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PORTRAITS OF SERVICES AND INSTITUTIONAL DILEMMA OF VILLAGE MATERNITY POST (*POLINDES*) IN INDONESIAN TRADITIONAL AND TRANSITIONAL VILLAGES

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Abstract:

Village Maternity Post (Polindes) in the last decade has been present as a health facility that focuses its services on the promotion, prevention, and treatment for maternal and under five-year-old infant health. In addition, due to limited health facilities in the village, almost all existing Polindes provide general health services apart from maternal and infant health. Polindes as a health facility unit designed and implemented in accordance with the principles of community-based health development and therefore the existence and development of these facilities are adjusted to the circumstance and dynamics of the community. The circumstance and dynamics of the community are technically classified based on the village typology. The typology of the village in which the Polindes is established has a significant impact on its strategic role in health services, institutional dynamics, and development programs. This article will describe how the portrait of health services and Polindes institutions in two villages with different typologies in Langkat Regency of North Sumatra Province, Indonesia. The two villages are Kepala Sungai which represents villages with traditional typologies and Teluk Meku which represents villages with transitional typologies.

Keywords:

Polindes, Services, Institutions, Traditional Villages And Transitional Typologies

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Introduction

Bakground of the Study

Village Maternity Post *(Polindes)* is a health facility that is prioritized by the government to provide childbirth services and health services for pregnant women and children at the village level. This service itself, in the framework of national and global health development, is very crucial. World Health Organization (WHO), for instance, noted that from 1990-2017 there were 19 cases of death out of 1,000 births (Hiola, 2020). Indonesian national health data in 2018 recorded there were 305 maternal mortality rates from 100,000 births and 22.33 infant mortality rates from 100,000 births (Rahmawaty, 2020). The role of *Polindes* is in fact very strategic for villagers for various reasons. Firstly, the lack of health facilities in rural areas when compared to similar facilities in urban or urban areas. Secondly, the easy access for villagers to the *Polindes* since these facilities are located in the geographical area of the village. Thirdly, service costs are relatively cheap and affordable for villagers. Fourthly, the expansion of health services provided by *Polindes* that exceed their basic role in childbirth and child health services. Lastly, the potential social relationship between midwives as health workers and the community as service recipients because the regulations recommend that every midwife at the *Polindes* must live in the village where they are assigned.

However, the *Polindes* utilization so far is considered not optimal due to the low number of residents or household visits to these facilities. The data of Riskesdas in 2007, for instance, only recorded 22.1% of total households in Indonesia who utilized this facility (Tumaji & Putra, 2018). In fact, the *Polindes* is a health facility at the forefront or at the lowest level of government which is the village government. The low number of community visits to the *Polindes* basically cannot be separated from the various problems faced by these health facilities. The problems start from the quality of the *Polindes* facilities themselves, the location of these facilities which are geographically far from settlements, the poor healthcare service system, inadequate management and governance, and the competence of midwives as health personnel at the *Polindes*. Even so, the existing position of the *Polindes* still has a strategic role in efforts to build a community-based healthcare development, especially when revitalizing its role and function can be carried out as well as the commitment of the parties to create creative health programs that involve the active role of the community.

Healthcare, however, is a form of basic service that is urgent and cannot be delayed. The international community through a series of collaborative programs such as the Millennium Development Goals (MDGs) followed by the Sustainable Development Goals (SDGs), from the beginning, has made this sector as part of a global effort that recommends all countries to pay serious attention to this sector. This attention is indicated through real programs accompanied by a commitment to make it as their respective national programs. It is then not surprising that developing countries like Indonesia have made various fundamental efforts such as improvements in the regulatory sector and a commitment to annually allocating a minimum budget for the health service sector. In the case of Indonesia, furthermore, Law Number 36/2009 concerning on Health is issued which is followed by synchronization and harmonization of various laws and regulations that include global efforts such as the Regional Government Law, the Health Insurance Law, the Work Safety Law and also the Law on Regional Government.

As the spearhead of health services at the village level, the institutions and programs implemented by the *Polindes* should be carried out in a participatory manner, namely programs

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that involve the participation of all stakeholders in the village, both elements of the village government as the executive body, the village legislative body, elements of civil society and villagers. The Ministry of Health nationally makes a simple concept of participatory methods like this through the concept of Community Based Healthcare Efforts (CBHE) which means that the program is carried out by the community, from the community and carried out with the community as well as is aimed at empowering and providing facilities for the community to obtain health services.

Participatory methods and community-based health development in the healthcare sector such as CBHE, however, must be adapted to the conditions and social dynamics of the community. In general, the conditions and dynamics of the community are expressed as village types or typologies. Government agencies in particular have developed a typology of villages in Indonesia. The Ministry of Home Affairs, for example, makes categories into three levels, namely self-sufficient (*Swadaya*), self-employment (*Swakarya)* and self-help (*Swasembada*), villages. The Ministry of Village makes categories at a more detailed level, namely villages that are independent, developed, developing, left behind and very left behind.

Apart from the typological categories of villages defined by the government, this study tends to create a simpler category in determining village typology. Theoretically, the development of a good community whose legitimacy has been enhanced to become a government entity such as a village can be seen from the dynamics that accompany the journey of the community or village. In simple terms, the status and development of a community or village can be classified as traditional, transitional and modern. This traditional community or village is embedded when the universal elements of the life of its citizens are carried out in minimal or limited terms. This culture universalism among anthropologists such as Malinowski and Koentjaraningrat breaks it down into seven dimensions which are economic/livelihood system, technology, knowledge system, belief system, social organization and the arts (Yuliati, 2007).

Problem Statement
Based on the background as introduced above, the problem of this research is formulated as follows: “how are the similarities and differences in organizational, program, service and ownership aspects of Polindes in traditional typology villages with Polindes in transitional typology villages in Langkat Regency, North Sumatra Province”?

Method

Model Specification
This study is a qualitative study using a phenomenological approach. The phenomenological approach seeks to describe the general meaning of a number of individuals towards their various life experiences related to a concept or phenomenon (Creswell, 2015). This research was conducted in Langkat Regency, North Sumatra Province by taking two villages as samples. The first village represents a village with a typology with a traditional typology, namely Desa Kepala Sungai in Secanggang Sub District. The second village is a village with a transitional typology, namely Teluk Meku Village in Babalan Sub District.

Materials
The main data sources in this study consisted of observations and in-depth interviews. Observations are made at several health facilities available in the village as well as observations about how health services are provided by health workers to villagers. In-depth interviews are

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conducted with almost all elements of government, legislative bodies, elements of civil society and citizens as users of health services. Apart from these primary data sources, this study also relies on the availability of secondary data from government agencies, statistical data, statutory regulations and relevant scientific references. Data validation is carried out by using credibility and confirmation standard approach and the application of the triangulation method to data sources and theories (Lincoln in Bungin, 2012).

Informants

The informants of this study consisted of midwives who manage Polindes in Kepala Sungai and Teluk Meku villages, *Puskesmas* leaders in Secanggang and Babalan districts, officers at the Langkat District Health Office and village government officials. From the community element, the research informants consisted of legislators, women and traditional leaders in Kepala Sungai and Teluk Meku villages. Informants in other villages such as Bukit Mengkirai and Pantai Cermin are also taken as a comparison.

Data Analysis

Data is analyzed qualitatively following the qualitative data analysis cycle as stated by Creswell (2015) which are organizing data, reading and making memos, describing, classifying and interpreting data into themes, presenting and visualizing data.

Literature Review

Public Service Managament

The study of government institutions and public services cannot be separated from the discussion of public management. Government management as an ontology of government and public administration discipline has evolved over a long period, starting from the classic Max Weber management model, Taylor's scientific management model, Elton Mayo's human relations model and Maslow's human resource model. All these models began to be abandoned along with the dynamics of society and state administration practices and shifted to a new model called modern management. The role of government in this model is shifting from its dominant position in development to a role that prioritizes the creation of a proper climate that is able to encourage community independence and auto-creativity (Qohar, 2012).

The era of globalization and openness, according to Etzioni, requires modern government management to be transparent in the sense that the public policy making process starting from the formulation, implementation to supervision level needs to involve related parties including the community (Purnamasari & Ramdani, 2018). The role of society is strategic because they believe that their ideas will be recognized and considered, that more solutions are offered and that creative solutions will emerge (Schiavo, 2016). In such situation, the administration of government and public services in the health sector should be carried out.

Public services, including in the health sector, are the main task as well as a product of government administration. In the terminology of public administration science, the public is translated as citizens both in the context of individuals, families and communities. Meanwhile, public service is interpreted as fulfilling the needs of people or communities who have an interest in state organizations in accordance with the basic rules and procedures set out (Kamarni, 2011). There are at least three characteristics to categorize a service as a public service which are the nature of the service which emphasizes on social benefits more than the

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economy, the service users are seen as citizens and the characteristics of complex service users from various dimensions such as individuals, families or community (Dwiyanto, 2011).

Health services are a form of basic or primary services that urgency cannot be postponed like other primary public services such as education. At the national and domestic levels, it is not surprising that this primary service is the sector that receives the most budget priority in annual expenditure. Likewise at the global level, this sector has also received special attention through global programs such as the Millennium Development Goals (MDGs) which ended in 2015 and continued with a new program called Sustainable Development Goals (SDGs) which will be implemented until 2030 (Hodin et.al, 2016).

Community Development

In order to meet modern management concepts with the need for health services, community-based development methods are needed. This terminology is not far from the meaning of community development defined by Braunstein and Lavizzo-Mourey as "an" industry "that focuses on the revitalization of disenfranchised communities and the empowerment of community members" (Hilt, 2019). This concept is interpreted as a method of planning, implementing, supervising and monitoring development programs by involving resources owned by the community. This model in the Indonesian context is formalized by health institutions as Community-Based Health Efforts (CBHE).

In the study of village development, village characteristics are generally differentiated into three forms which are traditional villages, transitional villages and modern villages. Traditional villages are villages where “relatively independent regional societies in which social activities and social relations occurred” (Zhang, 2015). Traditional village is that those historical villages remain intact village environment, buildings, traditional atmosphere and historical cultural features (Weia, 2015). The modern village is the antithesis of the traditional village concept where the social ties of the community are no longer strong, and the regional infrastructure development is very advanced. The next concept of a transitional village is a transition from traditional village conditions or limitations to a modern village (Zhang, 2008).

Findings and Result

Typology of Villages as a Strategic Development Base

The typology or characteristics of the village, however, are important as the basis for designing village development programs. To determine the real, accurate and up-to-date typology and characteristics of a village, serious effort is needed so that the basic data is not misleading to anyone who plans a program for village development. Indonesia actually still fails to make typologies and characteristics of the tens of thousands of villages in Indonesia. The Central Statistics Agency (CSA) in 2018 officially recorded that there were 83,931 villages in Indonesia (https://www.bps.go.id). North Sumatra Province itself consists of 6,132 villages and Langkat Regency with a total of 240 villages (CSA, 2020).

The Ministry of Home Affairs, from the New Order government, has created a village typology based on its level of development. This was marked by, among others, the implementation of the development work area unit (DWEU) implementation instructions issued by the Director General of Village Development, Ministry of Home Affairs in 1977 (Sardi, 1983). The document shows that there are village categories according to their level of development, namely self-sufficiency (*swadaya*) villages as the lowest category, self-reliant/employment

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(*swakarya*) villages in a transitional position and self-help (*swasembada*) village as the most developed villages. The determination of the next village category is based on the potential that exists in the village, including economic potential, social and institutional potential (Despica; 2018).

In further developments, especially after the village is regulated in a separate Law through Law Number 6/2014, there are adjustments to this categorization, among others, through the Minister of Home Affairs Regulation Number 12/2007 concerning on Guidelines for the Compilation and Utilization of Village and Village Profile Data. The regulation states that the level of village development is based on quantitative measures that reflect the success of village and sub-district development every year and every five years is measured by the speed of development: community economy, community education, public health, security and order, community political sovereignty, community participation in development, social institutions, the performance of village and sub-district government and guidance and supervision. The results of the analysis of the rate of development of the village are used to measure the level of development of villages and sub-districts every five years which results in 3 three forms of village classification which are self-sufficiency (*swadaya*), self-employment (*swakarya*), and self-help (*swasembada*). In each type, there is a further explanation of the existence of sub-categories called initial category, intermediate category and advanced category of self-sufficiency (*swadaya*), intermediate category of self-sufficiency and advanced level of self-sufficiency. The same category applies to the typology of self-employment (*swakarya*) and those of self-help (*swasembada*).

Table 1: Typology of Villages according to the Ministry of Home Affairs

No	Type of Village	Description
1.	Self-Sufficiency (*Swadaya)*	The level of economic development, education, health and so on is less than 60% of the maximum score for the level of development every five years.
2.	Self-Employment (*Swakarya*)	The level of economic development, education, health and so on is in the range of 60% to 80% of the maximum score of development level every five years.
3.	Self-Help (*Swasembada)*	The level of economic development, education, health and so on reaches more than 80% of the maximum score for the development level every five years.

Source: Minister of Home Affairs Regulation Number 12/2007

Other categories of village development are determined by other government institutions, namely the Ministry of Villages, Development of Disadvantaged Areas and Transmigration. This ministry, among others, through the Regulation of the Minister of Villages, Disadvantaged Areas and Transmigration of the Republic of Indonesia Number 22/2016 concerning of Priority Determination of the Use of Village Funds in 2017 distinguishes village types in more detailed characteristics, namely independent village, advanced village, developing village, disadvantaged village and very disadvantaged village. If the categories published by the Ministry of Home Affairs emphasize more on quantitative measures, then the regulations issued by this ministry tend to be on qualitative measures. These two categorization models basically have advantages besides their respective weaknesses. However, researchers see more advantages in the categorization published by the Ministry of Villages.

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Table 2: Village Typology by Ministry of Villages

No	Type of Village	Description
1.	Independent	Has the ability to carry out village development to improve the quality of life and life as much as possible for the welfare of rural communities with sustainable economic and ecological resilience.
2.	Advanced	Has the potential for social, economic and ecological resources, as well as the ability to manage them to improve the welfare of rural communities, the quality of human life, and alleviate poverty.
3.	Developing	Has the potential for social, economic and ecological resources but has not managed them optimally to improve the welfare of the Village community, the quality of human life and alleviate poverty.
4.	Disadvantaged	Has the potential for social, economic, and ecological resources but has not yet managed it, or has not managed it in an effort to improve the welfare of the village community, the quality of human life and experience poverty in various forms.
5.	Very Disadvantaged	Experiencing vulnerability due to natural disasters, economic shocks, and social conflicts so that they are unable to manage potential social, economic and ecological resources, and experience poverty in various forms.

Source: Regulation of the Minister of Villages, Development of Disadvantaged Areas and Transmigration Number 22 of 2016 concerning on Prioritization for the Use of Village Funds in 2017

On a more empirical level, the categories given by the Ministry of Home Affairs are more popular. This categorization is then used by the national statistical agency in each of its annual data development reports, which are summarized in a document known as "X" District in "Y" Figures. When viewed from the results of updating statistics published by this institution, it is almost certain that in the span of a decade, updates related to this typology have not changed. BPS or statistic agency as the official government agency is of course not necessarily blamed because the determination of this typology was carried out by other government agencies, especially local governments. BPS in this case only continues this category without further involvement in questioning this unchanging typology. Static data is also indicated by the absence of sub-typology of the existing village by not including the sub-typology: initial, intermediate or advanced. For social science researchers, this is of course confusing the simple assumption that rural communities are dynamic with dynamic economic growth and development. Of course, it does not mean that of course there is an increase in status over a long period of time but has the potential to decrease so that the village typology is not static.

The difference in determining village typology by government agencies however reflects the absence of integration and synchronization of the national village development program. In addition, the creation of village categories at the empirical level was not significant in giving different treatment regarding development programs between villages of different typologies. This study found that at the regional government level, the officials did not know exactly what the set measures were, so that the typology of this village was different and tended to be statically updated. The village government itself cannot confirm how the village is called a self-sufficient village while its access is far from urban areas or the economic capacity of its

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residents is not much different from other villages designated as independent villages or self-reliant villages.

> "We also don't know why our village is included in the self-sufficiency category. What is clear is that there is no official information from the upper level of the government. However, perhaps because the average income or the economy of the residents is better than other villages in general "(Interview/Former Village Official in Bukit Mengkirai Village, 2020).

If it is seen from the technical rules and guidelines determining the characteristics or typology of this village, it is actually quite good designed to differentiate villages and provide different treatment in order to build them. The important question that needs to be answered is whether the rules and technical guidelines have been implemented properly or have been carried out by institutions or personnel who are credible and have integrity in updating this village typology. This study provides a hypothetical answer that the determination of village typology has not been considered by all elements as an important database in an effort to build a village or the categorization loses its objectivity when the subjectivity of the typology determining personnel is more dominant in applying the village category. In the aftermath, the embedding of typology in the village was only as a document on paper which was not considered by policy makers and other elements of society as something that must be fought for or avoided. Creating a village in the highest topological category as a self-sufficient village as well as a developed village according to the two institutional categories mentioned above should be a common goal.

Portrait of* Polindes *Services in Traditional and Transitional Villages: The Case of Kepala Sungai and Teluk Meku Villages

Kepala Sungai Village is one of 17 villages in Secanggang Sub District, Langkat Regency, North Sumatra Province. This village consists of 11 hamlets with a total population of 5,828 people. The majority of its citizens work as farmers (69.73%). This village is geographically located in the lowland area of the eastern coast of North Sumatra. According to the village typology category published by the interior ministry, this village is classified as a Self-Sufficiency (*Swadaya)* village, while according to the categorization published by the village ministry; it is designated as underdeveloped village. This study theoretically categorizes this village as a traditional village where the universality of culture and community life is still limited.

Teluk Meku Village as the second sample of this study is one of the 8 villages/*kelurahan* in Babalan Sub District, Langkat Regency. This village consists of 7 hamlets with a total population of 7,386 people. The occupation of the people is very diverse and statistically the majority of its residents work as entrepreneurs (12.73%). This village is geographically located in the lowland area of the eastern coast of North Sumatra. According to the village typology category published by the ministry of home affairs, this village is classified as a self-employed (*Swakarya*) village, while according to the categorization published by the village ministry, it is designated as underdeveloped village. This study theoretically categorizes this village as a transitional village because the culture and life of its people have begun to move from a traditional position to a modern village.

The existence of Polindes in Kepala Sungai Village and Teluk Meku Village still needs to be maintained. This is due to the high population compared to other villages in the Langkat Regency area, the area of the two villages which each have 11 and 7 hamlets, the limited health

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facilities in the two villages and the focus of services provided which ideally are only for mothers giving birth and toddler health.

Table 3: General Profile of Kepala Sungai Village and Teluk Meku Village

No	Description	Kepala Sungai	Teluk Meku
1.	Total Population	5.828 inhabitants	7.386 inhabitants
2.	Number of Hamlets	11	7
3.	Number of BPD	9 persons	9 persons
4.	Percentage of Underprivileged Population	26,59	24,15
5.	Majority Educational Level	Elementary Schools	Elementary Schools
6.	Majority of Villagers Occupation	Agricultural	Entrepreneur
8.	Number of *Posyandu*	5	11
9.	Number of *Polindes*	1	1
10.	Number of *Pustu*	1	2
11.	Number of Pharmacies	-	1
12.	Number of Maternity Clinic	2	5

Source: Government of Kepala Sungai (2019); Government of Teluk Meku (2019)

In terms of health services provided by the *Polindes* in these two villages, it is very different. The services provided by the *Polindes* in Kepala Sungai village in the last two years have almost certainly been zero. Exactly, the only activities available are *Posyandu* (weekly healthcare service) activities which are held at the *Polindes* building once a week. This *Posyandu* service is certainly not an activity of the *Polindes* because the institutions are different and the service focus is different. Almost all residents who live around the *Polindes* location said that *Polindes* activities were almost non-existent in the last two years, long before the Covid-19 case broke out.

> There is no service, only once a week when there is immunization (*Posyandu*). Before Corona (Covid-19 cases) the Polindes had not been opened. If you want to go to a private midwife or go straight to the *Puskesmas*. But the *Puskesmas* is far away (Interview/Woman in Kepala Sungai village, 2020).

The physical buildings and health facilities in this village are very limited. The building area is less than 50 m^2 with two room units, namely the patient waiting room and the practice room. This building has air conditioning but does not have a bathroom. The electricity line is installed but there is no electronic equipment for either administrative purposes or medical examination needs. The only medical devices available are baby scales and equipment for bathing babies. The building is only about 24 m^2 of size. The road access to the *Polindes* is very poor; the broken road is used as thin asphalt so that during the daytime the dust on the road decorates the access road to this health facility.

Unlike the *Polindes* services at Kepala Sungai Village, the *Polindes* in Teluk Meku Village is in much better condition. Physically, the location is easy for residents to recognize and access. It has a large courtyard with a large parking area too. If the patient is busy, there is a kindergarten school canteen which is united with the *Polindes* area. Even so, a number of kindergarten children's playgrounds can be used by patients who come to bring their children. Due to its location which is very close to the coastline, the building was flooded several times

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by high tide from the sea. In the identity plank, this facility has changed its name to *Poskesdes* or Village Health Post.

Daily services at the *Polindes* are routinely carried out and there are always health workers or midwives who regularly attend this facility. However, midwives who have a daily schedule at certain times are forced to close the *Polindes* when a patient has to be visited at home and is unable to walk to the *Polindes*.

> "If there are patients who need help such as being unable to walk to the *Polindes*, we will come to the patient's house. But it's rare. We will temporarily close the *Polindes* if we are forced to visit a patient who needs help "(Interview/Midwife at the Teluk Meku *Polindes*, 2020).

Daily patients are neatly recorded and served well by *Polindes* officers or midwives. This building is quite spacious for the *Polindes* class and has four main rooms consisting of a front room as an administration room and patient waiting room, examination room, medicine supply room and medical equipment and a meeting room. This building is also equipped with a bathroom/toilet. This *Polindes* is also managed by two health workers or midwives. One of them is a civil servant who is also employed at the Securai *Puskesmas*. One more person is an honorarium/volunteer. The two midwives live in Teluk Meku so that it is easier to be contacted by the residents, especially in an emergency that requires care for pregnant women and other residents who are going for general medical treatment.

In the context of public services, the two facilities actually have not provided ideal public services, especially in the health sector for pregnant women, childbirth and toddlers. The *Polindes* in Kepala Sungai village in the last two years has almost certainly not provided public services in accordance with their duties and functions. Meanwhile, the *Polindes* in Teluk Meku Village has shown an embryo to provide excellent public services. This reason refers to the ideal categorization of public services which are reliability, empathy, responsiveness and tangible as stated by Parasuraman et al. (1998). Efforts to provide reliable service have been made by improving service facilities and also establishing daily service schedules at the *Polindes*. The initiative to visit patients to the respective villager's homes (door to door) should be considered as part of the responsiveness and care for patients (empathy) carried out by the *Polindes*. Regarding the physical appearance and communication (tangible) provided by health workers, it is appropriate, such as placing oneself as part of the village community through communication according to local habits.

In further context, health services provided by village midwives should follow the concept of prime public service starting from providing services quickly, accurately, consistently so as to have an influence on public loyalty as patients (Lail, 2019). Patient or customer loyalty in this case greatly determines whether a customer will return or not to a health facility (Laksono, 2008). In another part, the village midwife plays a role in disseminating health information to the community, among others, as a source/communicator that is credible and very helpful in the process of disseminating health information and the presence of messages in the form of various health information delivered by village midwives through various health programs in the village (Prasanti, 2018).

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Polindes *Institutional Problems: From Asset Ownership Status to Sustainability*

Polindes institution becomes important to be researched in connection with the planning of this facility as a community-based health effort and its function as a public servant in the promotion, preventive, curative and rehabilitative sectors for village residents, especially for mothers who give birth and toddlers. This study found a dilemma related to the *Polindes* institution in the two villages as the sample of the study. On one hand, the *Polindes* is considered part of the village government-owned institution and on the other hand is considered an institution belonging to the district government. Both views are an obstacle for the *Polindes* to work and maximize its services for villagers.

This institutional dilemma then becomes the task of all parties, especially the local government in developing *Polindes* in Langkat Regency. To solve this institutional problem, all parties must lay the foundation for the establishment of this *Polindes*. As previously described, *Polindes* is designed as a community-based health development model or in central government terminology as Community-Based Health Effort (CBHE). Therefore, all parties, especially district governments, must revisit the context of regional autonomy and village autonomy in forming, managing and implementing *Polindes* works.

In the context of regional autonomy, district governments have broad authority over the health sector. This sector is a mandatory affair for autonomous regions with performance achievement indicators designed to be measurable every fiscal year. District governments also have great resources in terms of both human resources and funding in this sector. The authority to nominate and appoint civil servants in the health sector becomes the district area so that this area has the opportunity to distribute human resources to the various health facilities in its geographic area. Various sources of funding, from the component of transfer funds from the central government, provincial governments and local revenue allow local governments to provide operational funding for health facilities to develop programs for community empowerment. However, the district government must respect the existence of village autonomy so that it does not assume that the direction of the *Polindes* is determined by the district government.

In the context of village autonomy, the village as an entity is a replica of a country or at least an imitation of an autonomous region such as a province, district or city. Theoretically, the concept of village autonomy should create villages that live independently and have the authority to manage their own households, organize them and organize their own government (Kushandajani, 2016; Azlina, 2017). There are still limitations to this village autonomy because the village itself is geographically and administratively a part of the state or an administrative area of other autonomous regions such as provinces or provinces. Village autonomy should then be read as a concept of self-government limited by the authority of other government entities.

Village autonomy with all its limitations and the obligations and authorities of autonomous regions in the health sector at the village level have implications for the *Polindes* institution in the village. On one hand, the context of cooperation between district autonomous regions and village governments in running *Polindes* as a community-based program creates positive synergies.

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> "Well, in the context of regional autonomy and village autonomy, the synergy in realizing community-based polindes should be realized. But again, this health sector is not yet a priority for the village. It is still difficult for us to make it happen" (Interview/Official at Health Office of Langkat Regency, 2020).

The village by the regulation independently provides land for building health facilities to assist the district government because it does not need to spend a large budget for the provision of land for health facilities which further helps to achieve performance indicators in the health sector. On the other hand, the government and villagers benefit from the presence of a midwife with the status of civil servants in the village, making it easier for them to access better health services. However, by the time and process, this ideal cooperation was not always maintained, particularly in Kelapa Sungai Village and Teluk Meku Village. There is a big problem related to the institution that accompanies the existence of the *Polindes* and its journey in providing public services for the health sector in the village. This study detected at least four problems related to this institution, namely: institutional status, sense of ownership, loyalty of health workers and program planning and sustainability.

Polindes as a form of community-based health program is basically part of the village community institution. Similar to *Posyandu*, this *Polindes* is an organizational unit in the community that carries out some of the health service functions. This *Polindes* occupies the position of social-community and economic institutions in the village. Even though there is a change in name or nomenclature such as *Poskesdes* in Teluk Meku Village, this institution is still part of the existing institutions in the village whose existence and sustainability are part of the responsibility of the village.

> "Both *Polindes* and *Poskesdes* are designed as forms of community-based health facilities. At the practical level, land or land for building health facilities is provided by the village community while the process of building facilities, equipment and health personnel such as village midwives and PTT midwives (Non-Permanent Employees) is provided by the government, in this case the central government and the Langkat district government" (Interview/Head of Teluk *Puskesmas*, 2020).

In this regard, the village government of Kepala Sungai and the village government of Teluk Meku has not shown its commitment by giving equal attention to other social institutions such as *Posyandu*, women group and youth groups through budget allocation for *Polindes*. The real form shown by the village government in its annual program is only limited to providing incentives for midwives and additional costs for medicines (Interview, 2020). To lead to the development of *Polindes* and increase in services has not been done substantially.

Table 4: Health Program in the 2019 Village Government Work Plan

No	Kepala Sungai Village	Teluk Meku Village
1.	Implementation of village posts, medicines, incentives for village midwives/nurses	Supplying additional food for toddlers
2.	Empowerment of *Posyandu* and family planning, additional food, incentives for *Posyandu* cadres and human development cadres	Anti-drug volunteer activities
3.	Health education and training	Maternal and Child Health Services

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No	Kepala Sungai Village	Teluk Meku Village
4.	Implementation of health alert villages	Health and nutrition counselling services
5.	Land acquisition and development of *Posyandu*	Health and social protection services
6.	Counselling about drugs.	Community empowerment in health and healthy community movements
7.	Women group training and procurement of women group uniforms and *Posyandu* cadres	-

Source: Village Government Work Plan (VGWP) of Kepala Sungai in 2019; VGWP of Teluk Meku in 2019.

The next institutional problem is the sense of belonging to the *Polindes* facilities. In accordance with the existing regulations and also the empirical facts, the land for the construction of the *Polindes* building must come from a village grant. In the context of participation, it can be interpreted as granting private citizens property to be public property or being released through the village government budget. In Kepala Sungai Village, the location of the *Polindes* is not very strategic, especially when compared to the *Polindes* building in Teluk Meku Village. The *Polindes* building in Kepala Sungai village is very simple if not worrying. It is located in one of the farthest hamlets and stands in a narrow location next to the residents' houses. This health facility does not have a proper yard for parking for visitors as well as there is no representative place as a patient waiting room at the *Polindes* yard. The road access to the *Polindes* is very poor; the broken road is used as thin asphalt so that during the daytime the dust on the road decorates the access road to this health facility. The main door of the building does not face the street so it would be difficult for ordinary people to know that the building was a health facility. Informants from elements of the village government as well as the community said that the previous *Polindes* building was in the middle of the village or on a protocol road in the village, but residents who were willing to provide land for grants were only residents of the hamlet where the *Polindes* location is now standing.

The issue of ownership of this facility is also further complicated when the district government considers that the *Polindes* building is an asset of the local government. This study found that the *Polindes* located in Kepala Sungai Village as well as the *Poskesdes* in Teluk Meku Village were declared assets of the district government. In the two *Polindes* buildings, an identity plank was established stating that the land for the building belonged to the local government. When this was confirmed with the village government, they stated that the land was sourced from a village grant and did not know why such an identity plank was made. The village government only knows that the construction of the building is fully funded through the district budget.

> "We are also confused about the placement of the nameplate. One side is that the authority regarding health services and the placement of village midwives is the authority of the district government. They also built the building, but the land was purchased or from the village budget" (Interview/Head of Kelapa Sungai Village, 2020).

The next institutional problem is the loyalty of health workers or midwives at the *Polindes*. Both the *Polindes* in Kepala Sungai Village and the Polindes in Teluk Meku Village each have two health workers or midwives. Their loyalty related to their duties and functions as village midwives as well as those responsible for health services at the *Polindes* was questioned. Research informants from community elements said that previously the midwives appointed

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by the local government and the central governments at the *Polindes* were very active and resided in the village through the PTT (temporary staff) program. However, after being appointed as a civil servant, the *Polindes* seemed to be left behind and the appointed midwives spent more time in other health facilities such as the *Puskesmas*. Informants from health workers said that specifically for childbirth, it had been directed by the district government not to take place in *Polindes* but to be done in better facilities such as *Puskesmas* or Hospitals.

> "Polindes services are nil or not like the services that existed before because they cannot be separated from the recommendation of the local government to provide delivery services to be placed in health facilities such as *Puskesmas* or hospitals" (Interview/Head of Teluk *Puskesmas*, 2020).

Other facts in the field show that the human resources distributed to community-based health facilities such as the *Polindes* are mostly used for work and health services which are the domain of mandatory regional government affairs. Midwives who are assigned to the *Polindes* are also employed at the *Puskesmas* in the respective sub district. It does not stop there, important functional positions such as treasurer for Operational Health Assistance (BOK) which is a joint program of the central and local governments through a task assistance scheme are also held by midwives who in fact are assigned to *Polindes*. Consequently, on the context of welfare, career development or the convenience of access to local government facilities, the village midwives who are stayed in the *Polindes* devote the majority of their time to health facilities owned by the district so that the *Polindes* is a second or more priority.

The next institutional problem is the planning of programs and activities at the *Polindes*. This study found that program planning for *Polindes* have not been planned comprehensively like the existing routine programs in the village and district governments. Based on the secondary data obtained, the budget for each village which is the object of this research is quite large. Kepala Sungai Village has a total income of almost IDR 1.5 billion in 2019 and Teluk Meku Village exceeds IDR 2 billion. However, it is entirely in favour of the concept of community-based development, especially for the health sector.

Table 5: Description of Village Income/Budget in 2019 (In Indonesian Rupiah/IDR)

No	Description	Kepala Sungai	Teluk Meku
1.	Village Genuine Income	74.500.000	12.923.830
2.	Funds Transferred by Regency Government	568.503.000	831.024.000
3.	Funds Transferred by Central Government	793.593.000	1.389.264.000
4.	Tax / Retribution Sharing	15.072.000	29.554.000
	Total	1.451.668.000	2.262.765.830

Source: Village Government of Kepala Sungai (2019); Village Government of Teluk Meku 2019.

The largest use of the budget is still allocated for the cost of administering the government, especially for the components of administering administration, honorarium and apparatus allowances. Physical development, such as repairing roads, is the next biggest expense component. Especially for this *Polindes*, there is no program specifically designed for the development or improvement of *Polindes* services.

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Conclusion

This research shows that there are differences in the condition of facilities and the quality of health services provided by the *Polindes* in villages with different typologies. In general, the physical facilities at the *Polindes* in the two villages were inadequate to carry out the main tasks of the *Puskesmas*, especially those related to delivery services. However, the physical facilities for the *Polindes* in transitional villages are better than the physical facilities for the Polindes in traditional villages. In the service quality sector, it is evident that the services provided by the *Polindes* in transitional villages are far better than the services provided by the *Polindes* in traditional villages. If in a transitional village, services are present every day, then services in traditional villages are only carried out once a week or only for immunization or *Posyandu*.

However, there are other things that show similarities in the management and funding of *Polindes*. The two villages with different typologies have not made *Polindes* programs and activities part of the annual village program and have involved the community in a participatory manner. The village administration has not made the *Polindes* program a village program like other sectors such as socio-cultural and religious activities. The budget allocation spent by the two villages for *Polindes* is a very small percentage compared to other sectors in the annual village program. The nutrition addition program for toddlers and additional incentives for village midwives is very small when compared to the potential budgets of the two villages.

Recommendation

In line with national regulations on health sector development, the role of the *Polindes* should still be used as the spearhead in providing health services, especially delivery services for pregnant women and health services for children in rural areas. Moreover, the majority of *Polindes* in Langkat Regency also provide general health services outside of childbirth and under-five health due to the lack of other health facilities in the village area. Therefore, a series of steps are needed to revitalize the role and function of the *Polindes* in community-based health development efforts. The revitalization needed is in the realm of service systems, service accessibility and cohesiveness of health workers with the community.

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