ACCELERATION OF DESA SIAGA AKTIF IN SUBDISTRICT BARENG, JOMBANG, 2012

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ABSTRAK

*Pengembangan Desa Siaga adalah untuk lebih mendekatkan pelayanan kesehatan dasar masyarakat desa, menyiapsiagakan masyarakat menghadapi masalah kesehatan, memandirikan masyarakat dalam mengembangkan perilaku bersih dan sehat. Belum semua Desa dan Kelurahan Siaga mencapai kondisi Siaga Aktif yang sesungguhnya sehingga perlu dilakukan akselerasi dengan menyelenggarakan Pengembangan Desa & Kelurahan Siaga Aktif berdasarkan Keputusan Menteri Kesehatan RI no. 1529/Menkes/SK/X/2010 tentang Pedoman Umum Pengembangan Desa Dan Kelurahan Siaga Aktif. Kecamatan Bareng memiliki 13 desa dan sudah menerapkan Desa Siaga sejak tahun 2008 namun belum melakukan akselerasi menjadi Desa Siaga Aktif. Tujuan penelitian adalah melakukan pemetaan Desa Siaga Aktif di Kecamatan Bareng, mengidentifikasi permasalahan yang menghambat pengembangan Desa Siaga Aktif di Kecamatan Bareng, menemukan solusi permasalahan Desa Siaga Aktif di Kecamatan Bareng; dan mengembangkan Desa Siaga Aktif di Kecamatan Bareng. Penelitian antara 24 Desember 2012 -12 Januari 2013, menggunakan metode penelitian operasional dalam 4 tahap, yaitu Information Building, Community Diagnosis & Program/Solution Development; Program Implementation/Solution Validation, dan Evaluasi. Besar sample sebanyak 31 orang secara purposive sampling. Instrumen berupa kuesioner mengenai 8 kriteria pentahapan Desa/Kelurahan Siaga Aktif. Didapatkan bahwa 13 desa semuanya Desa Siaga Aktif Pratama. Permasalahan adalah belum adanya Surat Keputusan Desa Siaga Aktif, dukungan dana masyarakat rendah, pembinaan PHBS tatanan Rumah Tangga rendah. Dilakukan penyusunan SK Desa Siaga Aktif di tingkat desa dan kecamatan melalui koordinasi dengan Camat Bareng, Kepala Puskesmas Bareng, 13 Kepala Desa, dan Seksi Promosi Kesehatan Dinkes Kabupaten Jombang. Tahap Evaluasi, dengan penerbitan SK Desa Siaga Aktif maka desa Nglebak dan Banjaragung meningkat menjadi Desa Siaga Aktif Madya.**(FMI 2013;49:55-61)***

***Kata Kunci**: Akselerasi, Desa Siaga Aktif, Kriteria Desa Siaga Aktif*

ABSTRACT

*Desa Siaga development includes efforts to bring primary health care to rural communities, to keep them alert to face health problems and independent in developing clean and healthy behaviors. Based on the evaluation by the Ministry of Health in 2009, from 75 410 rural and urban villages throughout Indonesia, 56.1% have initiated efforts to achieve Desa Siaga and Kelurahan Siaga. However, not all have achieved real Siaga Aktif condition. Therefore, it needs to be accelerated by organizing Pengembangan Desa & Kelurahan Siaga Aktif based on the Decree of the Indonesian Minister of Health no. 1529/MENKES/SK/X/2010 on Pedoman Umum Pengembangan Desa dan Kelurahan Siaga Aktif. District Bareng has already implemented Desa Siaga since 2008 but has yet to accelerate from Desa Siaga to Desa Siaga Aktif. The objective was to map the Desa Siaga Aktif in District Bareng, identify issues that inhibit its development, to find solution to the problems, and to develop Desa Siaga Aktif. This operational research study from December 24, 2012 to January 12, 2013i was in four stages: information building, community diagnosis and program/solution development, program implementation/solution validation, and evaluation. The stage of information building used secondary and primary data through indepth interviews with populations comprising of village head, village midwives, cadres health and community leaders. The sample size was 31 persons enrolled using purposive sampling. We found the absence of the Decree of Desa Siaga Aktif at village and sub-district level, low community financial support, and low PHBS coaching at household level. Decree on Desa Siaga Aktif was arranged at village and sub-district level. During Evaluation stage, by the enactment of the Letter of Decree of Desa Siaga Aktif, the villages Nglebak dan Banjaragung became Desa Siaga Aktif Madya. **(FMI 2013;49:55-61)***

***Keywords:** Acceleration, Desa Siaga Aktif, criteria of Desa Siaga Aktif*

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INTRODUCTION

By the decree of the Minister of Health no. 574/Menkes/SK/2000, the vision of health development, namely "Indonesia Sehat 2010", has been established. The vision illustrates that in 2010 the Indonesian nation will live in a healthy environment, have clean and healthy living behavior and be able to reach qualified health services fairly and equally to achieve the highest level of health. One strategy to reach the vision of the

health development is at the end of 2008 all villages have become Desa Siaga. Desa Siaga is a village whose inhabitants have readiness and capabilities of resources to prevent and overcome health problems, disasters and health emergencies independently. The development of Desa Siaga includes the efforts to bring primary health care to rural communities, to prepare the community to face health problems, to make the community independent in developing clean and healthy behaviors. Therefore, in 2006 the Ministry of Health issued a Decree of the Minister of Health no. 564/Menkes/SK VIII/2006 on the Guidelines for Desa Siaga Development (Ministry of Health, Republic of Indonesia 2006).

Based on the evaluation conducted by the Ministry of Health in 2009, from 75 410 rural and urban villages throughout Indonesia 56.1% villages have initiated efforts to achieve Desa Siaga and Kelurahan Siaga. However, not all of those villages have achieved real Siaga Aktif conditions. In 2015, the government has set a target that 80% of rural and urban villages throughout Indonesia has become the Desa/Kelurahan Siaga Aktif. In connection with these conditions, the Ministry of Interior strongly supports the efforts to revitalize the Village and Village development, which is based on the Standby community empowerment process and the implement regional autonomy in order to accelerate the achievement of the target of 80% Desa Siaga Aktif in 2015 by the Minister of Health through the Minister of Health Regulation no. 741/Menkes/Per/VII/2008 on Minimum Service Standards (MSS) in Health Sector at Districts and Cities, and the Decree of the Minister of Health No. 828/Menkes/SK/IX/2008 on Technical Guidelines for Minimum Service Standards (MSS) at the Districts and Cities. Desa/Kelurahan Siaga Aktif is one indicator of the Minimum Service Standards (MSS) in Health Sector in districts/cities. Targets to be achieved by 2015 is 80% of rural and urban villages in Indonesia has become the Desa/Kelurahan Siaga Aktif. Therefore, we have to accelerate of the Development of Desa/Kelurahan Siaga, which has been taking place. The acceleration is implemented by organizing the Development of Desa & Kelurahan Siaga Aktif by the Ministry of Health of the Republic of Indonesia no. 1529/Menkes/SK/X/2010 on the General Guidelines o the Development of Desa dan Kelurahan Siaga (Ministry of Health, Republic of Indonesia 2008, 2010).

Subdistrict Bareng is one of 21 subdistricts in District Jombang on the slopes of Mount Anjasmoro, so most of the region is a mountainous area. Up to the end of December 2009, Subdistricts Bareng has a population of 60,501 people, comprised 30,469 males and 30,032 females. The area of Subdistrict Bareng lies at coordinates 05.20.01 - 05.30.01 East Longitude and 07.24.01 - 07.45.01 South Latitude. Subdistrict Bareng has 13 villages and has already implemented Desa Siaga since 2008, but have yet to accelerate the development of Desa Siaga to become Desa Siaga Aktif.

The purpose this research was to map Desa Siaga Aktif in Subdistrict Bareng, District Jombang, to identify the problems that are impediments to the development of Desa Siaga Aktif at Subdistrict Bareng, District Jombang, find solutions to problems Desa Siaga Aktif at Subdistrict Bareng, District Jombang, and to develop Desa Siaga Aktif at Subdistrict Bareng, District Jombang.

MATERIALS AND METHODS

The study was conducted on December 24, 2012 - January 12, 2013. The method used in this study was operational research divided into 4 stages, the information building, community diagnosis and program/solution development, program implement-ation/solution validation, and evaluation.

Information Building

Information Building stage used survey approach, the collection of secondary data at health centers and district, as well as primary data collection in the community through in depth interview, with the population of the village heads, village midwives, health cadres and community leaders. Sample size of 31 individuals, taken using purposive sampling. Instrument was in the form of questionnaires that included questions about the 8 criteria of Desa/Kelurahan Siaga Aktif phasing. The criteria included: the care of village government and community leaders to Desa and Ke-lurahan Siaga Aktif as reflected the presence and activity of Forum Desa dan Kelurahan; the existence of Kader Pemberdayaan Masyarakat/Kader Teknis Desa and Kelurahan Siaga Aktif; the ease of public access to basic health services that open or provide services every day; the existence of Upaya Kesehatan Bersumberdaya Masyarakat (UKBM) which can perform a community-based surveillance, disaster management and emergency health, and environmental health; accommodated funding for the development of Desa dan Kelurahan Siaga Aktif in Village Development Budget as well as from the public and business community; active participation of communities and community organiz-ations in health activities in Desa and Kelurahan Siaga Aktif; regulations at urban and village levels that underlie and regulate the development of the Desa dan Kelurahan Siaga Aktif; and coaching Perilaku Hidup Bersih dan Sehat (PHBS) in the households in the villages.

Community Diagnosis and Program/Solution Development

Community Stage Diagnosis & Program/Solution Development workshop was conducted by using an approach that was attended by 48 people, consisting of 13 village heads, 13 midwives, 13 cadres of the village, the Head of Subdistrict Bareng along with the local Police Chief and Millitary Commandant, the head of health centers and staff, as well as related agencies (stakeholders) of the Public Health Service ,Jombang, as well as the East Java Provincial Health Office. Workshop was held at the 2nd floor hall Community Health Center, Bareng, on Thursday, January 3, 2013, at 9:00 to 14:00 pm

The method used was the presentation of field recognition, as well as Focus Group Discussion (FGD). FGD was divided into 3 groups: village midwives, cadres and village heads. The group discussion was followed by plenary. Community Diagnosis phase aimed to: identify priority issues and health problems, formulate community diagnosis, formulate solutions/ solving health problems in the form of community treatment program plan, identify local resources and participation that can be done, taking the decision to select the program/model/solution that will be done in the phase of community therapy.

Program Implementation/Validation Solution

The phase of Programme Implementation/Solution Validation was done by using a program approach, which was to prepare and implement programs/ models/solutions selected together, to move the part-icipation of local communities and to empower local communities, to manage local resources effectively and efficiently, to monitoring, coordinate, and supervise the implementation of rural development programs of Desa Siaga Aktif at Subdistrict Bareng, District Jombang.

Evaluation phase

The success of the development of Desa Siaga can be seen from the four groups of indicators, the indicators of input, process, output, and impact.

RESULTS

All villages in subdistrict Bareng have existing active role supported by community organizations (CBOs). The number of the active organizations varied. In Bareng and Ngebak villages there were two active organizations, while in Banjar Agung village there were three active organizations. The community organization was Aisyah and other religious organizations.

Table 1. Frequency distribution of Village Forum

Urban/Rural Village Forum	Number of villages	Percentage
Unexist	0	0%
A. Exist, not active	0	0%
B. Active, not routinely three-monthly	0	0%
C. Active, each three month	0	0%
D. Active, each month	13	100%

Table 2. Frequency distribution Community Empowerment Cadre/Health Cadre

Community Empowerment Cadre/Health Cadre	Number of Villages	Percentage
Unexist	0	0%
A. Exist, minimally 2 persons	0	0%
B. Exist, 3 – 5 persons	3	23.1%
C. Exist, 6 – 8 persons	2	15.4%
D. Exist, 9 person or more	8	61.5%

Table 3. Frequency Distribution of Primary Health Care Accessibility

Primary Health Care Accessibility	Number of Villages	Percentage
Uneasy	0	0%
Easy	13	100%

Table 4. Frequency Distribution of Active IHC & Other UKBM

Active IHC & Other UKBM	Number of Villages	Percent-age
Inactive IHC	0	0%
A. Active IHC. other UKBM exist but inactive	0	0%
B. Active IHC, other 2 UKBMs active	12	92.3%
C. Active IHC, other 3 UKBMs active	1	7.7%
D. Active IHC, other 4 UKBMs active	0	0%

Table 5. Frequency distribution of funds to support health activities in villages

Funds to Support Health Activities in Villages	Number of Villages	%
No fund from village government	0	0%
A. Fund from village government,no from other sources	11	84.6
B. Fund from village government & from one other source (community & business)	2	15.4%
C. Fund from village government & from two other sources (community & business)	0	0%
D. Fund from village government & from two other sources (community & business)	0	0%

Table 6. Frequency distribution of community & social organization engagement

Community & Social Organization Engagement	Number of Villages	%
No active role of the community	0	0%
A. Active role of community, but not from social organization	0	0%
B. Active role of community, and active role of one social org.	10	76.9%
C. Active role of community, and active role of two social org.	2	15.4%
D. Active role of community, and active role of more than two social organizations	1	7.7%

Table 7. Frequency distribution of the Regulation of Village Head or the Regulation of Regent/Mayor

Regulation of Village Head or the Regulation of Regent/Mayor	Number of Villages	Percentage
A. Unexist	13	100%
B. Exist, no realization	0	0%
C. Exist, with realization	0	0%
D. Exist, with realization	0	0%

Table 8. Frequency Distribution Household PHBS Improvement

Household PHBS Improvement	Number of Villages	%
No PHBS Improvement		
A. PHBS Improvement <20% existing household	0	0%
B. PHBS Improvement 20% - 39% existing household	1	7.7%
C. PHBS Improvement 40% - 69% existing household	9	69.2%
D. PHBS Improvement minimally 70% existing household	3	23.1%

Table 9. Distribution frequency of the levels of Desa Siaga Aktif

Levels of Desa Siaga Aktif	Number of Villages	Percentage
Pratama	13	100%
Madya	0	0%
Purnama	0	0%
Mandiri	0	0%

Table 10. List of issues Rural Development Active Standby group village head, village midwives, and village cadres.

Village Cadre	Midwife Cadre	Head of Village
a) Not all villages have Desa Siaga Aktif cadres	a) Low covarage of healthy latrine	a) Health service inaccesible because village midwive does not live there
b) Minimal budgeting for health	b) Less maximal exclusive breastfeeding	b) Delivery has not been managed by health care provider
c) Inactive UKBM	c) Many people smoke inside the house	c) Many people smoke in public places.
d) No clear village regulation	d) Low coverage of health promotion	d) Fund for health inactive
e) Less attention to environmental health		e) DHF outbreak still exists
f) Healthy latrine coverage less than 100%		f) Unclear Desa Siaga Active coordinating system

DISCUSSION

Building Information

District Bareng has an area of approximately 64.05 km2, consisting of 13 villages, among others Kebondalem, Mundusewu, Pakel, Karangan, Ngampungan, Jenisgelaran, Bareng, Tebel, Mojotengah, Banjaragung, Nglebak, Pulosari, and Ngrimbi.

Village Forum

All villages in Subdistrict Bareng, District Jombang, have already implemented village forum and runs every month. The village forum includes IHC monthly meetings, PKK monthly meetings, and the village council meetings. The forum is a means for rural communities to undertake Survey Mawas Diri (SMD) or Telaah Mawas Diri (TMD) or Community Self Survey (CSS), whose objective to make community leaders capable to carry out introspective study for their villages. This survey should be carried out by local community leaders with the guidance of health professionals. Thus, they became aware of the problems faced in the village, as well as the intention and determination to find a solution.

The output of the SMD is the identification of health problems in the village as well as a list of potential that can be actualize to address those health issues. Survey Mawas Diri was followed by Musyawarah Masyarakat Desa (MMD), which aims to find an alternative resolution of health problems associated with the potentials of the village, in addition to arrange long-term development plan of the village. The initiative of the the implementation of forum should come from community leaders who have agreed to support the development of Desa Siaga. Forum participants were community leaders, including women leaders and local youth. As far as possible it should also involve business community who want to support the development and sustainability of Desa Siaga (therefore, advocacy is needed). Data and other findings were obtained when the SMD were presented, particularly the a list on health problems, potential data, as well as the community expectations. The results of the data collection were discussed for the determination of priorities, support and contribution that can be contributed by each individual/institution it represents, as well as step-by-step solution for Poskesdes construction and development of each Desa Siaga.

Community Development Cadre/Health Cadre

Existing health cadres can be developed to Desa Siaga Cadres and by official election and Desa Siaga cadres through formal special meeting of village leaders and community leaders as well as some community representatives. Selection is made by deliberation and consensus, in accordance with prevailing procedures and criteria, facilitated by the health center.

Before performing their duties, the predefined Desa Siaga officials and cadres alert should be given orientation or training. The orientation/training conducted by the District/City Health Office in accordance with prevailing guidelines of the orientation/ training. Orientation/training material includes activities to be implemented in the village in order to develop Desa Siaga, including the management of Desa Siaga in general, the development and management of Poskesdes, development and management of other UBKM, as well as important issues related to healthy pregnancy and childbirth, Siap-Antar-Jaga, Keluarga Sadar Gizi, IHC, environmental health, communicable disease prevention, clean water supply and environmental sanitation settlement (PAB-PLP), day-to-day emergencies, disaster preparedness, extraordinary events, village medicine shop (WOD), diversification of food crops and the use of the yard through the Taman Obat Keluarga (TOGA), surveillance activities, and others.

Ease of Primary Health Care Access

Poskesdes already existed in 13 villages in Subdistrict Bareng, so that people can easily access basic health services in their respective villages. Ease of access to basic health services can be determined from primary health care that opens every day of 24 hours. Average farthest distance from the houses to the nearest healthcare center is 2-3 kilometers. The distance can be reached by using a motor vehicle/car. When Poskesdes has been successfully held, the activities continued by forming necessary UKBMs still not existing in the village in question, or revitalizinge the less or inactive existing ones.

Other Active IHC and UKBM

IHC was active in 13 villages. An active UKBM other than IHC is the village ambulance (9 or 69.3% rural villages have had ambulances using private cars of the villagers); IHC for elderly; sticker placement for pregnant women; class maternal Drink Consumption Controller (Pengawas Minum Obat, PMO); Mosquito Nest Eradication (Pemberantasan Sarang Nyamuk, PSN), and Clean Friday (Jumat bersih) or voluntary work. Other UKBM still need to be developed through coaching and training of other Desa Siaga cadres together with poskesdes, so the independence of the

community in disaster preparedness in the face of health problems in their village can be increased more.

Fund to support health activities in villages

All villages in subdistrict Bareng have received funding of rural/urban government, but not all of them have financial support from other sources. The villages Banjaragung and Nglebak, besides having financial support from the village government, there are also other sources of funding in the form of contributions of every citizen of every month in each village. Village government funding was taken from the Village Fund Budget (Anggaran Dana Desa, ADD) by 1-2% per year. Annual budget of the central government was Rp. 1,250,000 per IHC.

Community Engagement & Social Organization

All villages in subdistrict Bareng have existing active role supported by community organizations (CBOs). The number of the active organizations varied. In Bareng and Ngebak villages there were two active organizations, while in Banjar Agung village there were three active organizations. The community organization was Aisyah and other religious organizations.

Regulation Village Head or the Regent/Mayor

All villages in the subdistrict Bareng had no regulations at village level that underlie and regulate the development of the Desa/Kelurahan Siaga Aktif. The rule was in the form of Decree (Surat Keputusan, SK) issued by the district Jombang.

Household PHBs Improvement

Household PHBs improvement in villages in Subdistrict Bareng was not optimal. In general, from 10 indicators of PHBs, the indicators that were still a problem were smoking inside the house, healthy latrine, and exclusive breastfeeding.

Levels of Desa Siaga Aktif

The selected priority issues were the absence of clear village rules and low achievement of Household PHBs. All villages in subdistrict Bareng, District Jombang, were Desa Siaga Aktif Pratama

Community Diagnosis and Program/Solution Development

Community diagnosis revealed that 13 villages in the district Bareng had been Desa Siaga Aktif tingkat Pratama. The development of Desa Siaga in Subdistrict Bareng should be revilatized by arranging the Decree on organizational structure of Desa Siaga Aktif at village level and promoting the socialization of Household PHBs, in particular about the use of healthy latrines, exclusive breastfeeding and not smoking at home. The Decree (SK) on organizational structure of Desa Siaga Aktif at village level did not exist, because the head of the village did not know the model of the decree.

The selected solution was that all parties will act optimally in accordance to each duties and functions in order to realize the Desa Siaga Aktif to achieve the goal of developing Desa Siaga Aktif, namely the creation of village communities that have concern, responsive, and able to solve problems on their own health to improve health status. Subsequently, the planning, creation, and distribution of the Decree on Desa Siaga Aktif was done in each village, and the provision of general guidelines on active rural and urban village development according to the Decree of the Minister of Health, Republic of Indonesia no. 1529/MENKES/SK/X/2010. Furthermore, we carried out pervasive and educative improvement on knowledge among health professionals and public about Desa Siaga Aktif through x-banner posted at Bareng PHC, and increasing knowledge among health professionals and the public about PHBs through posters and leaflets in each Polindes or Pustu in Subdistrict Bareng.

Program Implementation/Solution Validation

Preparation of the Decree of Desa Siaga Aktif was under coordination with Subdistrict Head, Head of PHC Bareng and Health Promotion Section, Health Office of District Jombang along with 13 head of villages. Researchers also provided general guidelines on the development of the Desa dan Kelurahan Siaga Aktif according to the Decree of the Minister of Health of the Republic of Indonesia no. 1529/MENKES/SK/X/2010. After the local regulations in the form of SK Desa Siaga Aktif, there were two villages, the villages Banjaragung and Nglebak increased to Desa Siaga Aktif Madya.

Evaluation Phase

Input indicators were indicators to measure how much nput has been given in order to develop Desa Siaga. Input indicator consists of the presence/absence of the Village Community Forum, the presence/absence Poskesdes and building facilities and equipment, the presence/absence UBKM the community needs, and the presence/absence of health workers (minimum midwife) (East Java Provincial Health Office 2012).

Process indicators are indicators to measure how active efforts conducted in a village in order to develop Desa

Siaga Aktif. Process indicators consist of the frequency of meetings of the Village Community Forum, function/dysfunction of Poskesdes, function/dysfunction of existing UBKM, function/dysfunction of Emergency System and Emergency and Disaster Management , function/dysfunction of community-based surveillance systems, and the presence/absence of activities and home visits to nutrition awareness family and PHBS.

Output indicators were indicators to measure the results of activities accomplished in a village in order to develop Desa Siaga. Output indicator consists of Poskesdes basic health care coverage, coverage of other UKBM service, the number of emergency cases and outbreaks reported, and coverage of households receiving home visits for nutrition awareness family and PHBS.

Impact indicators were indicators to measure the impact and results of the activities in the village in order to develop Desa Siaga. Impact indicator consists of a number of people who suffer pain, the number of people suffering from mental disorders, the number of mothers who gave birth and died, the number of infants and toddlers who died, and the number of infants with malnutrition.

CONCLUSION

Thirteen villages in District Bareng were all Desa Siaga Aktif Pratama with almost similar problems in the development of the Desa Siaga Aktif, namely the absence of the Decree of the Head of the Village underlying and regulating Desa Siaga Aktif and the organizational structure of Desa Siaga Aktif, the lack of dedicated funding in health sector from the budget or independent funds of the village community and the business world, and less optimal improvement of Clean and Healthy Behavior (Perilaku Hidup Bersih dan Sehat, PHBs) at household level. Based on the results of the workshop attended by the District Head along wih the district leaders forum, Village Heads, Village Midwives, village cadres, community leaders, PHC Heads and staff, Health Office of District Jombang and Java Provincial Health Office, mutually agreed solution had been reached on the preparation of the Decree on Desa Siaga Aktif and the organizational structure of Desa Siaga Aktif, at sub-district and village level, to increase public knowledge about the Clean and Healthy Behavior (PHBs) and seek independent funds in the health sector from the public and business. By the enactment of the Decree on Desa Siaga Aktif, the villages Banjaragung and Nglebak were increased to Desa Siaga Aktif Madya, and with the realization of Desa Siaga Aktif in each village, the public health level in villages will be improved.

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