

Evaluation Strategy to Improve the Utilization of Posbindu As-Syifa I in the Facilities Aspect in Gerem Village, Banten Province

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Article Info

Article history:

Accepted: 5 January 2026

Publish: 1 March 2026

Keywords:

Posbindu PTM;

Strategic Management;

Service Quality;

Monitoring & Evaluation;

The Role of Human Resources.

Abstract

This study analyzes the implementation of service strategic management at Posbindu PTM As-Syifa I in Gerem Village, Banten Province, focusing on service quality, monitoring and evaluation systems, and the role of human resources and stakeholders. Using descriptive qualitative methods through in-depth interviews, observations, and document studies. Results show service quality is quite good with active cadre support and basic screening tools. However, limited infrastructure, absence of permanent facilities, and participant fluctuations remain obstacles. Monitoring and evaluation are conducted through primary health center supervision but lack structured internal evaluation mechanisms. SWOT analysis indicates the need for strengthening internal evaluation SOPs, cadre capacity building, and digitalization of recording. Limited funding and unintegrated stakeholder coordination emphasize the importance of formal cooperation and funding diversification for program sustainability.

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1. INTRODUCTION

Non-communicable diseases (NCDs) have become a significant global health challenge. According to the World Health Organization (WHO), NCDs cause 71% of all deaths worldwide, with the four main causes being cardiovascular disease, cancer, chronic respiratory disease, and diabetes. In Indonesia, the epidemiological transition shows an alarming increase in the prevalence of NCDs. Data from the 2018 Basic Health Research (Riskesmas) showed the prevalence of hypertension reaching 34.1%, diabetes mellitus 2%, obesity 21.8%, and stroke 10.9 per 1,000 population.

The economic burden of NCDs is enormous, not only in terms of medical costs but also lost productivity. NCDs require long-term management and high healthcare costs, placing significant pressure on the national health system. Therefore, preventive efforts and early detection are key strategies in controlling NCDs. The Indonesian government has developed various NCD prevention programs, one of which is the Integrated Non-Communicable Disease Development Post (Posbindu PTM), which is regulated by Minister of Health Regulation Number 71 of 2015.

Posbindu PTM is a form of community-based health effort (UKBM) that organizes early detection and monitoring of major NCD risk factors in an integrated, routine, and periodic manner. Posbindu PTM adheres to the principle of 5 tables, namely: registration and interviews (table 1), measurements of height, weight, waist circumference, and BMI (table 2), blood pressure measurement, lung function analysis, blood sugar, cholesterol,

triglyceride, and VIA examinations (table 3), counseling and education (table 4), and physical activity (table 5).

Gerem Village, Grogol District, Tangerang City, Banten Province, is one of the areas with a relatively high prevalence of NCDs. The As-Syifa I Community Health Post (Posbindu PTM), operating in this area, has been operating for several years as an effort to detect and control NCD risk factors at the community level. This program involves trained community health workers, collaborates with the Grogol Community Health Center, and receives participation from the local community.

Although the As-Syifa I Posbindu PTM program has been running, evaluation of its effectiveness remains limited. Various operational challenges remain, particularly related to facilities, service quality, monitoring and evaluation systems, and coordination between stakeholders. Limited facilities and infrastructure, such as the lack of permanent service locations, incomplete examination equipment, and a manual recording system, hinder the provision of optimal services to the community.

Previous research has shown that the success of the Posbindu PTM program is highly dependent on the quality of service strategy management. A study by Parasuraman et al. (1988) on SERVQUAL emphasized the importance of five dimensions of service quality: tangibles, reliability, responsiveness, assurance, and empathy. In the context of Posbindu PTM, these five dimensions need to be evaluated to ensure the services provided meet community expectations and needs.

Effective service strategy management requires thorough planning, structured implementation, and ongoing monitoring and evaluation. David & David (2021), in their strategic management theory, emphasize the importance of analyzing the internal and external environment to identify an organization's strengths, weaknesses, opportunities, and threats. Through SWOT analysis and TOWS matrix-based strategy development, organizations can formulate appropriate strategies to achieve their goals.

Furthermore, stakeholder collaboration is a key factor in the success of public health programs. Ansell & Gash (2008), in their theory of collaborative governance, emphasize the importance of multi-stakeholder involvement in decision-making and program implementation. In the context of Posbindu PTM, collaboration between community health centers (Puskesmas), village governments, community organizations, and the private sector is crucial to ensure program sustainability.

Based on this background, this study aims to analyze in depth the implementation of service strategy management at Posbindu PTM As-Syifa I in Gerem Village. This study will answer three main questions: (1) What is the quality of service provided by Posbindu PTM As-Syifa I to the community, (2) How is the monitoring and evaluation system implemented in the implementation of the Posbindu PTM program, and (3) What is the role of human resources and stakeholder coordination in supporting the sustainability of the program?

This research is expected to provide practical contributions in the form of strategic recommendations to improve the effectiveness of the Posbindu PTM program, particularly in terms of facilities and service quality. The theoretical contribution of this research is to enrich the literature on strategic management of community-based health services in Indonesia by integrating SERVQUAL theory, strategic management, and stakeholder collaboration in the context of Posbindu PTM.

2. RESEARCH METHODS

This study used a qualitative approach with descriptive methods to analyze the implementation of service strategy management at the As-Syifa I PTM Posbindu. The qualitative approach was chosen because it allows researchers to understand the

phenomenon in depth from the perspective of participants, exploring meanings and experiences that cannot be measured quantitatively. The study was conducted in Gerem Village, Grogol District, Tangerang City, Banten Province, from October to November 2024.

Research informants were selected by purposive sampling with certain criteria relevant to the research objectives. The total number of informants was 10 people, consisting of: (1) 5 As-Syifa I PTM Posbindu cadres who were actively involved in implementing activities for at least 1 year, (2) 2 health workers from the Grogol Community Health Center who played a role in supervising and coaching Posbindu, and (3) 3 Posbindu participants who regularly participated in activities for at least the last 6 months. The selection of informants with diverse characteristics aimed to obtain a comprehensive perspective on program implementation.

The data collection technique was carried out through method triangulation to increase the validity and reliability of the data, namely by conducting semi-structured in-depth interviews with a prepared interview guide. Interviews were conducted face-to-face with a duration of 45-60 minutes per informant. Interviews were recorded with the informant's permission and transcribed verbatim for analysis. Participatory observation of the implementation of Posbindu activities to directly observe the service process, cadre interactions with participants, facility conditions, and service flow. Observations were conducted on 3 Posbindu implementations. Documentation studies were conducted on monthly activity reports, participant visit data, coordination meeting minutes, Posbindu implementation guidelines, and other supporting documents.

Data analysis was conducted using the Miles and Huberman model, which consists of three stages: (1) Data reduction, namely the process of selecting, focusing, simplifying, abstracting, and transforming raw data that emerged from field notes. Interview data were transcribed and coded based on the main research themes. (2) Data presentation, namely the arrangement of information that allows conclusions to be drawn. Data is presented in the form of display tables and descriptive narratives that describe the research findings. (3) Conclusion drawing and verification, namely the researcher's interpretation of the data that has been collected and analyzed.

Data validity was maintained through source triangulation, comparing data from various informants, and method triangulation, combining the results of interviews, observations, and documentation studies. Research reliability was maintained through an audit trail that systematically documented the entire research process.

A SWOT analysis was conducted to identify internal factors (strengths and weaknesses) and external factors (opportunities and threats) that influence the implementation of Posbindu PTM. These factors were then analyzed using the TOWS matrix to formulate four types of strategies: SO (Strengths-Opportunities) Strategy, WO (Weaknesses-Opportunities) Strategy, ST (Strengths-Threats) Strategy, and WT (Weaknesses-Threats) Strategy.

3. RESEARCH RESULTS AND DISCUSSION

The research results show that the implementation of strategic service management at the As-Syifa I PTM Posbindu has complex dynamics with various strengths and challenges. Analysis of service quality using the five dimensions of SERVQUAL shows varying levels of achievement in each dimension, reflecting the actual conditions of program implementation in the field.

In terms of tangibles (physical evidence), Posbindu As-Syifa I has adequate basic screening tools, including digital tensiometers, weight scales, height meters, and waist circumference meters. However, a significant limitation lies in the lack of a permanent

service location, which requires cadres to move all the equipment each time an activity is carried out. As one cadre expressed: "We have to carry all the equipment every month; sometimes it's tiring, especially if the equipment is heavy." This condition not only causes physical fatigue for cadres but also increases the risk of equipment damage. The limited availability of cholesterol and uric acid testing equipment is another obstacle frequently complained about by participants, forcing them to come directly to the Community Health Center (Puskesmas) for complete examinations.

Despite limitations in the tangible aspect, the reliability dimension showed positive results. Posbindu As-Syifa I demonstrated good reliability in the consistency of its monthly routine activities, following a predetermined schedule. The implementation time was generally maintained, starting at 8:00 a.m. and continuing until completion. This consistency builds public trust in the program's existence and reliability, although reliability in terms of the availability of comprehensive check-up services is still hampered by limited equipment.

The responsiveness dimension indicates that Posbindu cadres are highly responsive to participants' needs. They are responsive to emergencies, such as those with high blood pressure or uncontrolled blood sugar, by immediately coordinating with health workers at the Community Health Center (Puskesmas). Cadres are also proactive in conducting home visits to participants who are absent several times in a row, demonstrating their concern for the need for ongoing health monitoring. This initiative aligns with the findings of Parasuraman et al. (1988), who emphasized the importance of responsiveness as a key determinant of service quality.

High public trust in Posbindu services reflects a strong assurance dimension. This trust is built through the competence of cadres who have received training from the Community Health Center (Puskesmas), support from professional healthcare workers, and consistency of service. Effective communication between cadres and participants, using easily understood language and avoiding medical jargon, also contributes to participants' sense of security and confidence. The empathy dimension is demonstrated through cadres' extra attention to special groups such as the elderly and people with chronic illnesses. However, maintaining a high level of empathy remains a challenge, given that cadres work voluntarily without financial incentives, potentially leading to burnout and fatigue.

Another challenge affecting service quality is the fluctuation in the number of participants, which is heavily influenced by external factors such as weather, national holidays, and people's work schedules. The number of participants ranges from 30 to 50 per month, with attendance tending toward the elderly and housewives. Meanwhile, participation among productive-age groups remains low due to the Posbindu schedule being held on weekdays. This situation is a significant concern because the productive-age group is the primary target for early detection of NCDs to prevent complications in old age.

Regarding the monitoring and evaluation system, the study found that despite the existence of a monitoring mechanism within the Community Health Center (Puskesmas), structured internal evaluation is still suboptimal. The implementation of the As-Syifa I Posbindu PTM refers to the General Guidelines for Posbindu PTM from the Ministry of Health, with routine supervision from the Puskesmas every three months to monitor activity implementation and compliance with the guidelines. However, internal evaluation mechanisms at the Posbindu level are still very limited and informal, conducted through discussions among cadres without a structured format or systematic documentation. This condition aligns with the findings of David & David (2021), who emphasized the importance of a structured monitoring and evaluation system in strategic management.

Community health centers routinely monitor the implementation of Posbindu, including staff attendance, participant numbers, equipment availability, and compliance

with guidelines. Follow-up on examination results is carried out through referrals to the community health center for high-risk cases, home visits to monitor participants with special conditions, and collaboration with health workers for follow-up consultations. However, the recording and reporting system, which still uses manual methods using registers, makes it difficult to analyze data and identify public health trends. The absence of a digital information system impacts the ability to conduct comprehensive, data-based evaluations.

Formal evaluations are conducted annually through coordination meetings discuss program achievements, challenges encountered, and follow-up plans. The evaluation focuses on the number of participants served, the coverage of NCD risk factor screening, referral rates to health facilities, and the availability of infrastructure. However, these evaluations are still top-down and administrative in nature, without involving Posbindu participants, resulting in underutilization of user feedback. The lack of participant satisfaction surveys or formal mechanisms to gather community input is a weakness in the existing evaluation system.

The program's success indicators include the number of participants in attendance, the coverage of NCD risk factor screening, the percentage of participants with risk factors detected and followed up, the referral rate to health facilities, and participant compliance with health recommendations. Results indicate that Posbindu successfully conducts routine screenings on 30-50 participants each month, with approximately 60% of participants identified as having NCD risk factors. Hypertension is the most common condition, but participant compliance with routine check-ups varies, influenced by health awareness, family support, and service accessibility.

An analysis of the role of human resources indicates that Posbindu cadres are the program's most important asset, playing a vital role in its implementation. Five volunteer cadres are responsible for preparing the site and equipment, conducting screening examinations, recording results, providing education, conducting home visits, and coordinating with the Community Health Center (Puskesmas). Although they have received training from the Puskesmas, there has been no follow-up training program or refresher training to improve competency, even though this is crucial given the ever-evolving nature of health science and screening methods.

Cadres' motivations for continued involvement in the program vary, with intrinsic motivation, such as a desire to contribute to public health, being the primary driver. However, without adequate incentives and appreciation, there is a risk of decreased motivation and long-term cadre burnout. Excellent support from the Community Health Center (Puskesmas) in the form of equipment, supplies, supervision, technical guidance, and follow-up for referred patients is the backbone of the program's sustainability. The presence of Puskesmas health workers in the Posbindu implementation to provide direct consultations is highly appreciated by the community and enhances the program's credibility.

However, support from stakeholders other than the Community Health Center (Puskesmas) remains minimal. Village governments provide moral support and outreach assistance, but there has been no significant financial or facility support. Community organizations such as the Family Welfare Movement (PKK) are involved in mobilizing participants, but there has been no strategic collaboration in program development. Collaboration with the private sector, including corporate social responsibility (CSR) programs, has not materialized despite the potential to provide financial support, facilities, or equipment assistance. Limited funding, relying on community self-help and personal contributions from cadres, has resulted in an inability to provide additional examination

equipment, a lack of cadre incentives, limited program innovation, and difficulties repairing damaged equipment.

Coordination with the Community Health Center (Puskesmas) is well-established through regular coordination meetings and informal communication, with clear service and referral channels. However, coordination with other stakeholders, such as the sub-district, health office, and community organizations, remains suboptimal due to the lack of a formal coordination forum or mechanism involving all relevant parties. This results in the Posbindu program not being optimally integrated into the health and community development system at the sub-district level, in line with the collaborative governance theory of Ansell & Gash (2008), which emphasizes the importance of multi-stakeholder involvement in decision-making and program implementation.

Based on the research findings, a SWOT analysis identified various internal and external factors influencing the implementation of Posbindu. Key strengths include active and experienced cadres, regular support from the Community Health Center (Puskesmas), availability of basic screening tools, good community trust, consistent implementation of activities, effective communication, and home visit initiatives. Weaknesses include the lack of a permanent service location, limited screening tools, a manual recording system, no structured internal evaluation mechanism, participant fluctuations, low participation among productive age groups, no cadre incentives, limited funding, the lack of further training, and minimal program innovation.

Opportunities that can be exploited include strong government policy support for NCD prevention, increased public awareness of early NCD detection, potential collaboration with external stakeholders, developments in digital technology for health information systems, the availability of corporate CSR programs, potential integration with other health programs, and increased access to health information through digital media. Threats include limited sustainable funding, competition for time with community economic activities, minimal cross-sector support, the risk of cadre burnout, demographic changes and population mobility, competition with other health programs, high dependence on Community Health Centers (Puskesmas), and the potential for equipment damage that cannot be immediately replaced.

Through the TOWS matrix, four types of development strategies were formulated. The SO strategy utilizes experienced cadres and effective communication to expand the program's reach, builds strategic partnerships with sub-districts and community organizations, integrates with other community health programs, and develops innovative programs such as group exercise. The WO strategy develops a digital recording system, establishes permanent service locations through multi-stakeholder collaboration, accesses CSR funding, develops advanced training programs for cadres, schedules activities flexibly, and establishes a structured evaluation mechanism involving external stakeholders.

The ST strategy develops reward and recognition programs for cadres, establishes a sustainable funding system through diversified funding sources, strengthens collaboration with Community Health Centers (Puskesmas), develops attractive and innovative programs, and establishes equipment maintenance protocols. The WT strategy develops structured internal evaluation SOPs, develops comprehensive multi-stakeholder collaboration proposals, builds a cloud-based digital recording system, develops a sustainable cadre capacity building program, and establishes a non-financial incentive system. Implementation priorities are divided into short-term: developing internal evaluation SOPs and a digital recording system; medium-term: building stakeholder collaboration and completing equipment; and long-term: building permanent service locations and a comprehensive digital health information system.

4. CONCLUSION

This study yielded three main conclusions. First, the service quality of the As-Syifa I PTM Posbindu demonstrated good performance across the dimensions of reliability, responsiveness, assurance, and empathy, with the support of active cadres and high public trust. However, the tangibles dimension remained weak due to the lack of a permanent service location, limited screening equipment, and fluctuating numbers of participants, particularly among the productive age group.

Second, a monitoring and evaluation system has been implemented through routine supervision by community health centers, including referral follow-up and home visits. However, a structured internal evaluation mechanism is lacking, participants are not involved in the evaluation process, and a manual recording system hinders comprehensive data analysis.

Third, cadres are the most important asset, with support from community health centers (Puskesmas) serving as the backbone of the program. However, support from other stakeholders is minimal, funding is limited to community self-help, there are no cadre incentives, and multi-stakeholder coordination is not yet integrated.

Recommended development strategies include: strengthening facilities through permanent locations and equipment, increasing cadre capacity through ongoing training, digitizing monitoring and evaluation, optimizing cross-agency collaboration, and diversifying funding through CSR and multi-stakeholder collaboration. Implementing these strategies is expected to increase the effectiveness of Posbindu PTM in early detection and controlling NCD risk factors at the community level.

5. ACKNOWLEDGEMENT

The authors would like to thank all the cadres of Posbindu PTM As-Syifa I who have dedicated themselves to providing health services to the community and who were willing to be informants in this research. Acknowledgement, are also extended to the health workers of the Grogol Community Health Center for their cooperation and support, as well as to the Gerem Village community, who have actively participated in the program. Thanks are due to the supervisors Dr. Dasrun Hidayat, M.I.Kom., and Dr. Yen Efawati M.M. for their guidance and direction throughout the research process. Acknowledgement, are also due to the Master of Management Postgraduate Program of Adhirajasa Reswara Sanjaya University for their academic support.

6. BIBLIOGRAPHY

- [1] Kementerian Kesehatan RI, "Pedoman Umum Pos Pembinaan Terpadu Penyakit Tidak Menular," Jakarta: Direktorat Pengendalian Penyakit Tidak Menular, 2019.
- [2] World Health Organization, "Noncommunicable Diseases: Progress Monitor 2022," Geneva: WHO, 2022.
- [3] A. Parasuraman, V. A. Zeithaml, and L. L. Berry, "SERVQUAL: A Multiple-Item Scale for Measuring Consumer Perceptions of Service Quality," *Journal of Retailing*, vol. 64, no. 1, pp. 12-40, 1988.
- [4] F. R. David and F. R. David, *Strategic Management: Concepts and Cases*, 17th ed. London: Pearson Education, 2021.
- [5] C. Ansell and A. Gash, "Collaborative Governance in Theory and Practice," *Journal of Public Administration Research and Theory*, vol. 18, no. 4, pp. 543-571, 2008.
- [6] Badan Penelitian dan Pengembangan Kesehatan, "Laporan Nasional Riset Kesehatan Dasar (Riskesdas) 2018," Jakarta: Kementerian Kesehatan RI, 2019.

- [7] H. Wehrich, "The TOWS Matrix: A Tool for Situational Analysis," *Long Range Planning*, vol. 15, no. 2, pp. 54-66, 1982.
- [8] M. E. Porter, *Competitive Strategy: Techniques for Analyzing Industries and Competitors*. New York: Free Press, 1980.
- [9] J. W. Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, 5th ed. Los Angeles: SAGE Publications, 2018.
- [10] R. K. Yin, *Case Study Research and Applications: Design and Methods*, 6th ed. Los Angeles: SAGE Publications, 2018.
- [11] M. B. Miles, A. M. Huberman, and J. Saldana, *Qualitative Data Analysis: A Methods Sourcebook*, 4th ed. Los Angeles: SAGE Publications, 2020.
- [12] Peraturan Menteri Kesehatan Republik Indonesia Nomor 71 Tahun 2015 tentang Penanggulangan Penyakit Tidak Menular, Jakarta: Kementerian Kesehatan RI, 2015.