

# The Excellent Sukoharjo District in Inclusive Health Services for People with Disabilities

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## Abstract

Sukoharjo district has Regional Regulation Number 18 of 2017 concerning Persons with Disabilities including Inclusion Health Services Policy. Problems completed during the implementation included four aspects that determined the success of policy implementation, they were communication between organizations, resources, disposition, and bureaucratic structure (standard operating procedures). Sukoharjo is the first district that has inclusive health service SOP. This research aims to analyze the implementation of the regional regulation which is an inclusive health service policy. This qualitative research was conducted at Community Health Centers in Sukoharjo from May to December 2020. Data collection techniques were in-depth interviews, observation, and document study. Subjects consisted of 20 informants consisted of Community Health Center officers, staff of health office and social office, disability communities, and patients with disability. The results showed that the number of physiotherapists was insufficient, the budget for supplementary feeding and therapy equipment was insufficient, disability-friendly infrastructures in several community health centers still need repairment.

*Keywords: Regional Regulation, Inclusive Health Services, Implementation, Disability*

## 1. Research Background

Health is a basic right for every human being, including persons with disabilities, to achieve a prosperous life. Disability is a form of different abilities owned by someone or different ability people. Persons with disabilities are everyone who experiences physical, intellectual, mental, and/or sensory limitations for a long period of time and has difficulties to interact with the environment and participate fully and effectively in society. According to law the types of disability are sensory disabilities; physical disabilities; intellectual disabilities; and/ or mental disabilities. People with disabilities have a greater risk of health problems compared to people without disabilities, however people with disabilities generally have limited access to health services.

The UN Convention of the Rights of Persons with Disabilities in 2007 in New York, United States contains the rights of persons with disabilities to get the highest standard

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Article history: Received, May 16, 2021; Revised, October 1, 2021; Accepted, October 26, 2021

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Published online at [ijds.ub.ac.id](http://ijds.ub.ac.id)

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of health without discrimination. It has been signed by Indonesia and followed up by issuing Law no. 19 of 2011 concerning Ratification of the Convention on the Rights of Persons with Disabilities. In 2016 the government issued Law No. 18 of 2016. In this law the government is obliged to provide health workers who have competence and authority for special health services of disabilities from first level to advanced level health facilities, efforts to provide assistive devices like the provision of adequate wheelchairs and other means required for disabilities, construction of ramps for access for persons with disabilities or wheelchair users.

Based on Law No. 18 of 2016, Sukoharjo government made a Regency Regional Regulation Number 18 of 2017 concerning Persons with Disabilities with Regent Regulation No.3 of 2019 as an implementation instruction. The initial process for the emergence of the regional regulation on disability was due to advocacy from the Sukoharjo disability group who fight for the protection and fulfillment of rights as regulated in Law no. 19 of 2011 concerning the Ratification of the Convention on the Rights of Persons with Disabilities (CRPD) and Law No. 8 of 2016 concerning Persons with Disabilities. Sukoharjo health office compiled the SOP for Inclusive Health Services with the Green Management concept in 2019 to actualize this policy and implement this SOP in 12 community health centers of respective sub-district. The excellence of Sukoharjo district is the existence of an inclusion center in each sub-district. Inclusion center activities use the Community Based Rehabilitation (RBM) strategy.

Data from the Sukoharjo public health office, in 2018 there were approximately 4,615 people with disabilities with a total of 2,425 men with disabilities and 2,190 women. Based on the types of disabilities, there were as many as 1,832 people with physical disability, 175 people with intellectual / mental retardation, 288 people with chronic extremity, 290 people who were mute and deaf, 155 people were deaf, 132 people were mute, 815 people with psychiatric/mental disorders, 162 people with sensory disability/ autistic, 386 were blind, 201 people with multiple disabilities, and 171 people with other disabilities. Based on data from Sehaati disability community, the number of people with disabilities in Sukoharjo district has increased from year to year. In 2015 there were 3,500. In 2016 the number remained constant which was 3,500. In 2017 it increased to 5,500. In 2018 there were 5,621. In 2019 there were 5,702. And in 2020 there were 6,041 people with disabilities. The increase in the number of disability was due to better data collection of Sehati disability community.

## **2. Research Methodology**

### **2.1 Type of Research**

This research is descriptive-analytic with a qualitative research design. The research was conducted from May to December 2020.

### **2.2 Research Data**

The data collection method in the research used a qualitative approach. Primary data were obtained directly from in-depth interviews from main informants and

triangulation informants by using in-depth interview guidelines with unstructured questions. Secondary data in this research were Regional Regulation of Sukoharjo District Number 18 of 2017, Sukoharjo Regent's Regulation Number 13 of 2019, Standard Operating Procedures (SOP) for Inclusive Health Services, profile of Sukoharjo district, profile of Sukoharjo health office, photo and video documentation, audio record of interviews with informants, books, and literature related to the research topic

Subjects or informants in this research were taken purposively in accordance with the purpose of the study, who were directly involved in the implementation of inclusive health service policies for persons with disabilities in Sukoharjo, consisting of 10 main informants and 10 triangulation informants.

### **3. Results and Discussions**

The main informants were 10 community health center officers who served as child attendants and physiotherapists in inclusion centers. Child attendants were in charge to check on children with disabilities in inclusion centers once a week, they were doctors or midwives from community health centers. Physiotherapists providing therapy to children with disabilities every week in the inclusion centers. The main informants' age ranged from 33 - 47 years with a length of work in community health center between 10 and 17 years. The level of education varied from medical doctor, associate degree in Midwifery and associate degree in Physiotherapy. The triangulation informants were 10 people. They were the head of Sukoharjo health office, a staff in the primary service sector of district health office, a staff from social office, a head of the Sehati disability community, and 6 persons with disabilities who used inclusive health services from respective unit of analysis community health center. The triangulation informants' age ranged from 39 - 47 years, with varying levels of education. From the two triangulation informants from health office, one of them came with medical education and another one with a bachelor's degree. Informants from the disability community had an undergraduate education. Informants from social office had an undergraduate education. Triangulation informants from persons with disabilities who used inclusive health services from respective unit of analysis community health center consisted of five persons with physical disabilities and one person with visual disabilities. The range of age of triangulation informants from persons with disabilities was from 39 - 48 years, with education levels from elementary to senior high school.

#### **3.1 The Implementation of Inclusive Health Services based on Regional Regulation of Sukoharjo Districts Number 18 of 2017**

The analysis result of the research was units of analysis five community health center had a work program for inclusive health services from the public health office, that program were therapy services, increasing family capacity regarding disabilities and health, family empowerment and socialization of social inclusion. This work program is in accordance with the regional regulation number 18 of 2017 in Sukoharjo district

guided by the Regent's regulation number 13 of 2019 which includes promotive, preventive, curative and rehabilitative health services for persons with disabilities.

According to the regent's regulation, appropriate promotive health services include disseminating information about disabilities, disseminating information on disability prevention and counseling on early detection of disabilities. These efforts had been carried out by the community health center, the disability community, Joint Business Group and Self-Help Group through workshops and routine community meetings. Based on the results of the analysis, the conducted counseling consisted of counseling on nutrition, child growth and development, handling children with disabilities at home

### **3.2 Promotive Inclusion Health Services**

The analysis result of the research was unit of analysis five community health centers had implemented this effort in accordance with the work program of the health office which included:

#### **1. Efforts to Increase Family Capacity**

Efforts to increase family capacity were carried out at Polokarto community health center by providing education to parents with disabilities on how to improve the function of disabilities at home. Bendosari community health center effort through SDIDTK programs to detect early delays in children. Sukoharjo community health center efforts by means of parenting education about nutrition, health promotion, children's welfare

#### **2. Efforts to Empower Families with Disabilities**

Polokarto public health service carried out this effort with the existence of Self Help Group (SHG) and Joint Business Group (JBG). JBG is an association of persons with disabilities or parents with disabled child who run joint businesses. Bendosari community health center carried out this effort by improving the skills of adults with disabilities or guardians of disabled person to improve the standard of living or the family's economy, such as making crackers, ciprat batik crafts. Sukoharjo community health center carried out this effort by organizing training to make knitted bags and make bread. Tawangsari health center carried out this effort by organizing training to make bag crafts, wallets, embroidery, cooking classes such as making salted eggs, egg pepes and other foods. Kartasura community health center carried out this effort by organizing training to make bag crafts, knitting and cooking classes.

### **3.3 Preventive Inclusion Health Services**

#### **Supplementary Feeding '(PMT)**

The analysis result of the research was unit of analysis five community health centers conducted supplementary feeding program. The budget was provided by Sukoharjo health office and according to the Letter of Accountability Polokarto provided PMT for 31 children, Bendosari provided PMT for 17 children, Tawangsari provided PMT

for 23 children, Sukoharjo provided PMT for 23 children, Kartasura provided PMT for 23 children. Supplementary feeding from Polokarto, Bendosari, Sukoharjo and Kartasura community health centers were given in the form of processed food like vegetables, fruit, biscuits and others, while the Tawang Sari community health center provided supplementary feeding in the form of raw materials including green beans, brown sugar, coconut milk and others. Supplementary feeding budget was Rp.15,000/ child for two weeks or Rp.30,000/child for a month. Supplementary feeding was given to all children with disabilities who came to inclusion centers even though the supplementary feeding budget according to the Letter of Accountability was not comprehensive so there was actually a shortage of budget for supplementary feeding.

Preventive health service efforts according to regent's regulation include efforts to prevent a health problem for disabilities by creating a healthy living environment that requires the participation of families of persons with disabilities, communities and disability organizations. The Sukoharjo government already implemented this effort by distributing 75 sitting toilets for families with disabilities in 2015. Another preventive measure was the early detection of child development by community health center officers and Integrated health care center.

### **3.4 Curative Health Services**

The analysis result of the research all health examinations and treatment services at the unit of analysis five community health centers were in accordance with the regulations of the health insurance scheme which is called BPJS (Health Care and Social Security Agency). In certain conditions, community health center officers performed home care and visit persons with disabilities with certain conditions who required health services. The officers also asked for inform consent before taking medical action to persons with disabilities.

According to the regent's regulation, curative health service efforts are carried out by conducting home care for disabled persons with medical indications; mobile health centers; health officers work according to minimum service standards with a disability perspective; quality care from professional health workers; active efforts by health workers to visit Persons with Disabilities who need health services according to medical indications, full support from family, community and sub-district social workers; and, consent of persons with disabilities and/ or their guardians for the medical treatment performed. These efforts were already carried out by community health centers and regional hospitals in Sukoharjo.

### **3.5 Rehabilitative Health Services**

The analysis result of the research was unit of analysis five community health centers had implemented home care for rehabilitation efforts by sending physiotherapists as therapy officers, doctors and midwives as child attendants, nutritionists as nutrition officers to provide health services to children with disabilities in inclusion centers. If a child with a disability did not show up, the officer would come and

pick up the child to do the therapy at the inclusion center and deliver the child back when it finished. In rehabilitation services, most of the community health center officers provided therapy services in inclusion centers. Rehabilitation in public health centers was usually intended for adults and elderly with disabilities. There were many kind of therapies provided namely speech therapy, occupational therapy, physical therapy for hyperactive children, and other therapies. Once a year specialists and psychologists visited to provide health services for children with disabilities in the inclusion center.

The results of the analysis showed the number of children with disabilities who visited the inclusion centers. There were 31-48 children in Polokarto area, 17-25 children in Bendosari area, 23-35 children in Sukoharjo area, 40-45 children in Tawang Sari area, and 23-35 children in Kartasura area.

Rehabilitation health services were supported by health office by providing 8 therapists who visited every week regularly 12 inclusion centers in respective sub-district to provide therapy services for children with disabilities in inclusion centers. Polokarto Inclusion center opened every Saturday. Bendosari inclusion center opened every Thursday. Sukoharjo inclusion center opened every Friday. Tawang Sari inclusion center opened every Saturday. Kartasura inclusion center opened every Tuesday. All inclusion centers started from 08.00 - 10.00 pm. The triangulation informant from the disability community stated that the activity in inclusion center were therapy services for 360 children with disabilities and the provision of disability aids like wheelchairs, walkers, crutches and others.

According to the regent's regulation, rehabilitative health service efforts are carried out through home care at the community health center. Special rehabilitation services can be provided at regional public hospitals and private hospitals in accordance with medical indications and applicable regulations. Rehabilitative efforts were supported by the full participation of families and communities, namely through Community Based Rehabilitation (RBM) and/ or Inclusion centers. Medical rehabilitation can be carried out with integrated health services by health workers according to the level of health facilities, including among others: doctors; nurses; psychologists; physiotherapists; occupational therapists; speech therapists; orthotist-prosthetist; and social workers.

This inclusion center was started in 2015. The first idea to form an inclusion center was initiated from Nguter sub-district. Inclusion centers were managed by village midwives or health cadres who were also parents of persons with disabilities. There are 12 inclusion centers including: Tunas Wijaya inclusion center in Bendosari sub district, Tunas Harapan inclusion center in Bulu sub-district, Anugerah Aulia inclusion center in Grogol sub-district, Kinasih Wijaya inclusion center in Kartasura sub district, Cahaya Mentari inclusion center in Kartasura sub-district, Bunda Kasih Sayang inclusion center in Mojolaban sub district, Tunas Bangsa inclusion center in Sukoharjo sub-district, Anak

Bangsa inclusion center in Weru sub-district, and Smile inclusion center in Weru sub-district.

Analysis in this research covered four aspects that supported the accomplishment of policies according to Edward's III theory, these aspects are inter-organizational communication, organizational resources, disposition and bureaucratic structure in the implementation of regional regulation policy number 18 of 2017 concerning inclusive health services in Sukoharjo.

Community health center which is the unit of analysis were Polokarto, Bendosari, Tawang Sari, Sukoharjo and Kartasura. The community health centers were chosen because those five community health centers were the mid-term target of the implementation program for the Inclusive Health Services of Sukoharjo public health office.

### **3.6 Communication between organizations**

The analysis result of the research at units of analysis five community health centers concerning communication included the transmission, clarity, consistency of policy information carried out by the Public Health Office and the Sehati disability community. Community health center officers disseminated the policy information through village midwives and they would visit parents of children with disabilities to give information about the government programs that provide free therapy services in inclusion centers for children with disabilities.

Polokarto community health center was the pilot project to implement the SOP for inclusive health services. Polokarto Bendosari, Sukoharjo, Tawang Sari, and Kartasura community health centers had invited persons with disabilities. They also organized outreach to most community health center officers concerning how to interact with persons with disabilities and inclusive health service procedures according to SOPs. In addition, they improved the shortcomings undergone by persons with disabilities.

Polokarto had conducted inclusive health service socialization for three times. The first one was when the leader of Sehati community visited the facilities and infrastructures of Polokarto community health center. The second time was when introducing how to interact with people with disabilities according to the respective type of disability and the third time was when formulating SOPs for inclusive health services. Whereas the socialization was only conducted once in Bendosari, Tawang Sari, Sukoharjo and Kartasura,

The analysis of communication between organizations which included the dissemination, clarity and consistency of policies showed that communication between health office, community health centers, the disability community, inclusion centers, other related agencies and the community had run well.

Good communication between the implementation team, managers, health office and other related cross-sector offices will affect the success of policy implementation to

achieve the desired goals. This is in accordance with the theory of Edward III in Agustino (206: 157) which states that communication is one of the important variables that influence the implementation of public policy. Communication is critical to the accomplishment of public policy implementation's goals. Effective implementation will happen if the decision-makers know what they are going to do. Information received by the decision makers can only be obtained through good communication. There are three indicators that can be used in measuring the success of communication variables, namely transmission, clarity and consistency, this is in accordance with this study.

### **3.7 Resource**

#### **1. Funds**

Budget for curative and rehabilitative services in unit of analysis the five community health centers was obtained from Health Care and Social Security Agency (BPJS) because most of the people with disabilities had become participants of National Health Insurance (JKN). Rehabilitative budgets in inclusion centers came from district government funds, village funds, private sector and entrepreneurs. Health office provided support budget for supplementary feeding with the amount of Rp.30,000/month for every child in 12 community health centers of each sub-district which would be distributed to children with disabilities in inclusion centers within the area of community health centers. The supplementary feeding budget for each community health center varied according to the number of children with disabilities in each inclusion center. Polokarto received Rp.1,440,000 for 48 children in 2019 but in 2020 decreased to Rp. 930,000 for 31 children due to covid 19 pandemic. Bendosari received Rp. 510,000 in 2020 for 17 children. Tawang Sari received Rp.690,000 for 23 children. Kartasura received Rp.690,000 for 23 children. The fund is in accordance with the accountability letter of each community health center. However in reality there were more children with disabilities who came to inclusion centers so that the supplementary feeding budget is considered insufficient.

According to Edward's III theory, resources are the input in the organization as a system that has economic and technological implications. The resource is economically attributed to the direct cost or sacrifices spent by the organization that reflects the potential value or utility in its transformation into output. In this study, health office of Sukoharjo district has provided resource support, including supplementary feeding budgets and this support needs to be increased so that the objectives of the policy can be optimally realized.

#### **2. Personnel**

The analysis result of the research at unit of analysis the five-community health center concerning the number of therapists was insufficient because once a week on certain days therapists provided therapy services in inclusion centers so that they could not perform therapy services at community health centers.



The results of interviews with the main informant from Polokarto community health center revealed that the total number of personnel at Polokarto community health center was 100, consisting of 1 head of community health center, 8 functional doctors, 15 nurses, 1 physiotherapist, 1 nutritionist, 3 drug clerks, 2 laboratory staff, 4 registration officers, 2 cleaning service officers, 2 customer service officers, 1 driver, 2-night watchmen, more than 30 midwives and the rest were administrative officers and other officers. Polokarto had four Health Sub-Centers, namely Karawuni, Kenokorejo, Kayu Ampak, Geneng Sari Health Sub-Centers.

The results of interviews with the main informant from Bendosari community health center explained that the number of staff was not enough. The total number of officers with day workers was 75 people consisting of 1 head doctor of community health center, 2 functional doctors, 2 dentists, 1 physiotherapist, 32 midwives, 12 nurses, 1 nutritionist, 1 laboratory analyst, 1 pharmacist, 4 registration officers, 2 cleaning service officers, 7 administrative staff, 2 customer service officers, 2 medical record officers, 2 security officers, 1 driver, 2 health workers. Bendosari Center did not have inpatient care ward. there were 4 Health Sub-Centers namely Gentan, Puhgogor, Cabean, Jombor.

The results of interviews with the main informant from Sukoharjo community health center revealed that the number of personnel was considered sufficient. The total number of officers was 80 consisting of 1 head doctor of community health center, 3 functional doctors, 2 dentists, 2 dental nurses, 2 physiotherapists, 13 nurses, 31 midwives, 2 nutritionists, 2 laboratory analysts, 3 pharmacists, 1 health promotion officer, 1 medical records officer, 1 officer for Self-Registration Kiosk, 5 registration officers, 1 parking attendant, 3 cleaning services, 7 administrative officers and others.

The results of interviews with the main informant from Tawang Sari community health center revealed that the number of staff was sufficient. The total number of staff was 75 staff consisting of 1 head doctor of community health center, 4 functional doctors, 8 nurses on duty in Emergency room and general practice polyclinic, 2 laboratory analysts, 3 pharmacists, 2 medical record officers, 1 officer for Self-Registration Kiosk, 1 parking attendant and the others were village midwives and administrative staff.

The results of interviews with the main informant from Kartasura community health center revealed that the number of personnel was considered insufficient since Kartasura consisted of 2 community health centers, they were Kartasura 1 and 2 which were incorporated into one Regional Technical Implementation Unit (UPTD) however there were no additional staff. The total number of officers was 100 consisting of 3 general practitioners, 5 dentists, one of them was the head of the community health center, 4 emergency room nurses, 6 inpatient nurses, 10 midwives, 3 physiotherapists, 2 nutritionists, 1 health promotion officer, 2 cleaning service officers, 1 security guard and also administrative officers and others.

The analysis result of the research regarding officers' competency in implementing standard operating procedures ( SOP ) in inclusive health services in five community health center units of analysis revealed that officers had provided health services to persons with disabilities according to SOPs and ways of interacting with persons with disability. The main informant of Tawang Sari community health center considered that he had problems in interacting with persons with hearing and speech disabilities in terms of understanding sign language and resolved this by communicating in written form. The similar problem was also found at the other community health centers.

An almost similar explanation was obtained from triangulation informants of persons with disabilities from units of analysis the five community health centers concerning the services of officers to persons with disabilities. Each time persons with disabilities visit community health center to get treatment, they would receive inclusive service starting from parking area, the parking attendant would find a parking space for them, then took them to the registration room. The APM (Self-Registration Kiosk) officer would get them the priority queue number then the APM officer or other officer would escort to the examination room. Doctors and officers conducted direct examinations toward persons with disabilities and interacted directly, if the required information is unclear, especially for persons with hearing and speech disabilities, the officers would ask help from the patients' companion, if any, or communicate in written form. After the examination, the officer escorts them to the waiting room to wait for the medicine, then the drug clerk would deliver the medicine directly to their seat. If laboratory examination or physiotherapy were required, the officer would take them to the intended rooms. Otherwise, the officer would escort them back to the parking area to go home by themselves or get picked up by their families.

According to Edward III's theory, the main resources in policy implementation are staff or employees (street-level - bureaucrats). One of the reasons for the failure to implement policies is inadequate, insufficient and incompetent staff or employees. Increasing the number of staff and implementers alone is not enough to solve the problem of policy implementation. It is necessary to have staff with skills and abilities (competent and capable) in implementing policies. In this research it is necessary to add skilled and competent physiotherapists to provide services to persons with disabilities so that services can be optimized and policy objectives can be achieved as expected.

### **3. Infrastructures**

The analysis result of the research concerning disability-friendly infrastructures in unit of analysis the five community health centers was they were in accordance with the standards. There were ramps, Independent Registration Kiosk (APM), running text, audio system in the front office, disabled bathrooms, ramps for wheelchair users, and wheelchair aids.

#### **3.8 Infrastructure at Polokarto Community health center**

The results of observations related to disability-friendly infrastructures at Polokarto community health center were as follow: Polokarto Community Health Center was equipped with Independent Registration Kiosk (APM), disabled waiting chairs, a wheelchair-bound waiting room, ramps, handles, running text, audio system in the front office, disabled bathrooms, wheelchairs and physiotherapy room.

#### **Infrastructure at Bendosari Community health center**

The results of observations related to disability-friendly infrastructure at Bendosari community health center were as follow: Bendosari community health center was equipped with Independent Registration Kiosk (APM), disabled waiting chairs, ramps, handles, running text, audio system in the front office, disabled bathrooms, wheelchairs, and physiotherapy room.

#### **Infrastructure at Sukoharjo Community health center**

The results of observations related to disability friendly infrastructure at Sukoharjo community health center were as follow: Sukoharjo Community Health Center was equipped with Independent Registration Kiosk (APM), disabled waiting chairs, ramps, handles, running text, audio system in the front office, disabled bathrooms, wheelchairs, and physiotherapy room.

#### **Infrastructure at Tawang Sari Community health center**

The results of observations related to disability-friendly infrastructures at Tawang Sari community health center were as follow: Tawang Sari community health center was equipped with Independent Registration Kiosk (APM), disabled waiting chairs, ramps, handles, running text, audio system in the front office, disabled bathrooms, wheelchairs and physiotherapy room.

#### **Infrastructure at Kartasura Community health center**

The results of observations related to disability-friendly infrastructures at Kartasura community health center were as follow: Kartasura community health center was equipped with Independent Registration Kiosk (APM), disabled waiting chairs, a wheelchair-bound waiting room, ramps, handles, running text, audio system in the front office, disabled bathrooms, wheelchairs and physiotherapy room.

The results of the analysis from the observation of disability-friendly infrastructures at units of analysis the five community health centers above showed that all community health centers were in accordance with the standard of inclusive infrastructures. They were equipped with APM, running text, audio system in the front office, disabled waiting chairs, handle, ramps, disabled bathroom and physiotherapy room.

The analysis of all the results of interviews and observations on resources was that the budget for infrastructure was sufficient. The supplementary feeding budget was still insufficient. The curative service budget was sufficient. It is necessary to add some more

physiotherapists. Disability-friendly infrastructures were in accordance with the standards although there were some buildings that needed repairment. The shortcomings that occur in each community health center were potentially improved in the future

Previous research by Aan Kurniawan entitled *Improving Accessibility of Basic Health Services for Disabilities in Sukoharjo, Central Java* in 2019 indicates that the needs of people with disabilities for basic health services at community health center include physical accessibility, the ability of officers to understand and the proper health insurance.

According to Edward III, physical facilities are an important factor in the policy implementation. The implementer may be adequate, capable and competent, however without facilities (infrastructures), the implementation of the policy will not be accomplished. This is in accordance with this research that physical facilities that are accessible for people with disabilities, such as equipment, infrastructures and buildings will support the realization of policy objectives and support the successful implementation of policies on inclusive health services for persons with disabilities in Sukoharjo district.

### **Implementer disposition**

The analysis result of the research at unit of analysis the five community health centers concerning implementer disposition was the majority of officers already approved and supported the implementation. Every officer in their respective section, from the parking area, registration room or APM, examination room, medicine room, laboratory room and therapy room had implemented inclusive health services which were in accordance with the SOPs stipulated by health Office of Sukoharjo District. Community health center officers assisted with inclusive health service activities in inclusion centers once a week without additional incentives. The officers were happy to be able to help children with disabilities. It shows a good commitment of the officers in supporting the implementation of the policy of inclusive health services in the analysis unit.

Edward III in Wianarno (20 ya05: 142 - 143) argues that trends or dispositions are some of the factors that have important consequences in implementing effective policies. If the implementer has a positive tendency or attitude or there are supports toward policy implementation, it will be carried out in accordance with the initial decision.

The result of analysis concerning the commitment of the implementers was the majority of the officers at units of analysis the five community health centers had a positive tendency or attitude and support for policy implementation. They had a good commitment and most of the officers were friendly in providing inclusive health services.

### **Bureaucratic structure**

Based on Regional Regulation Number 18 of 2017 on health inclusion is in the fourth part of articles 39 to 42 with the Regent's regulation number 13 of 2019 as implementation instructions (SOP) in Chapter V articles 13 to 19, to carry out policy implementation of inclusive health services and improving the quality of inclusive health services for persons with disabilities, Sukoharjo district has compiled and established SOPs for inclusive health services in 2019, which contains ways to interact between health workers and persons with disabilities according to the type of disability. This SOP must be implemented by 12 community health centers in respective sub-district.

The analysis result of the research at unit of analysis the five community health centers indicated that the five community health centers had implemented an inclusive health service in accordance with the regional regulation, the regent's regulation and the SOP of inclusive health services as explained in the previous aspects above.

The bureaucratic structure is the conformity between the implementation of policies in inclusive health services for persons with disabilities in the Sukoharjo district community health centers with Standard Operational Procedures (SOP). The bureaucratic structure is one of the important things in policy implementation. This aspect of bureaucratic structure involves two important things, namely the mechanism and organizational structure for implementing the policy itself. The program implementation mechanism has usually been determined through Standard Operational Procedures (SOP) which are included in the guideline. Policy SOP consists of clarity of relevance. It is systematic, straightforward and easy to understand by the implementer.

According to Edward III in Winarno (2005: 150) there are two characteristics of bureaucracy, namely SOP (Standard Operating Procedure) and Fragmentation. SOP is the development of internal demands for certainty of time, resources and the need for uniformity in a complex and broad work organization. By using SOPs, implementers can optimize the available time and can function to uniform the actions of officials in complex and widespread organizations, so that it can lead to great flexibility and great equality in the application of regulations. SOPs are very likely to be an obstacle to the implementation of new policies that require new ways or new types of personnel to carry out. In this research, inclusive health services are the new implementation policy. In accordance with Edward III's theory, SOPs for Inclusive Health services for persons with disabilities are new ways that should be implemented by public health services officers. The SOP for Inclusive Health Services was established by the Sukoharjo district health office in 2019, this SOP contains how community health center officers interact with persons with disabilities according to the type of disability

#### **4. Conclusions**

The results showed that the implementation of regional regulation number 18 of 2017 concerning inclusive health services for persons with disabilities in a unit of analysis the five public health centers in Sukoharjo district has been running according

to the regent's regulation number 13 of 2019 as a SOP's although there are some shortcomings during the course of the policy

This research finds shortcomings that include resources aspects and disposition aspects.; 1) resources aspects include insufficient supplementary feeding budget (fund resources), insufficient therapists (human resources), buildings infrastructures in several community health centers still need repairment to make it more accessible and safer for persons with disabilities (infrastructures resources). 2) Disposition aspects (commitment of implementers). There are still public health center officers who do not understand the concept of disability so they do not pay attention to persons with disabilities. The aspect of communication between organizations and aspect of bureaucratic structures have been running well.

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