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RESEARCH

Analysis of Transformation Alert Villages Program to Active Alert Villages Program in Ogan Ilir Regency in 2015

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ABSTRACT

Background: Transformation of Alert Villages Program to Active Alert Villages Program was very important for decrease Infant Mortality Rate, Maternal Mortality Rate, Infant under 5th years old. Mortality Rate, and environment-based disease. The aim of this study was to analysis transformation of Alert Villages Program to Active Alert Villages Program. Method: It was a descriptive study with qualitative approach at 4 villages (Sungai Pinang Nibung, Tebing Gerinting Utara, Ibul Besar I, Pipa Putih). The data was collected by in-depth interview to 28 informants. It was done a content analysis and triangulation (sources, methods, and data). Result: The results at physical setting, human resources, organizational structure and technology was no transformation. Internal factors (characteristic of stakeholder and behavior and decision maker) influenced the transformation, external factors (social trend) did not influence the transformation, and there was no individual resistance. Conclusion: It was concluded that was no transformation from Alert Villages Program to Active Alert Village Program in Ogan Ilir Regency 2015. The stakeholders suggested to coordinate each other to increase self-reliance of community in process of empowerment.
Keywords: Transformation, Alert villages, Active alert villages

INTRODUCTION

One of the community empowerment programs is the Alert village program (Minister of Health's decree 564/2006) with the criteria that villages that have Poskesdes (village health post) and at least 1 village midwife and 2 health cadres have been categorized as Alert village.(1) In 2008 it was targeted that all villages in Indonesia would become Alert village. The Alert Village Program was accelerated into the Active Alert Village Program (Minister of Health's decree 1529/2010) with eight criteria that had to be fulfilled so that the village was categorized as an Active Alert Village.(2)

The Acceleration of the Alert village program into the Active Alert Village Program is expected to be able to improve the health status of the community through the concept of community empowerment which generally includes the reduction in MMR (Maternal Mortality Rate), IMR (Infant Mortality Rate), and the incidence of environment-based diseases that are adapted to each region. The acceleration occurred because in 2009 only 56.1% of villages in Indonesia were categorized as Alert village, even though it was targeted that through minimum standard in 2008 100% of villages had been alert in Indonesia.(3) In Ogan Ilir Regency, in 2013 the role of the program has not been accelerated, because the IMR was 4.5 per 1,000 live births, the IMR was 1.18 per 1000 live births, and the MMR was 11 per 100,000 live birth. The death rate tends to increase in the last three years. The BTA (+) new case morbidity rate is 100.7 per 100,000 population, TB case notification rate is 144.4 per 100,000 population, while the pneumonia case finding rate is 17.23%, the percentage of diarrhea handled is 91%.(4) Whereas based on minimum standard, the number of environmental based disease findings should be 100%. The implementation of health behavior is also not optimal, because the percentage of households with health behavior practice was 50.7% and the percentage of healthy homes is still 59.31% even though the minimum standard target is 100%.(5)

The change in health policy from the Alert village program to the Active Alert Village Program in Indonesia should also be followed by an increase in the degree of public health, in accordance with the objectives of the Active Alert Village Program, which is to realize rural and urban communities that are caring, responsive, and able to recognize, prevent and overcome health problems faced independently, so that the degree of health increases.(2)

METHODS

This research was a descriptive study using qualitative methods. Informants were selected by purposive sampling technique with 28 informants consisting of village heads, village midwives, village cadres, community leaders, community members, and program holders at the community health care. The research units are 4 villages: Sungai Pinang Nibung, Tebing Gerinting Utara, Ibul Besar I, and Pipa Putih. Triangulation used is triangulation of sources, methods, and data. Data analysis techniques using content analysis.[6]

RESULTS

Changes in Physical Settings

Physical setting is explained by village health post building, access of road, access of transportation, and material. Regarding Poskesdes (Village Heath Post building)**,** 4 villages as the sample showed there was no transformation between alert village program and active alert village program, for example mentioned in these quotes:*" …Village Health Post stay at villager's home in 2012, however the old house is different with current…" (QM).* In the access of road, there were no changes from Alert Village Program and Active Alert Village Program in term of access of road. 1 village remains accessed by red ground and others are rough asphalt. It was mentioned by: *"…red ground. It was very difficult to access in particular rainy season…" (MZ).* The Access of transportation were not provided any transportation to do the health services, most midwifes use their own motorcycle or walk to do home visit. The referral patient needs to be moved by using the neighbor's vehicle otherwise there was any transportation available. That phenomena remains occurs in active alert village program. *"several years ago, I walk or sometimes drive motorcycle. However, for the referral patient I used the villager's vehicle" (MM.* In term of access opening hours, it was revealed that there were no changes between before and after alert village program. The fact showed that the health services only available on weekdays even though some villages give services 24 hours. It was mentioned in this statement: *"It used to open 24 hours, but during weekend it will be closed" (RI).* The mandatory health equipment has been available since active alert villages program launched, but the additional furniture to support the services in the room has not been available yet. *"Medical services are not available yet, although the most important medicine has been fulfilled already" (SM).*

From the results of in-depth interviews above, it can be seen that when the Alert village program is implemented, the physical regulation in the form of poskesdes (village health post) are still renting and riding status, road access in the form of red soil and asphalt is broken, transportation access to the poskesdes is walking and using a motorcycle, referral access using private vehicles or borrowing neighbor's vehicles, poskesdes opening hours have not provided services 24 hours poskesdes material conditions are not yet complete. This condition is the same as the condition when the Active Alert Village Program was put into effect, so that in the period from when the Alert village program was put into effect (2006) until the Active Alert Village Program (2010) there were no changes to the physical arrangements in the four villages observed.

Changes in Human Resources

Human resources in this part are explained by village midwifes, cadre, staff in community health care and society. The first important health worker is village midwife. They were consisted by 4 health staffs. 2 of 4 midwifes were taken as a sample including 2 were contract employees and 2 were civil servants. They have not been trained routinely. It was explained by: *"I am civil servant and I have been trained for example about emergency response. However, about alert village did not yet" (LS).* Cadre for alert village program consists of those who resided in the village and as volunteer want to help the health services. According to in-dept interview, in 4 villages, totally have 3-5 cadre in each village. It was mentioned by: *"It has been 4 or 3 of us. If I am not mistaken." (RS).* The staff who has responsibility to Alert Village Program is working in community health care. They have a duty to monitor and evaluate the program and ensure the good influence of that program. *"We monitor that program because it is my responsibility yearly" (RA).* In the society, villagers work together to help each other in particular issues like health and disaster. *"Since in the past we help each other, at least if someone was sick me visit them and give an advice" (FW).*

In accordance with the results of the in-depth interviews above, it can be seen that the human resources involved in these two programs are the village head, village midwife, cadre, community leaders, the community itself, and the holder of the Active Alert Village program at the Community Health Care. At the time of the Alert village program the quantity of village midwives was met, namely at least 1 village midwife for each

village, but in terms of quality the village midwife had never participated in training on an alert village. Standby village cadres are sufficient in quantity, namely at least 2 cadres for each village, but in terms of quality the training attended by the standby village cadres is only limited to knowledge about posyandu (integrated services post) while training for the standby village program has never been included. In developing Health behavior, Community Health Care's staff carry out routine village visits every month. The active role of the community only plays a role in reporting if there are health emergencies and is only involved in the Posyandu (integrated services post). The condition of the human resources has not changed when the Active Alert Village and Village Program is implemented. So, it can be seen that there has been no change in human resources from the Alert Village Program to the Active Alert Village Program.

Changes in Organization Structure

The organization structure is related to official regulation how the alert village program or active alert village program will be implemented in the society. In term of village forum**, s**takeholders in the village reported that they have regular meeting but not specific to health issue. *"We do not have the formal structure; regular meeting has been done. The problem was our village office has been burned" (AF).* Village regulation also found with no official regulation in the village to manage the alert villages program. *"We do not have the official regulation (SK), since the past I think" (QM).* Self-help funds was reported that to collect the self-help fund is not easy, because villagers has their own needs. *"It is not easy to collect the money from villagers" (IS).* At the time of the Alert village program, the organizational structure was established, namely the absence of a village forum structure, village level regulations regarding the Active Alert Village Program and community self-funding. The village forum that discussed health issues had never been carried out, village-level regulations governing the operational technicality of the Active Alert Village Program were not yet available, and funds for village activities were sourced from ADD (Village Fund Budget) and Ban-Gub (Governor Assistance). This condition did not change when the Active Alert Village Program was implemented in 2010. So, in general it can be seen that there has been no change in the organizational structure aspect from the Alert Village Program to the Active Alert Village Program.

Changes in Technology

Technology should take a part in order to report the regular surveillance data. In the fact, midwifes in the village still use the manual report without computer and access of internet. *"We have not got because we still use manual, like this (show the monthly report). We write based on visiting patient and community health care also collect that data" (RI).* From the quote it can be seen that there is no role of technology (hardware, software) in surveillance, health emergencies, environmental health, and empowerment program. The recording and reporting system still use blanks, in the event of an outbreak and an emergency of the village midwife using a personal mobile phone. Environmental sanitation activities have not been carried out routinely. Only Posyandu (integrated services post) and Family Medicinal Plants were active. Information related to empowerment program is shown in the following table:

Table 1. Health Services based on Society

No.	Kind of Health Service based on Society	Sungai Pinang Nibung	Tebing Gerinting Utara	Pipa Putih	Ibul Besar I
1.	Posyandu (integrated services post)	√	√	√	√
2.	Family medicine plan	√	-	-	√
3.	Trash bank	-	-	-	-
4.	Pregnant save	-	-	-	-
5.	Village ambulance	-	-	-	-
6.	Others	-	-	-	-

From the table above, it can be seen that of the 4 villages observed, all villages have implemented of empowerment program. Posyandu (integrated services post), but only 2 villages have implemented Family Medicinal Plants.

Factors Influence the Changes

Internal factor (human resource characteristics, behavior, and managerial decision). Regarding human resources characteristics, head village has their own characteristics to manage the territorial for example in the alert village program they may do different way based on the input they got. *"I am a farmer (not a civil servant), we got the incentive as a head of village, villagers supported me and I have been chosen from the voting process" (QM).* In term of, behavior and managerial decision, head of village may have different system to decide the regulation. This part will explain that system. *"We have not gotten the reward. We did the discussion among the important people to solve the conflict and decide some issue" (QM)*. Based on the results of in-depth interviews above, it can be seen that the nature of the workforce in the form of accommodation is accommodation in the form of money received by the village head and village midwife while cadres more often get accommodations in the form of uniforms. From the aspect of village head recruitment patterns, all village heads are elected through direct elections. Internal factors such as managerial behavior and decisions can be seen that in overcoming conflicts and leading the village head community to hold deliberations for consensus, on the other hand the reward system has not been implemented.

External factors (social trends), the social trends including how tradition takes a part in the society. *"We have tepak as a tradition in wedding ceremony and religious recitation regularly" (SK).* From the results of in-depth interviews above, it can be seen that the social tendencies found in society are marriage, recitation of ladies and gentlemen. In the process of changing the Alert village program to the Active Alert village Program, it does not show the role of social trends in the change process.

Individual resistance namely the stakeholder may resist through the system and may do insufficient way in term of decision. *"We will join the training, competition in the village. We also write the proposal (RI).* From the above quotation, it can be seen that all stakeholders involved are ready to make changes and are willing to attend training if invited. Stakeholders involved want to take part in the village standby alert and are always active in Posyandu (integrated services post) activities (village midwives and village cadres on standby).

DISCUSSION

Based on Table 1, it is known that the Poskesdes (village health post) conditions are inadequate in terms of facilities and infrastructure and do not have permanent buildings. So, it can be concluded that there has not been a change in physical regulation. Based on the guidelines for the development of an Active Alert Village, Poskesdes (village health post) should have independent and permanent buildings1, have adequate road infrastructure access, be easily accessible by transportation, have referral transportation, provide daily health services and be equipped with complete spatial and material [(7)]. Constraints experienced were due to the absence of evenly procuring Poskesdes (village health post) materials and the construction of Poskesdes (village health post) that were constrained by grant land. The role of the government was also conveyed by Kusuma [(8)], who stated that the Poskesdes (village health post) physical facilities needed government support. The location requirements for the Poskesdes (village health post) to be built by the government also occur in the Mentawai Islands, Ayuningtyas stated that the obstacle to establishing the Poskesdes (village health post) was due to the location and technical requirements set by the Ministry of Health. [(9)] Study conducted in Sawarak Malaysia also found the importance of alert village program and the physical characteristics in term of the changes of non-communicable disease behavior. [(20)]

Based on the results of the study it can be concluded that in aspects of changes in human resources there has not been a change in both quantity and quality. Based on the Active Alert Village guidelines, the number of village midwives is at least 1 person for 1 village, the training that must be followed by the village midwife is management and implementation training. [(1)] The number of cadres must be at least 2 people for each village, the training that must be followed by cadres is to prepare an active alert village development plan, participatory development, mutual cooperation, community self-help, health promotion and solving health problems. Officials at the Puskesmas conduct PHBS training based on 10 indicators. The community is demanded to play an active role in health activities in the village and to be active in empowerment program. [(2)] The results showed that the conditions in the 4 villages observed were not in accordance with the reference. The importance of community participation is in line with Laksana's research [(10)] which states that community participation can be expressed in the form of energy, possessions, and ideas. According to Musa, health behavior monitoring can be developed in various ways such as counseling, outreach / meetings, and posyandu (integrated services post). [(11)] The discrepancy can have an impact on the process of community empowerment that is not running optimally. Constraints experienced by informants were the absence of training invitations for village midwives and cadres,

Puskesmas staff were hampered by village access that was difficult to reach, and the community was constrained due to unsupportive socio-economic conditions.

Based on the results of the study, it can be seen that there has been no change in the organizational structure in the form of village forum structures, village level regulations regarding active standby villages, and community self-funding. Based on the guidelines for the development of an Active Alert Village, a village forum should be held at least 4 times a year with the aim of socializing health problems encountered, prioritizing problems, establishing UKBM, strengthening village potentials, and mobilizing community participation. The socialization of village level regulations should be carried out to encourage community participation. Community self-funding is important to encourage community independence. The results of the above study are not in accordance with the guidelines, it is constrained due to the absence of direction and socialization so that only the top stakeholders know. The lack of initiative causes suboptimal stakeholder roles because they are only waiting for instructions. FKK (Village Health Forum) is very important in accordance with the results of Amiatiningsih's research which states that FKK is shown by formulating policies. [(12)] The changes of alert villages program have been transformed from suami siaga or "husband alert" which reflected the importance of alert in the society. [(14)]

In accordance with the results of the study, it can be seen that there has been no technological change from the Alert Village Program to the Active Alert Village and Village Program. Based on the policy on Poskesdes (village health post), the minimum facilities for emergencies are special mobile phones, computers and couriers. [(2)] The technology is not yet available because there is no procurement, so village midwives still use privately owned technology. The technology has a role in empowerment program, but it has not been well utilized. Misnaniarti's research states that the formation of Alert village has not yet fully utilized the empowerment program. [(13)] Active empowerment program should not only be Posyandu (integrated services post) and Family Medicinal Plants. Technology in this era also affect to empower community especially the social media. [(18)]

Regarding the Internal Factors (Nature of Labor and Behavior and Managerial Decisions), based on the results of in-depth interviews, it can be seen that the nature of the workforce in the form of accommodation and incentives has not been fulfilled in full, the pattern of stakeholder recruitment is largely of its own volition. Behavior and managerial decisions of village heads in overcoming conflicts, leading communities and making decisions that is with the consensus system. This condition has occurred since the Alert village program and Active Alert Village Program was in force. So, it can be seen that these internal factors do not affect the process of change. The internal of community in villagers level influenced the effectiveness of empowerment program including Alert Village Program[18]. In the external factors (social trends), based on the results of in-depth interviews, it can be seen that the social tendencies that occur in the community are routine recitation, wirit, the tradition of tepak in marriage, and celebration events. This condition illustrates the condition of the community which has a high intensity of gathering, thus it can be seen that the community tends to be more compact. The existence of a good community trend is not followed by a process of change, so it can be seen that external factors tend not to affect the process of change. The external factors such as the authority team development and community team development were influence the effectiveness of Alert Village Program. [(17)] The development of Alert Village Program in Evu Village mentioned by Rahantoknam in the line in this research. trend in society and the role of communication mass also important to empower society. [(18)] It was seen that the individuals involved in these two programs are willing to follow the process of change. However, this is not supported by community initiative and independence, stakeholders at the village level tend to only wait for instructions from superiors. Village midwives and cadres are always active in Posyandu (integrated services post) activities and are willing to attend training if invited. In general, there is no individual resistance. The most important point to sustainable the health services in society scope are professional health worker and cadre. [(15)] Cadres who had to be active in this program should be supported by financial, it was found by the previous research that explained passive cadres were because of the insufficient village funds. [(16)] Study conducted in Sakatiga Village found that counseling and training of cadres and community members were the efforts to gain the Alert Village goals. [(19)]

CONCLUSION

Based on the results of research and discussion, the researcher can draw some conclusions. There has not been a change in physical, human resources, organizational structure and technology arrangements from the Alert village program to the Active Alert Village Program. Internal factors tend to affect the process of change, while external factors tend not to affect change. There is no individual resistance.

From the conclusions above, the researcher has a suggestion that the change process can work:

1. For the Ogan Ilir District Health Office

Ogan Ilir District Health Office should coordinate more often across sectors, namely with the Office of Community Empowerment and Village Government. Conduct training of village midwives and cadres. Distribute health workers and medical devices equally.

2. For Village Government and Community
   It is better to increase coordination with stakeholders in the village through village forums and try to shape community empowerment towards an independent community.

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