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Management Model Development of Prospective Pilgrim Coacing as a Waiting Time Optimalization Strategy in South Sulawesi

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Abstract

The existing problem in the implementation of Hajj is still the high number of morbidity and death of pilgrims one of the factors that influence the management of Hajj health. Research aims to develop a model of coaching to obtain the optimal health status in running the worship with as well as to become Mabrur pilgrimage. This research method is observational with cross-sectional study design and combination design of quantitative and qualitative research using secondary data and empirical data. The results of this study show that high risk, congregational profile, resource, time, and environment are problems arising from the process of health Hajj, from emerging problems requires a proper management model, the variables that are considered to be central issues in the development of the model are long-term coaching and waiting time in South Sulawesi, after risk management has been implemented, the management of Comprehensive, Holistic and integrative coaching Is a development model that is expected to address the problems of Hajj health care in present and future Indonesia, which will create a healthy, wholesome community of Mabrur pilgrims.

Keywords: Management model; Coahing; Hajj Waiting Time and optimalization strategy.

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1. Introduction

Health is the main capital of the journey of pilgrimage, without adequate health conditions, undoubtedly the procession of ritual worship becomes not maximal. The various risks posed by Haj pilgrims due to the extraordinary density of people that require Jamaahs to be at the same point at the same time, with extreme environmental conditions are significantly different from the condition of the country, the condition is an epidemiological determinant of health risk factors Which can lead to morbidity and death caused by infectious or non-communicable diseases [1,2]. So far, to anticipate the health status of Hajj pilgrims, the only activities undertaken are with a health examination covering the first inspection and a second examination, with this model will not give maximum results to the health condition of Jamaah because it is not accompanied by the follow-up of the examination results except with Perform treatment against indications of disease found against prospective congregation. Then improved by doing coaching and fitness exercises to get the health status of prospective Jamaah is optimal [3,4]. The long waiting list of Javanese that is approximately 30 years old in South Sulawesi (Regional Office of the Ministry of Religious Affairs of South Sulawesi Province), is a separate problem in South Sulawesi due to the great interest of the community to perform the pilgrimage. However, these conditions can be an opportunity on the coaching model And health services of prospective Jamaah in order to prepare themselves early to manage, maintain and even improve their health status until the time of departure. In order to provide holistic and comprehensive health services, all aspects affecting health status should receive equal attention. As we know that many factors affect the implementation of hajj especially hajj health so that aspects of coaching plays an important role in the intention to improve the health status of pilgrims, efforts to optimize the coaching, the waiting period in South Sulawesi becomes an opportunity / strength as an optimization strategy in South Sulawesi.

2. Materials and Method

This research is observational with cross-sectionalstudy design which study the dynamics of linkage between cause and effect through observation approach and simultaneous sampling at certain time span (Point Time Approach) [5]. In this study using qualitative data directed to analyze, study and describe the design of this penitian selected based on considerations easy to do, simple, economical, and the results can be obtained quickly. This study also uses quantitative data in the form of secondary data based on reference search results that are considered quite complete and accurate. According to Sugiyono [6], the research data is empris data (observed) that have certain criteria that is valid or show the degree of accuracy, ie with respect to aspects of reliability and objectivity. The variables studied in this study as quantitative data, namely: independent variables of High Risk (Risti) in the form of Risti Disease, Risti Age (60 years and over) and a combination of both. Quantitative research results from secondary data.

3. Results

In general, the results of this study obtained the results of health checks of High Risk Hajj Pilgrims (Risti) from 2014 until 2016 as follows:

Table1: Distribution of Jamaah Risti in South Sulawesi By Regency / City, 2014

NO	Regency/city	Number of Jamaah	Number of Risti	Persentage
1	Makassar	916	621	68%
2	Pare	101	42	42%
3	Pinrang	284	140	49%
4	Gowa	482	215	45%
5	Wajo	338	185	55%
6	Bone	603	321	53%
7	Tanatoraja	28	20	71%
8	Maros	247	142	57%
9	Luwu	216	141	65%
10	Sinjai	186	106	57%
11	Bulukumba	324	173	53%
12	Bantaeng	148	85	57%
13	Jeneponto	268	144	54%
14	Selayar	90	53	59%
15	Takalar	208	117	56%
16	Barru	138	91	66%
17	Sidrap	203	113	56%
18	Pangkep	245	133	54%
19	Soppeng	202	121	60%
20	Enrekang	151	102	68%
21	Luwu Utara	183	95	52%
22	Palopo	86	52	60%
23	Luwu Timur	125	73	58%
TOTAL		5.772	3.285	57%

Table 2: Distribution of Jamaah Risti in South Sulawesi By Regency / City, 2015

NO.	Regency/city	Number of Jamaah	Number of Risti	Persentage
1	Bantaeng	148	98	66%
2	Barru	136	85	63%
3	Bone	599	392	65%
4	Bulukumba	328	252	77%
5	Enrekang	151	118	78%
6	Gowa	486	306	63%
7	Jeneponto	274	162	59%
8	Luwu	218	139	64%
9	Luwu Utara	183	93	51%
10	Luwu Timur	125	68	54%
11	Palopo	86	53	62%
12	Maros	249	143	57%
13	Pangkep	241	164	68%
14	Pare-Pare	97	53	55%
15	Pinrang	286	193	67%

16	Selayar	91	45	49%
17	Sidrap	203	121	60%
18	Sinjai	186	104	56%
19	Soppeng	201	132	66%
20	Takalar	211	138	65%
21	Tana Toraja	28	18	64%
22	Makassar	924	616	67%
23	Wajo	326	245	75%
TOTAL		**5.777**	**3.738**	**65%**

From the overall data of Jamaah Risti described above, it can be concluded that the percentage of Jamaah Risti in South Sulawesi in 2014-2016 is still above 50% of the total of the entire South Sulawesi Community. In addition, Jamaahs with age above 60 years old or elderly still remain the highest from year to year in the percentage of Jamaah Risti from the aspect of age group.

Table 3: Distribution of Risti Jamaah Based on District, 2016

NO	Regency/city	Number of Jamaah	Number of Risti	Persentage
1	Makassar	939	556	59%
2	Parepare	98	63	64%
3	Pinrang	284	175	62%
4	Gowa	487	340	70%
5	Wajo	324	208	64%
6	Bone	594	438	74%
7	Tator	27	13	48%
8	Maros	244	128	52%
9	Luwu	216	137	63%
10	Sinjai	186	119	64%
11	Bukukumba	328	216	66%
12	Bantaeng	150	84	56%
13	Jeneponto	274	158	58%
14	Selayar	89	69	78%
15	Takalar	208	117	56%
16	Barru	140	96	69%
17	Sidrap	212	164	77%
18	Pangkep	243	151	62%
19	Soppeng	202	142	70%
20	Enrekang	150	102	68%
21	Luwu Utara	181	91	50%
22	Palopo	85	62	73%
23	Luwu Timur	125	77	62%
TOTAL		**5.786**	**3.706**	**64%**

4. Discussion

(A). Analysis and discussion of the formulation of what problems and how the health problems of Hajj during this time, as described on the results of this study are the problems that arise from the preparation of the departure of Hajj pilgrims to be a risk during the operational period of Hajj is as follows:

1. Jamaah Profile

Based on the data obtained that the profile of Jamaah who departed from year to year is actually almost the same with almost the same risk, such as almost all the Jamaah who depart each year have an average education level is dominated by the level of elementary education (SD) and Senior High School (SLTA), this condition correlates with the level of understanding and experience.

2. High risk (risti)

From the description of the data obtained from the results of research, it can be analyzed that high risk is a fundamental problem of the risk of organizing the health of Hajj.

From these data (2014-2016) illustrates that the high risk (Risti) each year is at a percentage above 50%. This means that more than half of the composition of Jamaah South Sulawesi is a health-risking Jamaah. The high-risk juveniles in question are those consisting of elderly, suffering from disease, and a combination of both [7-9].

3. Readiness of resources

Result of Focus Group Discussion (HCV) conducted on selected kab / ur hajj health program managers, obtained information that the readiness of resources is still very less in the lack of available costs and lack of trained human resources in the effort of examination and fostering Hajj health.

4. Inspection and Coaching Time

Results DKT done to get an explanation from the manager of the district / municipal elected, can dismpulkan that during that widened the problem is time examination and coaching very short. So that waiting time in South Sulawesi is an opportunity for more optimal coaching efforts. Where the average waiting time in South Sulawesi, which is approximately 23 years with a maximum Timeout is Sidrap and Wajo for 30 years and the lowest in Luwu district for 13 years. Management of Soil Water and Risk Factors for the purpose of providing health care Hajj the pilgrims so as to achieve the conditions Istithaah Health Hajj by controlling health risk factors Hajj for in the country, during the trip, and the Arab Saudiserta prevent the transmission of infectious diseases that might be carried out or entered by Jamaah Haji (Permenkes 62, 2016). The following description coaching model and checks given to pilgrims by Minister Regulation No. 62 of 2016, namely: Chart of Stages of Examination and Development

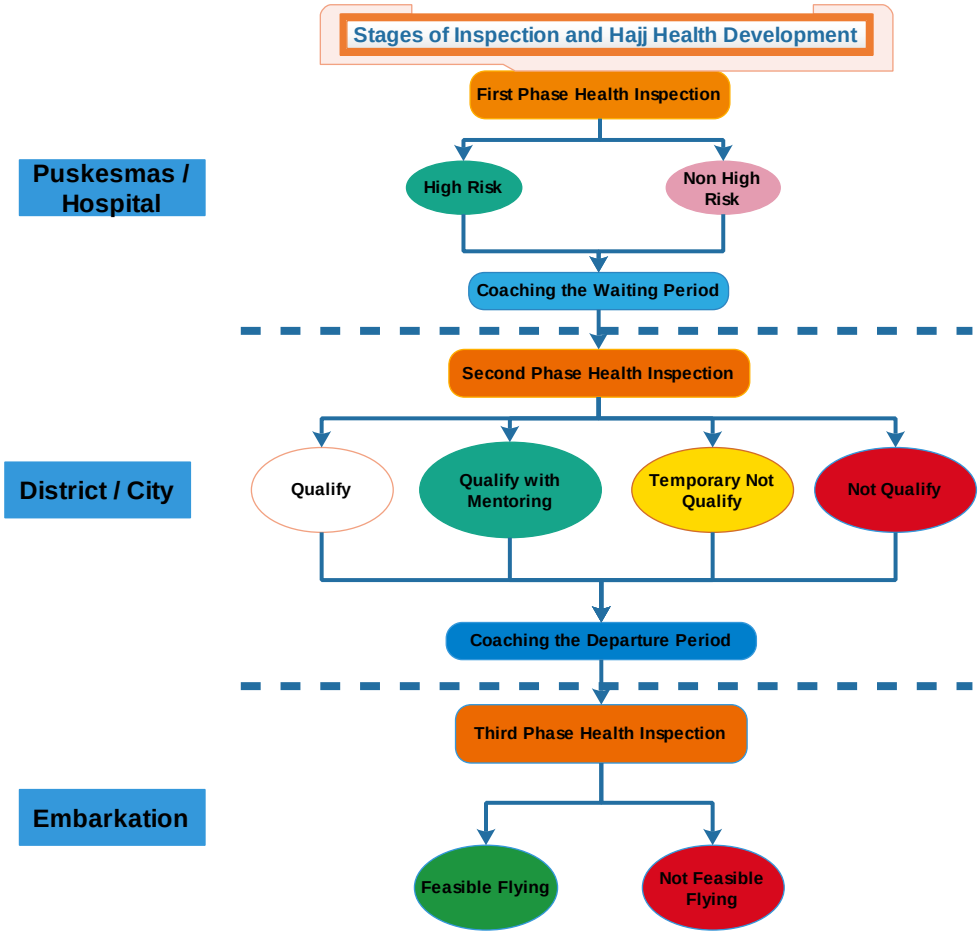

Figure 1: Health Service Scheme of Hajj on the Management of Homeland and Risk Factors

The development model is still not considered to answer some of the problems that arise from the lowest level or at the health center, on the way, in Saudi Arabia, until returning to the country.

As one FGD responded, the Statement received support from most district / municipal program managers with a larger number of members.

(B). Analysis and discussion of the problem formulation of how the model can be problems in the framework of holistic and comprehensive services.

That ideally someone who will perform the pilgrimage are those who really have implemented the pillars of Islam is good and correct starting from mengikrarkan two sentences shahadah, establishing a good prayer, fasting in the month of Ramadan with the predicate of true taqwa, issuing zakat as a means of worship To cleanse themselves and possessions, so that then be perfected by the implementation of the pilgrimage.

The need for counseling as early as possible and for a long time, both issues become the main issues for researchers to develop the management model especially in South Sulawesi. Both issues are short-term and cross-sectoral and cross-program support or coordination (comprehensive and holistic services).

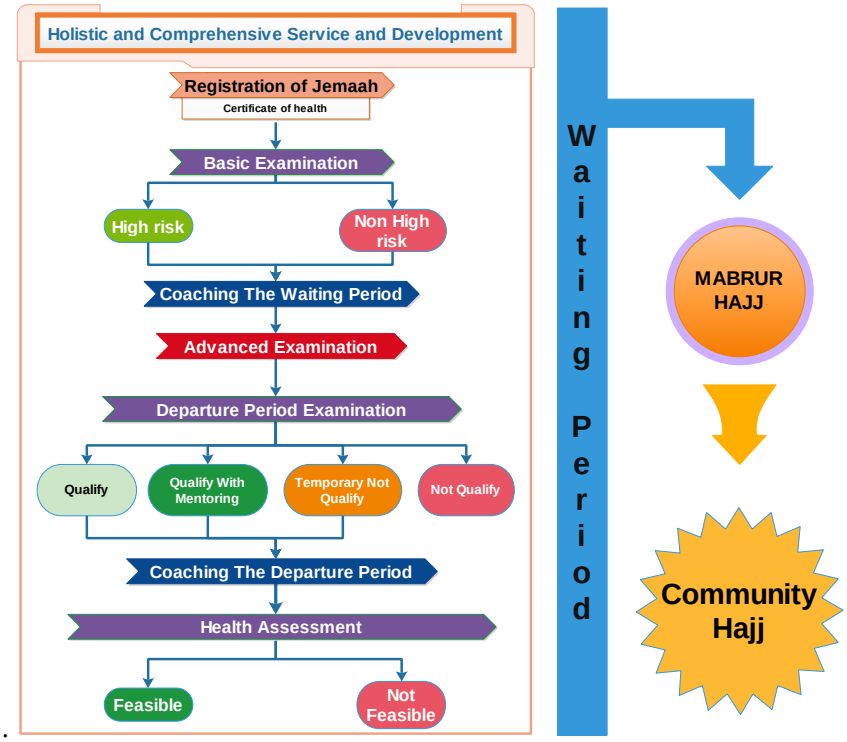

Figure 2: Health Service Scheme of Hajj

From the chart it can be seen that the health service effort of Haj pilgrims started from the registration of candidate pilgrims through the initial deposit at the bank receiving deposit that has been determined by carrying a health certificate from health care institutions signed by medical examiner doctors. Prospective pilgrims are required to perform a basic health check up to 6 months after initial deposit. The basic health checks are conducted to determine the health status of Jemaah in risti or non-risti conditions. Furthermore, there is a waiting period for improving health status, understanding and changing health behavior Would-be pilgrims. In essence, further medical examinations are conducted with the aim of following up the baseline examination and guidance of the waiting period. Which means that the follow-up examination is not the second examination that is awaited for the execution time. Further examination can be done many times in line with the coaching efforts conducted until the departure period. Departure check is conducted at least 10 days before departure to embarkation as well as an assessment of vaccination status of candidate for Hajj and determination of status of Istithaah pursuant to Permenkes Number 15 year 2016. The guidance of departure period is done at the post-health inspection period of departure to embarkation.

5. Conclusion

Hajj pilgrimage has several problems, including high risk (Resti), low education level, dominated by women, and housewife job, all of which is very influential on the level of knowledge and understanding and low experience. Profile of pilgrims and availability of resources that are still very lacking and the timing of coaching and health checks are very short, based on WM and DKT results. From several management model studies that have been applied in the implementation of Hajj health, the model offered that can answer some of these problems, the development of a comprehensive management model, holostik and integrated with cross-sector,

cross program and mass organizations and NGOs, which will eventually get the community Mabrur pilgrims who can be the pioneers of goodness, example and suritauladan in society.

6. Suggestion

It is hoped that with the existence of a good model is expected to influence the paradigm of study both human qualities in the congregation and in terms of management program mamajemen, that the hajj health program in the fore future has become a routine program with various activities throughout the year. It is suggested that there is cohort research for further verification in the framework of implementation of this model, further commitment is needed between sectors, especially local government in realizing mabrur haj community in its area so that it can become catalyst and development process of region, province and even national level.

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