

THE REVITALIZATION OF *POSYANDU* IN THE FRAMEWORK OF DECENTRALIZATION AND VILLAGE AUTONOMY IN NORTH SUMATRA, INDONESIA

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ABSTRACT

The main objective of this study is to analyze the current roles of the *Posyandu* (one-stop healthcare service) in providing healthcare services to the community and to analyze the potentials for improving its role within the framework of decentralization and village autonomy. *Posyandu* is a community-based organization (CBOs) at lowest level of governance hierarchy in Indonesian government system. Theoretically *Posyandu* in the era of decentralization is a local potential that plays an important role as a form of community empowerment which is obviously one of the objectives of decentralization (Smith, 1985; Cheema and Rondinelli, 1983; Mahwood, 1983). However, over a decade of decentralization implementation in North Sumatra, the performance of *Posyandu* has not been maximized according to the decentralization blueprint. This research takes place in two districts in North Sumatra province and uses qualitative methods as well as in-depth interviews and documentation as the primary data collection technique. The finding of this research is the village autonomy is very important in revitalizing *Posyandu*, but for two districts in North Sumatra this has not worked as expected.

Keywords: *Posyandu*, village autonomy, decentralization, health sector

1. INTRODUCTION

Indonesia has systematically and comprehensively implemented a decentralized system of governance notably since the issuance of Law No.22 of 1999 on Regional Government which

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became effective in 2001. Formerly Indonesia implemented a dominantly centralized governance system within 32 years even though the decentralization system was introduced in the law of local governance (Law No. 5 of 1974). This decentralization policy has a positive impact on the region because beside bringing its own affairs independently it can also bring the efficiency and effectiveness in local governance. One of the affairs or sectors that are the autonomous authority of local government is the healthcare services.

At the local level, healthcare affairs is the responsibility of the *Dinas Kesehatan/Dinkes* (healthcare service) both at the provincial and district/municipal levels which is a form of delegation from the authority of the local head which are governor, regent or mayor. In local government legislation, the authority of the provincial healthcare office and the authority of district healthcare offices has clearly been separated. *Dinkes* of districts are the main implementer of healthcare services while the provincial government has more authority that is not yet fully managed or unable to carry out by districts/municipals or in other terms is referred as the residue authority of the districts/municipal in the healthcare sector. One of the roles the *Dinkes* of districts/municipal in the decentralization era related to the subject of this research is to build a *Puskesmas* (public healthcare center at sub district level or at part of the sub district geographical administration). While *Puskesmas* is the front guard that faced directly with the community in providing health services. However, this role is not easy to conduct mainly due to the several limitations of the *Puskesmas*.

Therefore, *Puskesmas* is assisted by *Posyandu* which is an organization established by village or *kelurahan* (an administrative, urban area and non-utonomous area) as a form of community empowerment in health sector.

In the empiric practice of *Posyandu* management related on both technical and cadre empowerment, the development of *Posyandu* has much been implemented by the central government through the provision of operational healthcare fund (*Bantuan Operasional Kesehatan/BOK*) sourced from the central or state budget. In addition, the provincial and district/municipal governments also provide other funding for the management and the *Posyandu* development which is relatively small compared to those of funds provided by the central government. Although there is a fund for the management and development of *Posyandu* from central and local governments, those contribution are still considered to be less than optimal in the management and development of *Posyandu*. On the other hand, the village as a geographical base and *Posyandu* work area, has the potentials to develop *Posyandu* to provide significant meaning in the development of the healthcare sector in Indonesia through the allocation of annual budgets from the village budget. This paper will further examine the current circumstance

of the *Posyandu* in North Sumatra as well as opportunities to develop village autonomy in assisting the development of *Posyandu*.

2. RESEARCH METHOD

The purpose of this study is to analyze the role that *Posyandu* performs in providing healthcare services to the community and to analyze the potential to develop and improve the role of *Posyandu* within the framework of decentralization and village autonomy. Regulations on decentralization basically have provided broad authority for autonomous regions in this case the district in performing governmental services functions including the healthcare sector.

However, the broad authority has not been followed by the ability to allocate budget and program for *Posyandu*. On the other hand, there is the potential to optimize the role of villages with their genuine authority in assisting budgets and *Posyandu* programs. In the frame of governance structures, in the district areas there are villages where *Posyandu* is established. Villages are autonomous regions that have their own budgets through village funds allocated specifically in the annual state budget or in each village annual budget. This is certainly different from urban areas (*Kelurahan*) that are non-autonomous but district sub-ordinance under the supervision of sub-district governments and their autonomy is very limited.

This research uses qualitative method with in-depth interview as main technique in data collection. Besides, secondary data either in the form of published and unpublished documentation is also used as supporting data in this study. The research informants came from employees at the sub-district, village and hamlet levels as well as *Puskesmas*, *Posyandu* cadres and community members. This study was conducted from the year 2013-2016 so that the rules of legislation adopted primarily taken within that time period. Restrictions on the use of these laws and regulations are however another limitation of this research.

3. RESULT AND DISCUSSION

3.1. Decentralization and Regional Potentials

It is not easy to define the concept of decentralization as it involves various aspects, shapes and dimensions. The shape of decentralization can be seen from different values and practices (Rees & Hossain, 2010). While (Hart, 1972) says decentralization can be seen from various perspectives because some disciplines and theories pay attention to decentralization such as the science of administration, politics and economics. In the global level, decentralization is discussed in a broader range with regard to democracy, political reform, community participation, empowerment, rural development, fiscal and economic development, accountability and capacity building of human resources (Smoke, 2003). However, from the

diversity of meanings of decentralization, in principle, it has a common thread of thought, namely the need to divide authority and responsibility centered on one unit to be shared or distributed to other units within an organization or entity.

One of the potentials owned by the regions in Indonesia are community-based organizations or CBOs, private sector or non-governmental organizations (NGOs)). However, in this era of decentralization, the discussion of community-based organizations such as *Posyandu* is much more relevant because decentralization is interpreted as having great authority in the regions to develop all the potentials in the region. In addition, decentralization has made governments closer to the community, so the community needs to be empowered to be involved or participate in local development.

3.2. *Posyandu* as Community-Based Organization (CBOs) in Healthcare Sector

Before the *Posyandu* was established there was an institution so called *Pembangunan Kesehatan Masyarakat Desa (PKMD)* which is community healthcare development at the village level. The purpose of the establishment of *PKMD* is to improve the capacity of the community in the healthcare sector so as to help themselves in realizing a better community life. *PKMD* is implemented based on the principle of mutual assistance and community self-help with government support through cross-sectoral coordination. The concept of *PKMD* is basically similar to the Primary Health Care (PHC) stated in the Alma Ata Declaration in 1978 which is a primary or essential healthcare service that makes healthcare recognized as a human right regardless of social, economic, racial, citizenship, religious status and gender.

The *PKMD* at the beginning of its establishment has several activities such as nutrition improvement, diarrhea prevention, community treatment in rural areas, immunization and family planning. These activities are carried out by each work unit resulting in healthcare services being fragmented. For this reason, in 1984 the activities in the community were put together into a platform so called *Posyandu*. Furthermore, the Ministry of Health (1990) said the services provided in *Posyandu* are integrated, it aims to provide convenience and benefit for the community because within the *Posyandu* the community can obtain full service at the same time and place.

Based on the Ministry of Home Affairs Regulation No. 19 Year 2011, Article 1 paragraph 1 mentioned that *Posyandu* is one form of community healthcare effort that is managed and organized from, by, for and with the community in the implementation of healthcare development, in order to empower the community and provide convenience to the community in obtaining basic healthcare services for accelerate the decline in maternal and infant mortality. From this understanding, *Posyandu* is one unit or place of healthcare service at the lower level

that directly in contact with the community. The goal is to empower communities in the health sector, so that communities themselves can solve healthcare problems in their own areas. As a form of healthcare effort, *Posyandu* is assisted by *Posyandu* cadres who work voluntarily to deliver healthcare programs to the community.

Based on the concept of establishing and managing *Posyandu* or based on legal rules issued by the government, this organization is a community-based organization (CBOs) so that self-help, voluntarism and mutual cooperation principles are the foundation of this organization. This organization is a nonprofit organization and certainly not a business organization that has a commercial purpose in its establishment. All parties responsible or working in *Posyandu* activities should eliminate the desire to obtain financial benefits from *Posyandu* activities. Therefore, all components of the community, both the government itself and the citizens as a whole, have a responsibility in developing *Posyandu* and ensure that the organization is running according to the principles of community-based organizations that contribute positively to the public healthcare sector.

3.3. *Posyandu* Position in Government Structure

In the decentralization era, the *Dinkes* of district or municipal are the highest institutions that take care of the healthcare sector at the district or municipal level. Subsequently, the *Dinkes* of district shall be established by *Puskesmas* as technical executing unit to carry out some technical operational activities and/or supporting technical activities that have a working area on one or more sub-districts. The operational technical activities are directly related to the public service while the supporting activities are activities to support the implementation of the task of the main organization. To carry out this task at the sub-district level, *Puskesmas* is assisted by *Posyandu*. Thus *Posyandu* position to *Puskesmas* is as a platform of community empowerment in healthcare sector which is medically constructed by *Puskesmas*.

Village government is the institution responsible for the implementation of development in the village. In each village there are several *Posyandu*. Thus the *Posyandu* in the framework of organizational is as a forum of community empowerment in the healthcare sector and is fostered by the village government. Within the village governmental structure there are four working groups and the working group IV is responsible for managing healthcare programs, environmental sustainability and healthy planning. One of the tasks of this working group is to develop and foster the implementation of *Posyandu* activities. Just as at the village level, at the sub-district level the working group IV manages healthcare programs, environmental sustainability and healthy planning and one of the priority healthcare programs is the optimization of *Posyandu*. The role of working groups both at the village and sub-district level towards *Posyandu* is to provide guidance in the administrative, financial and program aspects.

In addition to the above institutions, there are obviously many parties or related institutions that help *Posyandu* such as the agency of Community Empowerment and Village Administration (*BPMPD*), Healthcare Office, Regional Family Planning Work Unit, the Regional Development Planning Agency (*Bappeda*), and the Ministry of Religious Affairs (*Depag*), Agency of Education (*Disdik*), the Agriculture Agency (*Distan*), Small and Medium Enterprises (*Dinas UKM*), Trade Service (*Disperindag*) and so on. All bodies are supporting the technical operation of *Posyandu* in accordance with their respective roles and functions. Meanwhile, the *Posyandu* working group, the women group (*PKK*) at sub district level, community organizations or NGOs and the private sector/business world also plays a role to assist the smoothness of *Posyandu* activities.

From the above description, the relationship between village and sub-district government and *Puskesmas* is most visible relation in conducting *Posyandu* empowerment. *Posyandu* cadres are recruited by the head of sub-village and nurtured by the head of village as well as the head of sub district as a form of community empowerment in the healthcare sector. While the *Posyandu* cadres run the *Posyandu* activities that receive direct assistance from the *Puskesmas* which is the unit of technical implementation of the *Dinkes*. These two parties, both villages or sub-districts on one hand and *Puskesmas* on the other hand can increase the role of *Posyandu* in the community if conducted in synergy but otherwise becomes less useful if solely done for sector interests only.

3.4. *Puskesmas*: the Urgency of *Posyandu*

In the districts, the *Posyandu* was established in each sub villages. But it can happen or there are times when there is no *Posyandu* in a village because only a few family members have children aged (0-6 years) so that *Posyandu* in the village is combined with *Posyandu* in another nearby sub district in the same village or neighboring sub village. Meanwhile in each village there are several sub-villages, thus in each village there are several *Posyandu*.

There is a significant similarity between *Posyandu* in urban and rural areas during decentralization such as the low visit or community participation to come to *Posyandu*. However, compared to *Posyandu* in rural areas, the number of community visits to *Posyandu* in urban areas is much lower. There are many factors of that low participation, such as there are many clinics or hospitals around *Posyandu*, the economic status of the community which is in the middle to upper level and the education level of the community is relatively high so it demands a professional service even to get the service people have to pay. Even in the area where Chinese are the major inhabitants, the attendance of the community to *Posyandu* is very low. While *Posyandu* in rural areas is found little more role in improving public healthcare status. Some of the causes are the distance between rural and healthcare facilities such as clinic

or hospital is far enough. In addition, education and socioeconomic factors in the rural areas that are not high affect the desire of the community to come to *Posyandu*.

Posyandu is the front guard to help ensure the growth of children. However, most mothers still consider *Posyandu* only a place to get immunization, so many people leave *Posyandu* after their child has received complete immunization. In fact the *Posyandu* is not only to get immunization, but it is also important to monitor and weigh the child's weight through routine weighing and health counseling. Because, most children under five there is a so-called difficult phase of eating so that in this phase need to be monitored so it do not let the child malnourished. That's why mothers should routinely carry babies/children until the age of five years despite having received full immunization.

Facing such challenges, *Posyandu* need to work with other parties such as *Puskesmas*, village and sub-district government in preparing everything before and during *Posyandu* days. In addition, the community as the recipient of *Posyandu* services should be involved as much as possible by providing continuous socialization about the importance of *Posyandu* specifically for maternal and child health as well as in general for the healthcare of sub district community. By the common understanding between all sectors at the sub-district and community levels, *Posyandu* activities can benefit all parties.

Table 1: Tasks of the *Posyandu* cadres during the *Posyandu* session

Before the <i>Posyandu</i> Session	During the <i>Posyandu</i> Session
<ul style="list-style-type: none"> ▪ Preparing staff, tools, and equipment for undertaking <i>Posyandu</i>. ▪ Inviting the community members (mothers of infant or child) to come to <i>Posyandu</i>. ▪ Coordination with the village authorities to get known whether the <i>Posyandu</i> Help Desk within the village government is available on the day of <i>Posyandu</i>. ▪ Briefing among cadres to prepare what to be done and who must be in charge on each activity during the day of <i>Posyandu</i>. 	<ul style="list-style-type: none"> ▪ Filling in report within the KMS (Card of Healthcare History) into Registration Book or Cadre Notebook. ▪ Evaluating the activities within the day of <i>Posyandu</i> and planning the activities to be undertaken in a month to come. ▪ Conducting discussion among the mother of infants or children whose residents are neighbor. ▪ Conducting Home Visiting (door to door coaching) to remind the mother of infant or child to come to <i>Posyandu</i> for the next month.

Source: Adopted From *Kementerian Kesehatan RI (2012a)*.

Each *Posyandu* unit has 5 cadres, although it is very rare that all cadres are present on the day of *Posyandu*. The official role of the cadre can be seen in every *Posyandu* activity called "the five table service". Although from the observation, these tables currently are no longer visible and adjusted to the conditions where the day of the *Posyandu* took place. The arrangement of services at the *Posyandu* table is done in sequence by means table with the largest serial number is the last table in the service cycle in *Posyandu*. At the beginning, on the Table 1 cadre receives registration from the community who came to *Posyandu* while on the Table 2 the cadre weighs children or babies. On Table 3, the cadre note in papers the weighing result of children or babies as it is performed on table 2. The weighing results are listed in a control card known as the book so called *Kartu Menuju Sehat (KMS)*. On table 4 the cadre conducts counseling to the mother or community attending to *Posyandu*. Counseling is intended to provide advice on general health as related to hygiene and nutrition for infants or children brought by mothers to *Posyandu*. Sometimes cadres can also provide limited medical advice on infant or child health. The last table which is the Table 5 is occupied by healthcare officer from the *Puskesmas* who are responsible for immunizing infants and children. In addition, this table can also provide consultation and medical treatments for a program so called "family planning" such as contraceptive services and injections.

The division of tasks in *Posyandu* is actually done in turns so that each cadre understands the task at each service desk. But the research finds the fact the division of this task is not done anymore for several reasons including the accuracy and potential of cadres to occupy the existing table. This study shows that the majority of each cadre only performs a similar task on a regular or continuous basis. An old cadre, for example, never weighs a baby or fills *KMS* for the reason that the eyes are nearsighted and inadequate in filling out the form. Meanwhile, young cadres are sometimes never positioned on the table IV as a counselor because it is considered not too experienced so less confident or less mastering matters relating to health. Details of table numbers and activities performed on each table in the *Posyandu* can be seen in Table 2.

Table 2: Profiles of Title, Activities of Each Table on *Posyandu* Session

No. of Table	Title	Activities	Remarks
1	Registration of Infants, Pregnant Mother and Breastfeeding Mother	1. Registration of Infant 2. Registration of Pregnant Mother	The infants are registered in a form
2	Infant Weighting	Weighting Infant or Child Under 5 years old	The weighting record is noted in a small paper attached to KMS (Card of Healthcare History)
3	Reporting of Infant Weight	Copying the weighting record in to KMS of each infant or child.	In case the infant or child has a birth certificate, the date must be copied into to KMS
4	Coaching and Services on Nutrition for Infant Mothers, Pregnant Mothers and Breastfeeding Mother	The cadres or medical staff brief the infant's mother of their children health profile, give the instructions or recommendations to be done by mothers	This table is also placed as a platform for having discuss among mothers of children, <i>Posyandu</i> cadres or medical staff
5	Healthcare Services, Family Planning, Immunization, Vitamins and Oralit Corner	Delivering services on family planning, immunization, and passing oralits to the infants or child	The infants are registered in a form

Source: *Kementerian Kesehatan* (2012b).

From the findings in the field, people who bring children or infants to *Posyandu* are still around 45-55 percent. This causes *Posyandu* cadres to visit the home of parents who do not bring their children or infants to *Posyandu*. A family from the middle to upper class in term of economic status eagerly bring their children or infants to immunize to the clinic or hospital. However, *Posyandu* cadres must ensure that all children or infants in the village or work area of them have been immunized which can be seen from the *KMS* card of the children or infants. This is important because immunization or vaccine is a future investment of children so that they avoid

dangerous diseases and infections in the days to come. In addition, *Posyandu* cadres also do weighing, measuring height and head circle of children or infants to know the nutritional status, whether including the category of good nutrition or malnutrition. The nutritional status of children or infants is also recorded in the *KMS* card. If included in the category of malnutrition, the cadres will report to the *Puskesmas* for further actions or given additional food.

The *KMS* cards contains normal child growth charts based on anthropocentric index of body weight according to age. There are three main functions of *KMS* card which are a tool to monitor the growth of children or infants, health record of children or infants and learning tool. Thus *KMS* card is one way to know the state of maternal and child health and subsequently given a response if the mother and child health conditions are not that good. But the problem is the data or information in the *KMS* card is not entirely reliable. Limited ability and lack of awareness of the importance of appropriate data is not fully owned by most cadres yet. Therefore, it is not surprising if there is a difference of data of children or infants or information issued by *Posyandu*, *Puskesmas*, village, sub-district and also the national agency of Indonesian statistics. Nazri et al. (2015) said the way to improve the quality of *Posyandu* services is through the provision of quality resources, including capable human resources of cadres.

Besides playing role in *Posyandu* programs or related to mother and child program, cadre also play an important role outside *Posyandu* program which is as a companion of *Puskesmas* staff delivering healthcare programs to the community, such as mosquito nest eradication program. However, some new cadres are willing to participate if they get money from the *Puskesmas*. This happens because there are misperceptions among the cadres and the community that eradicate mosquito breeding or other *Puskesmas* programs solely for the benefit of *Puskesmas*. Whereas the duty of *Puskesmas* staff is to socialize the programs to the community so that the community is empowered and understands healthy way of life.

There is a difference in the scope of the role of *Posyandu* cadres according to the Ministry of Home Affairs and the Ministry of Health. Based on the definition derived from the Ministry of Health, *Posyandu* cadres play a role in community activities. This means that in addition to the *Posyandu* activities, the cadre also plays a role in assisting *Puskesmas* staff in other healthcare activities outside the *Posyandu* program, such as eradicating mosquito nest, malnutrition, dengue fever and so on. However, according to the regulation of the Ministry of Home Affairs, *Posyandu* cadres only assist healthcare officers in *Posyandu* activities or related to maternal and child healthcare programs. The different scope of this work affects a number of cadres in providing assistance to *Puskesmas* officers such as asking for a reward for assistance provided outside the *Posyandu* program such as mosquito nest eradication program.

3.5. *Posyandu* Challenges: The Lack of Healthcare Budget

Posyandu as a community-based organization plays an important role in delivering healthcare programs to the community, especially on maternal and child health. However, in the decentralization era, not all regions give full attention to *Posyandu*. There is a difference between *Posyandu* in the “new order” era or the era of President Soeharto administration and decentralization era. The success of the government of the “new order” reduced the mortality rate of mothers and children can not be separated from the Indonesian government system which at that time embraced mostly the centralization system. President Soeharto as the supreme leader directly lead the policy on maternal and child healthcare, increases the healthcare budget to reduce maternal and child mortality and mobilizes provincial and district governments to pay attention to maternal and child problems. In this case, *Puskesmas* and *Posyandu* are the spearheads of implementing the mother and child programs. *Posyandu* services that spread up to remote villages or sub village managed to reduce infant mortality and control the spread of disease outbreaks. In contrast to the decentralization era, districts/municipalities as autonomous regions have the authority to regulate their respective regional affairs, including healthcare affairs. Consequently, the attention to *Posyandu* is not the same across the region and depending much on the vision and mission of the regent/mayor as the supreme leader of the district/city.

One of the obstacles in paying attention to *Posyandu* in the era of decentralization is related to the allocation of local budget for healthcare. Nevertheless, when compared to the era of centralization, the decentralization era has increased healthcare budget in North Sumatra. This indicates that there is awareness of the region to pay attention to the healthcare sector which is the district or municipal genuine affair. This budget comparison can be seen in Table 3.

Table 3: Comparison of Total Healthcare Sector Budget at Centralization and Decentralization Period in North Sumatra (in Million IDR, 00)

Centralization Period			Decentralization Period		
Amount	%	Year	Year	Amount	%
4,134	0.67	1998/ 1999	2015	398,538	4.59
5,333	0.72	1997/ 1998	2014	401,700	4.72
5,801	0.63	1996/ 1997	2013	297,944	3.36
5,454	0.51	1995/ 1996	2012	263,492	3.43
4,592	0.91	1994/ 1995	2011	153,438	3.28

Source: Processed from *Kementerian Keuangan, D.J.P.K.* (2016)

Although the healthcare sector budget has increased in the era of decentralization compared with the era of centralization but the amount allocated to the healthcare sector has not complied with the provisions of legislation that is at least 10% of the Annual Regional Revenue and Expenditure Budget (*APBD*). As in 2015, the amount of *APBD* in North Sumatra was IDR 39,9 trillion , of which the budget for the healthcare sector was only Rp 3,7 trillion or 9.41 per cent of the total of local budget (Ministry of Finance, 2015). While based on the performance of the Ministry of Health (2015) in 2014 only 48.87% of all districts/municipals in Indonesia have allocated a health sector budget of at least 10% of total local expenditure excluding salaries (Health Act). As many as 51.13% of district/municipals governments still allocate budgets for health affairs below 10% of annual local budget (Table 4).

Table 4: APBD Allocation on Healthcare

Sector Percentage	Number of Local Government Unit	Percentage
At least 10 %	239 Districts/ Municipalities	48.98 %
5 % - 9.99 %	234 Districts/ Municipalities	48.05 %
1.44 % - 4.99 %	15 Districts/ Municipalities	3.07 %

Source: *Kementerian Kesehatan* (2015)

Compared to the year of 2015, the amount of budget allocations in the healthcare sector in 2014 is almost the same or no significant increase. This is because the amount of budget allocation for salaries of public servants. Of all the districts/ municipalities in Indonesia, as many as 131 local governments allocate half of the local annual budget for staff salaries excluding of the salaries of central government employees who work in areas such as police and soldiers (detik.com, 2017). The remaining budget that is not too large is finally not fully arrive to the community in the form of community development such as the development of healthcare services. There are times when the funds do not reach the public due to the corrupt practices of state officials and civilian apparatus which commonly occurs simultaneously with the implementation of decentralization in Indonesia. This is on the one hand in line with the opinion of Wildmalm (2008) which states that in developing countries the most fundamental challenge in health and education development comes from corrupt practices by government officials, police, teachers and health workers.

One of the causes the amount of fund cannot reach at least 10% of total of local annual budget for the healthcare sector is due to the small local revenue (*PAD*) of a district/municipality. Smaller *PAD* is used more for infrastructure construction or additional income of local officials. According to the provisions of the *PAD* legislation itself, the local revenue comes from local

taxes, regional restitution, the result of local assets management and so forth. Local taxes and retributions are not optimal in assisting regional revenue due to lack of potential, lack of diversification and intensification of local taxes and levies. Of all districts in North Sumatera, the district of Deli Serdang has the largest amount of local revenue in fiscal year of 2014, 2015 and 2016 and the district of South Nias being the region with the smallest local annual revenue. Nevertheless, the healthcare sector budget of Deli Serdang has not reached at least 10% of local annual budget as mandated by law (Table 5).

Tabel 5: Amount of Distric/Municipality Genuine Revenue in the Province of North Sumatra

No	Distric/Municipality	Genuine Revenue (In. Million IDR,00)		
		2014	2015	2016
1	Deli Serdang	566,665	630,720	672,229
2	Serdang Bedagai	61,004	72,418	89,259
3	Simalungun	110,000	112,414	119,980
4	Langkat	114,868	110,900	115,313
5	Karo	67,343	53,557	92,659
6	Tapanuli Selatan	77,252	98,438	90,666
7	Nias	44,641	63,227	69,414
8	Mandailing Natal	50,000	65,720	85,508
9	Tapanuli Tengah	32,447	47,720	64,005
10	Tapanuli Utara	36,990	50,000	67,183
11	Toba Samosir	23,408	34,197	37,451
12	Labuhan Batu	85,350	146,290	161,886
13	Asahan	59,129	71,255	104,816
14	Dairi	24,331	60,481	75,647
15	Nias Selatan	76,559	50,640	14,110
16	Humbang Hasundutan	26,959	27,752	35,045
17	Pakpak Bharat	10,498	14,960	15,235
18	Samosir	23,773	26,595	30,786
19	Batubara	29,448	43,361	50,426
20	Padang Lawas	34,250	40,117	49,991
21	Padang Lawas Utara	28,547	26,315	32,165
22	Labuhanbatu Selatan	35,635	39,900	41,169
23	Labuhanbatu Utara	28,547	30,421	35,326
24	Nias Utara	15,000	30,000	28,000
25	Nias Barat	10,000	20,000	24,000
	Sumatra Utara	3,499,002	4,089,547	9,973,988

Source: *Badan Pusat Statistik*, Sumatra Utara (2014) (2015) (2016).

In the era of decentralization, the attention of local governments to the existence of *Posyandu* differs depending on the its regent/mayor who is the head of regency/municipality. As an autonomous region, the regent/mayor has the authority to regulate their respective regional affairs, including healthcare sector affairs. Therefore, the attention to *Posyandu* is not the same depending on the vision and mission of the regent/mayor who is directly elected by the local community. One indicator that a regent/mayor is concerned about healthcare problems can be seen from the amount of budget allocation for the healthcare program. The two districts that serve as the location of this study still allocate health affairs under 10 percent of local annual budget. This means that *Bantuan Operasional Kesehatan* (BOK), funds from the central government, are used to be the main funds in the healthcare sector program. This causes some programs are not maximal and arrived down to the community because of the small amount of funds available. Meanwhile, healthcare programs or activities that must be implemented in *Puskesmas* and *Posyandu* are quite a lot.

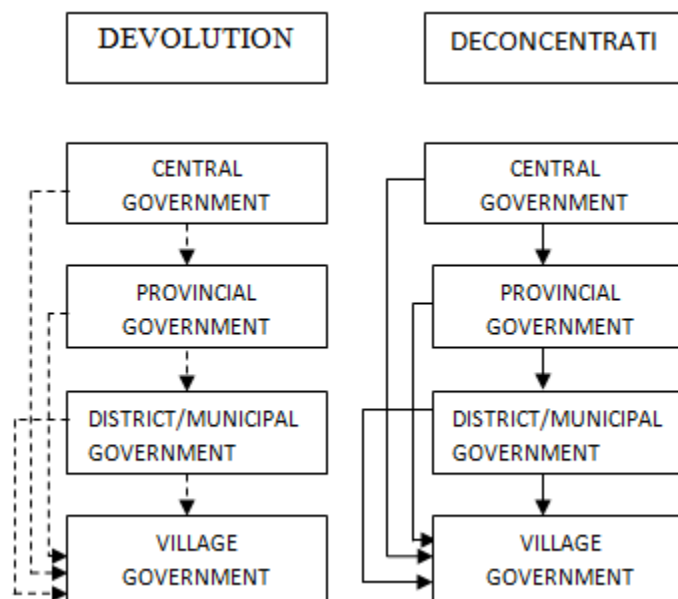
3.6. Village Position Under The Decentralized Indonesia Framework

In the history of the regulation on the village, the village during the new order period has been regulated through its own regulation, namely Law No 5/1975 on village government but after the political reform in 1998, the village is included as part of the substance of the local government Law which is the Law No 22/1999 and the Law No 32/2004. But in the dynamic of state administration, the village has evolved in various forms so it needs to be protected and empowered to be strong, advanced, independent and democratic so as to create a strong foundation for governance and development towards a just, prosperous and prosperous society so that the arrangements are formed in a single constitution. The law on villages is further regulated in Law No. 6/2014.

Philosophically the village is a unitary of customary law community formed based on three basic principles, namely genealogical, territorial, and/or a combination of genealogical with territorial. In that connection, the state recognizes and respects the unity of indigenous and tribal peoples along with their traditional rights as long as they are alive and in accordance with the development of society and the principle of the unitary state. Implementation of indigenous and tribal peoples have existed and live in the territory of Indonesia, such as *huta/nagori* in North Sumatra, *gampong* in Aceh, *nagari* in Minangkabau, *clans* in southern Sumatra, *tiuh* or *pekon* in Lampung, *pakraman* village in Bali, *lembang* in Toraja, *banua* and *wanua* in Kalimantan, and *negeri* in Maluku (Law No. 6 of 2014).

Within the framework of deconcentration, different terminology regarding the name or designation of the village basically does not receive different treatment in the case of government administration. All villages with their unique names and titles have equal rights and obligations

within the framework of governance. If described in a hierarchical manner, the village position within the framework of decentralization applies equally to provincial and district/municipal governments. From the aspect of political decentralization or in other terms called devolution, the village stands as an autonomous organization with original authority in the field of governance as regulated by law. From the aspect of administrative decentralization or deconcentration, the village becomes an integral part of the national administration system and hierarchy that is subject to the district government and so forth. Both forms of decentralization are run by villages simultaneously and both complement each other in an effort to provide services to the public. From the two forms of decentralization, the devolution aspect applies the coordination mechanisms in the field of village governance and the deconcentration aspect applies the command or control mechanism as illustrated in Figure 1. However, the problems of capacity, knowledge and commitment of the village administration in interpreting both forms of decentralization are often consistent in the field.



Source: Adpoted from Law No 32/2014

Figure 1: The Position of Village in The Framework of Decentralized Indonesia

In the process of organizing devolution, the village has a wide and independent autonomy that can not be intervened by the government at any level. This has been regulated comprehensively through other laws and regulations on the village. The autonomy includes planning programs, activities and budgets for the government sector including the healthcare sector. Higher levels of government can only coordinate and communicate if there are things that should be village

priorities but not done, policies that are potentially violating the law or may create instability. On the other hand coordination can also be done when policies made by the village government are discriminatory and counterproductive. The extent of authority and autonomy of the village is not surprising if the political and democratic processes that exist in the village sometimes resemble the dynamics of politics and democracy applicable to the district/municipal and provincial governments.

In the process of deconcentration, the village acts as a governmental tool at the upper level so that command authority can be carried out by the district/municipality government, the provincial government and the central government towards the village administration. Villages in this context are positioned as the subordination of higher government. One form of this deconcentration implementation is the allocation of the village fund allocation (*Anggaran Dana Desa/ADD*) made by the central government each year or other funding from the provincial and district/municipal governments. Because of its deconcentrative nature, higher levels of government can provide verdicts, sanctions or other forms of punishment addressed to village governments if judged to violate the use of funds provided by the higher government. The nature of the verdict is administrative such as delay of disbursement of annual funds up to annual budget cuts.

3.7. Village Autonomy and Budget of Village Funds: A Solution for *Posyandu*

The village is the smallest unit of government that is autonomous within the framework of the unitary state of the Republic of Indonesia. As an autonomous region, villages have authority, duties and responsibilities in the field of governance like other autonomous regions both provinces and districts or municipalities. According to Article 1 Paragraph 1 of Law No 6/2014 concerning on villages, villages or other so-called is a legal entities which have territorial boundaries that are authorized to regulate and manage the government, the interests of local communities based on community initiatives, the right of origin, and/or traditional rights recognized and respected within the system of government of the unitary state of the Republic of Indonesia. An autonomous village (local-self-government) is established on the basis of decentralization with the law so that it has full authority to manage and manage its own household.

As an autonomous region, the village is actually a replica of an autonomous region of provinces as well as districts/municipalities. The similarity of autonomy forms can be seen in at least three aspects, namely the selection method of government leadership, the mechanism of democracy and the independence of the budget. Selection of government leaders at the village level is conducted directly through an election similar to the election of provincial and district/municipal leaders. The mechanism of democracy is related to executive and legislative relations in the

management of the same government, namely the role of legislation, control and budgeting presented by the Village Consultative Board (*Badan Pemusyawaratan Desa/BPD*) as well as the role of the Regional House of Representatives (*Dewan Perwakilan Rakyat Daerah/DPRD*) in provincial and district/municipal governments. Budget independence is characterized by an annual budgeting system in every village government known as Village Annual Budget (*Anggaran Pendapatan dan Belanja Desa/APBDes*) where the components are the same as provincial and district/municipal annual budgets.

In order to develop *Posyandu*, with its creativity, village government can participate especially in capacity building and competence of *Posyandu* cadres located in their respective villages. This is in line with several village authorities as set forth in the law on the village which are: (1) fostering the life of the village community (2) fostering and improving the village economy and integrating it to achieve a productive-scale economy for the greatest prosperity of the village community (3) proposing and receiving part of the state's wealth to improve the welfare of the village community (4) developing the socio-cultural life of the village community, and (4) coordinating the participatory village development.

Posyandu development in this context certainly related to efforts to foster the lives of villagers, especially healthcare life. With the creation of public health life of the village it of course bring about the progress of social and cultural welfare of the people living in a village. To achieve this goal, the village government needs a regular, harmonious and sustainable program that is also routinely funded from the village budget.

The central government through the regulation of the ministry of home affairs No. 37/2007 on Guidelines for Village Financial Management has also set up the financing sources for the villages in order to provide services to the community which are from the village genuine income (*Pendapatan Asli Desa (PADes)*), the obligation for the central up to district/municipality government to provide fund transfers for villages, grants or donations from the third party such as company or other private organization. This *PADes* is worthy of being reviewed in conjunction with increasing the potential of village revenues. *PADes* consists of business results, village asset yields, self-help and participation, mutual assistance including revenues as a result of cooperation with third parties and assistance companies located in the village. Villages in this context may have village-owned enterprises (*Badan Usaha Milik Desa/BUMDes*) such as village-owned paddy machines as well as clean water management. In certain areas such as in a Sibanggor Julu village of Mandailing Natal district, it has an asset in the form of a village rice field called "*saba wakaf*" where the village obtains a share of the asset management proceeds. In addition, the village earns revenues from parking fees in hot springs and levies for tourists who climb mount Sorik Marapi. This creativity is merely an example of

how village potentials can be developed into village original revenues and provide significant support in the village's annual budget.

As a form of applying the principle of administrative decentralization or deconcentration, the ministry of home affairs regulation No. 37/2007 also regulates the transfer of funds from the central government, known as Allocation for Village Funds (*Alokasi Dana Desa/ADD*). The *ADD* has been set at 10% of the central and local government balance funds received by each district/municipal government. The use of the *ADD* budget is 30% for village government apparatus and government expenditure, 70% for community empowerment costs. For the community empowerment expenditure is used for: the cost of improving public facilities on a small scale, community capital investment through village owned enterprises, costs for food security procurement, improvement of environment and settlement, appropriate technology, healthcare and education improvement, socio-cultural development and so on which are considered important. For villages with limited assets and limited source of village revenues, the *ADD* is still a major source in their respective annual revenue.

Based on regulations made by the central government, villages as autonomous regions can use the *ADD* funds as part of efforts to improve the healthcare and education sectors of villagers. The commitment to allocate certain funds to the healthcare sector at the village level is crucial. Village that is particularly already self-reliant in terms of income, revenue and village assets other than the *ADD* fund, it can allocate funds for healthcare development especially through capacity building and the competence of *Posyandu* cadres. One informant said that he has budgeted part of the *ADD* funds for the development of *Posyandu* in the village although the nominal amount of the budget is considered inadequate. The amount of budget allocated is certainly not apart of the vision and mission and commitment of each village head as the chief executive at the village level.

Based on data released by the ministry of home affairs through the regulation No. 137/2017 Regarding on code and data region government administration, the number of villages in Indonesia is 74,053 while the urban is 8,300. For the province of North Sumatra, the number of villages consists of 5.417 while the urban is 693. From the above data, it can be concluded that almost reaching 90% of the smallest government unit in Indonesia is village. It can also be concluded that the majority of Indonesians live in the village and certainly have direct access with *Posyandu* in their respective areas. Village involvement in the development of *Posyandu* within the framework of village autonomy becomes crucial. Making some villages as a pilot activity in synergizing the concept of village autonomy with *Posyandu* revitalization can be used as a first step to make *Posyandu* more empowered and provide great benefits for health development in Indonesia.

4. CONCLUSIONS

Posyandu as a form of community empowerment in the healthcare sector plays an important role in helping the *Puskesmas* which is the implementing unit of *Dinkes* in the province of North Sumatra. *Posyandu* empowerment requires extra effort because so far the attention of stakeholders is still minimal. As a community-based organization (CBO) and not a commercial organization it requires sufficient funding to provide financing for the development of *Posyandu*. The development of *Posyandu* currently has been done by the central government and local government. With the limited budget of the central government, the village government, especially the villages that are already financially independent, can participate more in developing *Posyandu*. The allocation of village fund allocation (*ADD*) as done by a village in the district of Deli Serdang can serve as one of the pilot projects that can be imitated by other villages in the province. Although from the two districts that became the location of this study, *Posyandu* revitalization has not been able to run optimally.

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