigma in carrying out hypertension preventive and control procedures

on one's own. To address this, increased coordination is required among hypertension service program executors at health centers/health professionals, across sectors, and local community leaders. Integrating the health system across programs and sectors is also required to accomplish a wide range of community aims with limited resources (WHO, 2020).

Resource

In terms of resources, such as human resources, they had met staff standards in both the health office and Public Health Centers; however, there were a number of officers with an excessive workload, and there was still a lack of health workers in the field to support cadres who were inadequate for carrying out activities. Where this caused delays in the city health office's Public Health Centers surveillance data reporting system and data input procedure. In terms of authority information pertaining to the implementation of program policies, it had been implemented through the establishment of a management and implementing team, as stipulated in the organizational structure decree for the program manager in each relevant institution. Nonetheless, some Public Health Centers continued to experience difficulties with the budget distribution procedure, resulting in supply delays for activity programs because it took so long to acquire the necessary resources.

Concerning the need for human resources, it had been met within the boundaries of the city's government and the Banjarmasin city health office, both of which have procedures, regulations, and policies in place for fulfilling human resources. However, the availability of human resources in the regions was still influenced by a number of factors, including the implementation of central government policies, regulations, internal and external organizational systems, all of which had an impact on the availability of human resources in institutions and agencies, particularly health and Public Health Centers. Some of the major elements influencing human resource fulfillment in local government, Regional Apparatus Work Units, and Public Health Centers include recruitment, position/position selection, delegation, and human resource management to be able to carry out the assigned job obligations.

Human resource availability limits the ability to choose position, duties, implementation, and procurement of human resources from the center. Because these health personnel perform services, administration, reporting, and so on, this has an impact on increasing workload and optimizing services. Human resources capable of carrying out administrative operations such as audit, data, reporting, and archive centers are looked for. Each program should be administered by one individual for one program/sector in order to be more focused and optimal in both management and field implementation. This is consistent with the research findings of Maula, 2020 and Habibi *et al.*, 2017^{27,28} who stated that the problem that frequently occurs within the scope of the Public Health Centers is multiple positions, despite the fact that the health worker or the party assigned the main duties and functions accepts and is willing to fulfill this role. This is due to the limited number of employees, which affects the number of programs that must be administered by a single individual. As a result, additional individuals are required to optimize the implementation of performance achievements more effectively and efficiently.

The workforce at the health office and Public Health Centers had reached standards, although certain officers had an excessive workload, and a lack of field health workers results in an insufficient number of health cadres for these activities. This caused delays in the reporting system and the input of Public Health Centers surveillance data to the city health office. According to Ratnasari's research,²⁰ 2020 claims that fulfilling human resources is one of the primary resources in

executing programs such as Integrated Development Post of Non-Communicable Disease, which demands the presence of health workers with coordination and task division.

Every year, the Public Health Centers in their region provided training to health cadres to improve their knowledge and skills in conducting various health checks, as well as information about health programs, noncommunicable diseases, and risk factors (including hypertension). According to Regulation of the Minister of Health and Regulation of the Minister of Home Affairs No. 100 of 2018, health workers (doctors, nurses, nutritionists, and analysts) are responsible for performing health checks such as measuring blood pressure and providing health education, while health cadres are tasked with assisting administration such as recording, attendance, and activity schedule information through coordination with health workers and the community in their area, and medical therapy is only provided by doctors.

In the system of budgeting and financing management, regional/city governments had divided it evenly across all Regional Apparatus Work Units in accordance with their program planning. The Regional Apparatus Work Units of the City Health Office, especially in the Prevention and Control of Non-Communicable Diseases field, routinely carried out the hypertension service program every semester to once a year by applying for financing through the Annual Work Plan and Budget. After implementing the program, Regional Apparatus Work Units would report and be accountable for one year to the mayor, Regional Development Planning Agency, Research and Development, and Regional People's Representative Council with Regional Revenue and Expenditure Budget and Health Operational Assistance funding sources. The budget at the Public Health Centers was obtained through the management of Health Operational Assistance funds and part of the Regional Public Service Agency budget. However, when it came to health care budgets, financing for program execution was not administered by the health cadres themselves. Their participation just served to facilitate activities, and they would be compensated.

Technical and operational challenges existed in the budgeting and finance processes of the hypertension program management and implementation. The Public Health Centers independently controlled the entire budgeting process through Health Operational Assistance, sourced from the city health office and Regional Public Service Agency, although Regional Public Service Agency had not been fully adopted by all Public Health Centers in the city of Banjarmasin. According to Maula's analysis, 2020 claims that all costs for implementing the hypertension care program are covered by the Health Operational Assistance and National Health Insurance budgets. The funds are readily available and fulfilled in line with each institution's planning/needs, up to routine monthly, quarterly, and annual evaluations/reporting to all relevant parties, including local government, service heads, and Public Health Centers leaders. The community can participate in and receive hypertension service programs and activities outside of the Public Health Centers, such as outreach, health education, Integrated Development Post of Non-Communicable Disease, and Integrated Healthcare Center linked to hypertension prevention and control, for free. However, individuals who do not have Social Security Agency of Health /general patient category will be charged Rp. 10,000 for doing health checks and treating hypertension at the Public Health Centers. Meanwhile, those who have Social Security Agency of Health can access free health checkups and treatment.

According to Utari and Rochmah's 2019²⁹ research findings, the Burden of Disease (BOD) Study demonstrates that society bears large costs owing to specific disorders, including hypertension. BOD categorizes expenses into two types: direct and indirect costs. Direct costs are the annual fees that hypertension patients must pay for routine visits to the Public Health Centers, the purchase of medications at pharmacies,

and the purchase of traditional medicines. While indirect costs include unanticipated expenditures such as transportation costs for outpatient or inpatient care, prices for assistive devices, and other costs during outpatient or inpatient care, direct costs are costs that are incurred during outpatient or inpatient care.

According to the study's findings, indirect costs outweigh direct expenditures, which might result in significant economic losses for the society owing to unforeseen spending when unwell. As a result, it is critical to raise public awareness about hypertension prevention and control in order to avoid financial costs that might impair individual, household, regional, and even national welfare.^{30,31}

The Health Office's Regional Apparatus Work Units fully managed the provision of facilities and infrastructure to enable the operation of the health program, which was disseminated to all Public Health Centers in Banjarmasin City *via* regular Annual Work Plan and Budget submissions. These facilities and infrastructure included instruments and supplies for health checks that have been made accessible to the City Health Office through submissions by the Public Health Centers and were routinely renewed when they run out. According to Maula's 2017 research, facilities are one of the primary factors for smoothness, performance productivity, and the effectiveness of program implementation. These facilities include infrastructure and facilities, a location for program activities, tools and supplies, and a variety of other supporting facilities such as tables, seats, record books, educational media such as brochures/leaflets, guidebooks, and so on. Facilities that are missing or broken must be fixed immediately because they can impede the program's smooth implementation. The Public Health Centers collaborates with RTs and kelurahans to improve community access to the location and timing of program execution. So that the community can best meet the variety of health facilities in the activity program. The community benefits from the provision of a location and time for the implementation of programs such as non-communicable disease, hypertension in socialization activities, Integrated Development Post of Non-Communicable Disease, Integrated Healthcare Center, and other activities in the local village/neighbourhood. This also helps the community approach by involving local leaders such as the local village head/neighbourhood head.

According to Fauzi *et al.* (2020),¹² efforts to fulfill facilities, including time and place, were vital to promote community access to health programs/services, which had an impact on the program's success. One strategy that can be presented is to develop a door-to-door campaign system or home visits in a family health approach that is done on a regular basis. This enables persons with limited time to participate in Public Health Centers events or other health initiatives to access health services such as health education, medical examinations, and consultations. According to the study's findings (Arifa, 2018),³² there is a substantial association between the level of adherence and timeliness in chronic illness treatment programs, one of which is hypertension.

With the success of minimal service standards Health Sector, which was adopted and entirely managed by Regional Apparatus Work Units in the health sector, information on authority already had a fairly clear system from the honorable city government, Regional Development Planning Agency, Research and Development, and Regional Apparatus Work Units of Health Office of the city of Banjarmasin. The evaluation outcomes or the product of the established program policies and the attainment of success targets are the restrictions on authority information. Where this is influenced by the process, implementation and determination of several main tasks and functions in managing the health sector from the city health office which specifically in the field of Prevention and Control of Non-Communicable Diseases have not fully adjusted to the stipulations of main tasks and authorities from the central government, where there is a change in the management of

the Prevention and Control of Non-Communicable Diseases program should have focused on non-communicable disease, meanwhile for other programs outside non-communicable disease, they have entered other fields, namely the field of public health. The Public Health Centers contains information and authority in the form of an official decree from the head of the Public Health Centers to each party in the position/field of fulfilling responsibilities, the role of managing to implementing program activities, specifically by the non-communicable disease sector including hypertension. If the Public Health Centers determine and cadres to be involved and play a role in Integrated Development Post of Non-Communicable Disease activities, as well as other activity programs that directly include the community, and cadres. Health cadres do not have SK, thus their tasks and authorities are registered through a cadre certificate, making them more flexible if they move cadre.

Policy implementation is also influenced by resources such as enough and skilled employees based on needs, policy knowledge, implementers' authority, and existing facilities.¹⁴ The availability of resources, including human resources, funding sources, information on authority, and support for important facilities to be developed for community organizations, plays an important role in the successful implementation of any public health program/policy.³³

Bureaucratic structure

The bureaucratic structure had efficiently adopted program mechanisms, as indicated by the existence of SOPs (Standard Operating Procedures) utilized in service/program implementation; nevertheless, not all agencies had complete and standard documentation and SOPs.

Local government guidance documents or SOPs were based on broad guidelines established in stages by the center and were typically delivered in the form of report documents at the health office. There was also a particular SOP owned by the Banjarmasin city health office's Prevention and Control of Non-Communicable Diseases division that was relevant to the hypertension prevention and control program. This SOP was based on center guidelines, such as the 2020 Non-Communicable Disease Hypertension Management Guidelines. The program in Banjarmasin was entirely executed based to center criteria, hence no program innovations had been developed. The SOP for the hypertension program was contained in the recommendations for the management and service of hypertension at the Public Health Centers, which adopted the system from the Indonesian Ministry of Health's central guidelines. The lack of an appropriate file and documentation system, however, was an impediment to applying SOPs, therefore paperwork and hardcopies were only available for the benefit of the Public Health Centers accreditation program. Furthermore, the abrupt change of party in power made the archive and document delegation procedure less than optimum. Not all agencies had comprehensive and standardized SOPs, and a lack of attention to SOP procurement might have an impact on the quality assurance/quality of the relevant agencies. SOPs (Standard Operating Procedures) were employed in program services and implementation; however, not all agencies had complete and consistent documentation and SOPs. According to Indiahono's perspective,¹⁹ 2017, SOP is a collection of concepts from many frameworks that are clear, methodical, directed, and easily understood by everyone, serving as a reference for program implementers. The unavailability of SOPs or lack of attention to procurement of SOPs in program implementation will have an impact on quality assurance/quality of related agencies, and if SOPs are not clear, directed and systematic, then guidelines/guidelines that can be used as references are not available, which has an impact also on the lack of understanding of the concept in the management and implementation of the program, as well as the decline in the guarantee/quality of program service quality.

Fragmentation which is the division of roles, tasks and functional officers from the city government and the city health office had been provided

through a decree from the mayor of Banjarmasin. This demonstrates that the bureaucratic structure had been formed in accordance with their respective domains through a good regulatory system. The division of tasks to accomplish the tasks, roles, and responsibilities of program management at the Public Health Centers was defined directly by the Public Health Centers's head, accompanied by an decree, and the Public Health Centers's requirement for human resources. The division of roles and functions for individuals responsible for not just administering one program, but also for program holders who have obligations in multiple programs, is an impediment to fragmentation. This will result in less concentrated program implementation optimization, because if numerous programs are required and carried out at the same time, there will be programs that cannot be followed until they are executed by a single program holder. Finally, numerous program implementations were delayed and could not even be completed within the time frame specified. An organizational structure that has been formed by an institution as a manifestation of the description of tasks, functions, lines of authority, responsibilities, and the number of officials and formal boundaries in the event that the organization is formed/operates (Ratnasari, 2020)²⁰ is available for fragmentation or division of labor. The impact of policy actors' unclear division of tasks, mechanisms, functions, authorities, and responsibilities will result in disharmony of organizational relations between implementers, performance results, performance quality, and policy implementation failure.³⁴

Bureaucratic structures that influence policy implementation are work procedures and basic measures, hierarchical organizational structure, coordination and authority. An important aspect of this bureaucratic structure is the program implementation mechanism established through Standard Operating Procedures *via* program/policy guidelines, as well as the organizational structure of implementing the policy/program itself *via* division of responsibilities, roles/positions.¹⁹

Disposition/Attitude

Dispositions/attitudes had gone well and been carried out with full responsibility because of the commitment by the local government, heads of the city health office, program managers and implementers in every health center to health cadres. Even though the community's attitude was still below the achievement target, this will be related to motivation, perception, awareness, belief and the achievement of various community goals had not been fulfilled, such as more program participants consisting of the elderly compared to the productive age target.

According to Oo (2018),³⁵ attitudes, perceptions, beliefs, and motivation created in a person are influenced by various factors ranging from knowledge, socio-culture, medical history, and so on, which then affect health behavior, which is also known as social cognitive theory through self-efficacy. The local government demonstrates attitudes and dispositions by providing support to all stakeholders, including Regional Development Planning Agency, Research and Development, in the planning of health programs, particularly hypertension care.

Starting with the head of the service, the field head, and the Prevention and Control of Non-Communicable Diseases coordinator, all workers at the health office demonstrated attitudes and dispositions in program evaluation through emotional, material, democratic, and innovative support. At the Public Health Centers, the leadership fostered a positive attitude as a leader, advisor, facilitator, supervisor, and support system for all personnel involved in the program's operation and management, including the awarding of incentives to health cadres as a form of recognition. This is reinforced by Artyasari *et al*,³⁴ 2021 research findings, which show that implementing pledges can also generate incentive and responsibility for program implementation. Disposition is a characteristic possessed by the implementor manifested in commitment, honesty, motivation and democratic nature. Stakeholders

who are the main actors play an important role in the implementation of program policies. If implementers have a positive attitude, they can run the program according to the wishes of policy makers. This can create a positive impression on program targets, increasing their trust and concern for the program/policy.¹⁹

In the community, disposition was also shown through satisfaction with the services of health workers in conducting hypertension prevention and control programs, which stimulated community motivation and engagement. Individual awareness, motivation, and compliance in the implementation of hypertension prevention and control programs are the major challenges. This inclination was shown in the form of satisfaction with the services provided by health workers for the implementation of health programs in this community. Through this satisfaction motive, most people were encouraged to participate in implementing hypertension prevention and control programs, such as through periodic independent health check-up activities at Public Health Centers and Integrated Development Post of Non-Communicable Disease activities in the community. Attitude, commitment, and high motivation in implementing the program originate with the individual and are supported by the environment, which then becomes a value that is integrated with the individual, ultimately producing performance that meets organizational objectives. On the other hand, an open attitude, good support, and complete support in implementing programs both inside the institution's internal and exterior scope to the community would result in success in attaining the policy program's objectives.³⁴

CONCLUSION AND SUGGESTION

To achieve targets in each region, the role of local government in executing hypertension prevention and control program policies is critical. This is governed by Government Regulation No. 02 of 2018, which specifies the minimum service requirements that must be offered to the population, including hypertensive patients. Health services must meet criteria such as blood pressure monitoring, lifestyle education, medication, and follow-up referrals. The city of Banjarmasin met the minimum service standards for people with hypertension 86.73% of the time, which demonstrated the government's success in providing fundamental health needs. It is possible to infer that the hypertension prevention and control program in Banjarmasin Regency/City was a success.

On communication indicators, namely transmission, clarity, and consistency. The entire communication process between the policy makers, namely the Mayor of Banjarmasin, the Head of the Banjarmasin City Health Service through the local government's Research and Development Planning Agency division to the Health Service's Prevention and Control of Non-Communicable Diseases field, had performed well. Then, from the City Health Office, the information was forwarded to all program implementers in all Banjarmasin City Health Centers, especially for program holders in the field of non-communicable disease prevention and control services along with non-communicable disease health cadres, until finally it reached the community in Banjarmasin City.

Human resources, for example, had reached manpower norms at the health office and Public Health Centers, but certain officers had an excessive workload, a lack of availability of field health workers, and insufficient cadres to carry out tasks. This caused delays in the reporting system and the transmission of Public Health Centers surveillance data to the city health office. In terms of authority, the execution of program policies had been carried out through the construction of a management and implementing team for the person in charge of the program in each relevant institution, as provided in the organizational structure decree. The Public Health Centers' program-related facilities and infrastructure were adequate and available 60-80% of the time.

However, numerous Public Health Centers were still facing budget distribution issues, which was causing delays in the supply of necessities for activity programs because it took a long time to give them.

The bureaucratic structure had carried out program mechanisms quite effectively, as proven by the existence of SOPs in service/program implementation. However, not all agencies had complete and standardized documentation and SOPs.

Because of the commitment of the local government, heads of the city health office, program managers, and implementers in each health center to health cadres, the disposition/attitude had been going well and carried out with full responsibility. Even though the community's attitude remained below the achievement target, this was due to motivation, perception, awareness, and belief, as well as the failure to meet various community goals, such as having more program participants who were elderly compared to the productive age target.

The implementation of hypertension prevention and control program policies in the city of Banjarmasin was concluded to be quite successful, though there were still obstacles in several aspects such as methods and variations in program target participation from the communication aspect. There is still a need for a more evenly distributed budget management system in terms of resources, as well as a systematic equalization of authority tasks. Furthermore, each agency must develop organized documentation requirements in terms of bureaucratic organization.

REFERENCES

1. Purnamasari, Widya E. *Perencanaan dan Evaluasi Kesehatan Terpadu*. Bandung : Manggu Makmur Tanjung Lestari. 2020.
2. Signh GK. Social Determinants of Health in the United States: Addressing Major Health Inequality Trends for the Nation, 1935-2016. *Int J MCH AIDS*. 2017;6(2):139-64.
3. Tina L. Faktor Risiko Kejadian Penyakit Diabetes Melitus Tipe 2 Di Wilayah Kerja Rumah Sakit Umum Daerah Kabupaten Umum Tahun 2018. *J Ilmiah Mahasiswa Kesehatan Masyarakat*. 2019;4(2).
4. Kemenkes RI. Hasil Utama Risdas 2018. Jakarta : Kementerian Kesehatan RI. Diakses melalui. 2018.
5. Kemenkes RI. Renstra RI Tahun 2015-2019. Jakarta:Kementerian Kesehatan RI. Diakses melalui. 2017.
6. WHO. Hypertension. Diakses melalui. 2019. https://www.who.int/healthtopics/hypertension/#tab=tab_1 pada tanggal 24 Juli 2022.
7. Kemenkes RI. Pedoman P2PTM. Jakarta : Kementerian Kesehatan RI. Diakses melalui. 2019.
8. Kalssa A. Prevalence and Associated Factors of Hypertension among Civil Servants Working in Arba Minch Tohabihwn, South Ethiopia. *Int J Public Health Sci*. 2016;5(4):375-83.
9. Anggriani LM. Deskripsi Kejadian Hipertensi Warga Rt 05/Rw 02 Tanah Kali Kedinding Surabaya (Social Description Of The Incidence Of Hypertention At Residents Of Rt 05/Rw 02 Tanah Kali kedinding Surabaya). *J Promkes*. 2016;4(2):151-64.
10. Firmansyah RS, Lukman M, Citra WM. Faktor-Faktor yang Berhubungan dengan Dukungan Keluarga dalam Pencegahan Primer Hipertensi. *JKP*. 2017;5(2):197-213.
11. Kusnadi D. The Influence Of Policy Implementation From The Change Of Institutional Status Toward Quality Of Patient Service In Hospital. *Int J Sci Technol Res*. 2015;4(10):159-64.
12. Fauzi R. Program Pengelolaan Penyakit Hipertensi Berbasis Masyarakat Dengan Pendekatan Keluarga Di Kelurahan Pondok Jaya, Tangerang Selatan. *Wikrama Parahita : J Pengabdian Masyarakat*. 2020;4(2):69-74.

13. Awan H. Antropologi Kesehatan Untuk Keperawatan. Yogyakarta : Ar-Ruzz Media. 2020.
14. Ayuningtyas D. Analisis Kebijakan Kesehatan Prinsip dan Aplikasi. Depok: Rajagrafindo Persada. 2018.
15. Creswell, John W. Penelitian Kualitatif & Desain Riset. Yogyakarta : Pustaka Pelajar. 2015.
16. Direktorat Jenderal Pencegahan dan Pengendalian PTM. Buku Pedoman Manajemen Penyakit Tidak Menular. Jakarta Selatan : KemenKes RI & GERMAS. 2020.
17. Kemenkes RI. Profil Kesehatan Indonesia Tahun 2019. Jakarta: Kementerian Kesehatan Republik Indonesia. Diakses melalui. 2020.
18. Edward George. Implementing Public Policy. Amerika Serikat: Hopkins University. 1980.
19. Indiahono D. Kebijakan Publik Berbasis Dynamic Policy Analisis. Yogyakarta: Gava Media. 2017.
20. Ratnasari IA. Implementasi Program Pos Pembinaan Terpadu Penyakit Tidak Menular. HIGEIA J Public Health Res Dev. Diakses melalui. 2020.
21. Fitri AS. Penatalaksanaan Hipertensi Pada Era Adaptasi Kebiasaan Baru. 2021;17(2):105-12.
22. Nugraheni WP, dan Hartono RK. Strategi Penguatan Program Posbindu Penyakit Tidak Menular di Kota Bogor. J Ilmu Kesehatan Masyarakat. 2018;9(3):198-206.
23. Wardana IE. Analisis Proses Penatalaksanaan Hipertensi (Studi Kasus Di Puskesmas Purwoyoso Kota Semarang). J Kesehatan Masyarakat. 2020;8(1).
24. Damayantie, Netha. Faktor-faktor yang mempengaruhi perilaku penatalaksanaan Hipertensi oleh penderita di Wilayah Kerja Puskesmas Sekernan Ilir Kabupaten Muaro Jambi Tahun 2018. J Ners dan Kebidanan. 2018;5(3):224-32.
25. Padek. Toward Optimal Implementation of Cancer Prevention and Control Programs in Public Health: a Study Protocol on Mis-Implementation. Implementation Sci J. 2018;13(490).
26. Hasanah U. Pendidikan Kesehatan Pencegahan dan Perawatan dengan Pengaturan Diet pada Pasien Hipertensi. Seandanan: J Pengabdian pada Masyarakat. 2022;2(1).
27. Maula IN. Pelaksanaan Standar Pelayanan Minimal pada Penderita Hipertensi. Hal 799-811. HIGEIA J Public Health Res Dev. 2020.
28. Habibi. Gambaran Pengelolaan Pelayanan Kesehatan Berdasarkan Fungsi Manajemen Pada Program Pengendalian Penyakit Menular (P2M) Di Puskesmas Tamangapa Makassar Tahun 2016. 2017;9(1):43-54.
29. Utari AB, dan Rochmah TN. Analisis Burden of Disease Hipertensi Pada Masyarakat Di Kabupaten Kediri. Indonesian J Public Health. 2019;14(2):138-49.
30. Kartini W. Pengaruh Pelaksanaan Kebijakan tentang Puskesmas dan Dukungan Sarana Prasarana terhadap Manajemen Pelayanan Kesehatan untuk Meningkatkan Produktivitas Kerja. J Publik: Online Journal Universitas Garut. 2017;11(2):146-56.
31. Istiqomah AN, Rochmah TN. Beban Ekonomi Pada Penderita Hipertensi Dengan Status Pbi Jkn Di Kabupaten Pamekasan. J Manajemen Kesehatan STIKES. 2016;2(2):124-32.
32. Arifa, Auliya FC. Pengaruh Informasi Pelayanan PROLANIS dan Kesesuaian Waktu Terhadap Pemanfaatan PROLANIS di Pusat Layanan Kesehatan UNAIR. J Administrasi Kesehatan Indonesia. 2018;6(2).
33. Valaitis. Moving Towards a New Vision: Implementation of a Public Health Policy Intervention. BMC Public Health J. 2016;16(412).
34. Artyasari ADSP. Pelaksanaan Program Intervensi Pada Penyakit Hipertensi Di Puskesmas Purwoyoso Kota Semarang. J Kesehatan Masyarakat. 2021;9(3).
35. Oo H, Sakunhongsophon S, Sangthong T. Factors Related to Health Behaviors in Persons with Hypertension, Myanmar. Makara J Health Res. 2018;22(3):107-14.
36. Annas F. Gambaran Fungsi Manajemen Program Promotif Dan Preventif Penatalaksanaan Hipertensi Puskesmas Gang Aut Kecamatan Bogor Tengah Kota Bogor Tahun 2018. J Mahasiswa Kesehatan Masyarakat. 2019;2(4):260-7.
37. Dinas Kesehatan Provinsi Kalimantan Selatan. Profil Kesehatan Provinsi Kalimantan Selatan. Banjarmasin. 2018.
38. Dinas Kesehatan Provinsi Kalimantan Selatan. Laporan Kinerja Dinas Kesehatan Provinsi Kalimantan Selatan Bidang Kesehatan Masyarakat Tahun 2020. Banjarmasin. 2021.
39. Maula IN. Evaluasi Pelaksanaan Standar Pelayanan Minimal (SPM) Pada Penderita Hipertensi Di UPTD Puskesmas Mayong I Kabupaten Jepara Tahun 2018. Skripsi. Universitas Negeri Semarang. 2019.
40. PermenKes RI. Standar Teknis Pemenuhan Mutu Pelayanan Dasar Pada Standar Pelayanan Minimal Bidang Kesehatan No. 04 Tahun 2019. Menteri Kesehatan RI. 2019.
41. PermenKes RI. Tentang Rencana Strategis Kementerian Kesehatan Tahun 2020-2024 Nomor 21 Tahun 2020. Menteri Kesehatan RI. 2020.
42. PP RI. Tentang Standar Pelayanan Minimal No. 02 Tahun 2018. Peraturan Pemerintah Republik Indonesia. 2018.
43. Pusat Data, Infodatin Kemenkes RI. Hipertensi; Mencegah dan Mengontrol Hipertensi Agar Terhindar dari Kerusakan Organ Jantung, Otak dan Ginjal. Jakarta: Kementerian Kesehatan Republik Indonesia. 2014.
44. Pusat Data, Infodatin Kemenkes RI. Riset Kesehatan Dasar 2007 & 2013. Jakarta: Kementerian Kesehatan Republik Indonesia. 2013.
45. WHO. Guideline for The Pharmacological Treatment of Hypertension in Adults. World Health Organization. Diakses melalui. 2021.

Cite this article: Pobas S, Nazaruddin B, Palutturi S, Arifin MA, Wahiduddin, Russeng SS, et al. Policy Implementation of Hypertension Prevention and Control Program in Banjarmasin. Pharmacogn J. 2023;15(4): 641-649.