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Efforts to Improve the Capacity of Midwife in the Village to Conduct the Community Empowerment Process Towards an Active Alert in Pidie Jaya

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Author's contribution

The sole author designed, analyzed, interpreted and prepared the manuscript.

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ABSTRACT

Community empowerment is very important to do with the aim that people become independent, in the sense that they have the potential to be able to solve the problems they face, and are able to meet their needs by not depending their lives on outside assistance, both government and non-government organizations. Midwives in the Village with individual characteristics are mostly aged less than 35 years, married status, Diploma-III education, with a working period of more than 6 years and most have become civil servants. The knowledge of village midwives about the development of Desa Siaga is 91.5% good, but the attitudes of village midwives towards the community empowerment process in developing Desa Siaga are more unsupportive, namely 57.3% and those who support 42.7%. Meanwhile, midwives in villages who have high work motivation as facilitators for Desa Siaga development are 58.5% and those who have low motivation are 41.5%. The level of activeness of the Village Midwife in social organizations, such as TP activities. PKK in the village, TP. PKK. Only 57.3% of midwives in the village can carry out the

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community empowerment process well, while 42.7% are still considered unfavorable. Of the 6 (six) stages of the empowerment process, only 70.7% help determine priorities. in sub-districts, and activities of religious organizations, is still very low at 3.7%.

Keywords: Midwife; health workers; employment status; place of residence.

1. INTRODUCTION

Health efforts are organized in the form of activities with promotive, preventive, curative and rehabilitative approaches that are carried out in an integrated, comprehensive and sustainable manner in accordance with Article 47 of Law number 36 of 2009 concerning Health. Furthermore, in article 174 it is explained that the community participates, both individually and in an organization in all forms and stages of health development in order to help accelerate the achievement of the highest degree of public health [1-7].

Community participation is developed so that the community has the opportunity to implement health efforts and their resources, while the government fosters, encourages and mobilizes community self-help in the health sector so that they can be more efficient and effective. This is in line with Law number 17 of 2007 concerning the RPJP-N 2005-2025 that health development is directed at increasing awareness, willingness and ability to live healthy for everyone so that the highest possible increase in health status can be realized [8-14].

The National Health System (2009) explains that community empowerment is the focus of health development which is held to produce individuals, groups and the general public who are able to play a role in implementing health efforts. To implement community empowerment activities, a guideline for the Implementation of Desa Siaga Development with the Decree of the Minister of Health of the Republic of Indonesia number 564 of 2006 has been issued.

The guideline explains that the meaning of Desa Siaga is a village where the population has ready resources and the ability and willingness to prevent and overcome various health problems, disasters and health emergencies independently [15-22]. Desa Siaga is a breakthrough to achieve conditions for people who are aware, willing and able to prevent various threats to public health, including malnutrition, infectious diseases and disasters.

The development of Desa Siaga is carried out to anticipate various health problems in Indonesia, such as the high maternal mortality rate (MMR) of 228 per 100,000 live births (KH) in 2007 which is expected to decrease to 102 per 100,000 live births (KH) in 2015. Infant mortality rate (IMR) of 34 per 1,000 live births (KH) in 2007 is expected to decrease to 23 per 1,000 live births (KH) in 2015, the prevalence of malnutrition is 18.4% in 2007, it is expected to decrease to 9.5% in 2015 and infectious diseases which are still a prominent public health problem, especially: pulmonary TB, malaria, HIV-AIDS, Dengue Hemorrhagic Fever (DHF) and diarrhea (SDKI, 2007 and SKN, 2009).

In accordance with Article 51 paragraphs 1 and 2 of Law number 36 of 2009 concerning Health that health efforts are carried out to realize the highest degree of health for individuals or communities based on Minimum Service Standards (SPM). Furthermore, in the Compulsory Authority for Minimum Service Standards (SPM) for Health Promotion and Community Empowerment, a target of 80% of villages has been set to become Active Alert Villages in 2015 according to the Minister of Health of the Republic of Indonesia no. 741/Menkes/PER/VII/2008, July 29 2008. The definition of an Active Alert Village is a village that has a Village Health Post (Poskesdes) or other UKBM which is open every day and functions as a provider of basic health services, disaster and emergency management, surveillance community-based which includes nutrition, disease, environment and behavior so that the community implements Clean and Healthy Behavior (PHBS). To operationalize the notion of Active Alert Village, we agree that villages have functioning Poskesdes and Desa Siaga are at the growth, development and plenary stage [23-28].

The role of health workers in realizing Desa Siaga is very important, they are expected to be able to facilitate community empowerment by building partnerships with the community, involving the community's active role in overcoming various problems faced by taking into account the potential of the community and all available resources in the community.

Community empowerment is very important to do with the aim that people become independent, in the sense that they have the potential to be able to solve the problems they face, and are able to meet their needs by not depending their lives on outside assistance, both government and non-government organizations. This is reinforced by the results of Rohaeti's research (2008) in Subang District that community empowerment efforts can produce a range of MCH service activities and foster a sense that health is a community need.

The policy for placing Civil Servant Midwives (PNS) in villages is in accordance with the Circular of the Director General of Community Health Development, Ministry of Health of the Republic of Indonesia number 429/Binkesmas/ DJ/III/89 dated March 29, 1989.

Due to the existence of a zero personal growth program which was motivated by limited government funds, in 1994 the Presidential Decree of the Republic of Indonesia, number 23 of 1994 dated April 7, 1994, was renewed by Presidential Decree number 77 of 2000 dated June 2, 2000 concerning the appointment of Midwives as Employees Non-Permanent (PTT) placed in the village [29-35]. While the technical instructions for its implementation are regulated in the Decree of the Minister of Health of the Republic of Indonesia number 1212 of 2002, September 26, 2000.

In the Midwife Guidebook at the village level (1996) Midwives in Villages are midwives who are placed, obliged to live and are tasked with serving the community in their working area, reporting directly to the head of the local Puskesmas and working with village officials. The activities of the village midwife include activities related to MCH services including family planning, management of the MCH program and fostering community participation in the field of MCH.

With the implementation of the Desa Siaga program, the duties of midwives in the village have increased, they have become administrators of the Village Health Post (Poskesdes), namely UKBM which was formed in the village in order to bring/provide basic health services to the village community. Poskesdes was developed as a health facility which is a meeting between all community efforts and government support [36-44]. Services include promotive, preventive and curative efforts carried out by health workers (especially midwives) by involving cadres or other volunteers (Ministry of Health RI., 2006). Midwives are health workers who are closest to the community, exist and live with the community in the village so that they can know firsthand what is happening in the community and can help the community to overcome various existing problems and improve their health. One of the roles of the village midwife in developing Desa Siaga is as a guide for mobilizing and empowering the community through partnerships. Thus the role of midwives is very important in facilitating community empowerment to achieve independence in healthy living (Depkes RI., 2007).

The RPJMD of Aceh Province prioritizes public health efforts, one of which is by expanding the service function of the Polindes (Village Maternity Boarding School) from only serving maternity patients to Ponkesdes (Village Health Boarding School) which also provides basic health services by placing paramedics, in this case nurses. This policy is closely related to the development of Desa Siaga because with the help of village nurses it is hoped that they will work together with village midwives in facilitating the community empowerment process.

In principle, both Poskesdes as a forum for community empowerment in developing Desa Siaga and Ponkesdes as stated in the Governor's Regulation both aim to make the community self-sufficient for a healthy life, only administrative management is slightly different. The existence of Poskesdes is still a community-based activity, while Ponkesdes is a network of Puskesmas in order to bring access and quality of public health services closer.

2. METHODS

This type of research is observational, namely observations about individual characteristic factors, psychological conditions and the involvement of village midwives in social activities and the ability of village midwives to carry out community empowerment processes in an effort to increase active village alertness in Pidie Jaya district. The design of this study is an analytical research with a cross-sectional approach where the independent variables (independent variables) in the form of individual characteristics, psychological conditions and the involvement of the village midwife in social activities, are collected simultaneously at the same time as the dependent variable, i.e. community empowerment process by midwives in the village (Notoatmodjo, S., 2000). The study

population was village midwives who had participated in Desa Siaga training and functioned as facilitators for the development of Desa Siaga, totaling 298 village midwives out of 317 midwives in Pidie Jaya District. The sample in this study were village midwives who were representatives of the population to be studied.

3. RESULTS

3.1 Relationship between Individual Characteristics, Psychological Conditions and Involvement in Social Activities with the Ability of Midwife in the Village to Conduct the Community Empowerment Process

The results of the analysis using the Chi-Square test show that there are no significant individual characteristics that affect the ability of village midwives to carry out community empowerment processes.If we pay attention to the data in Table 1, descriptively it can be explained that those aged <35 years are in the dominant condition for carrying out the empowerment process properly, namely 64.2%. Meanwhile, for the age group above 35 years, namely 44.8%, they were able to carry out the community empowerment process well, while 55.2% were not able to carry out the community empowerment process properly.

From the results of the Chi-Square test with a Continuity Correction value of 0.145 > α (0.05) it means that there is no significant relationship between age and the ability of village midwives to carry out the community empowerment process in developing Desa Siaga.

Descriptively, the percentage of midwives in the village who are married can be shown in Table 2. that 54.7% have carried out the empowerment process properly, and 45.3% are still in the less criteria. Meanwhile, 85.7% of those who were unmarried were able to carry out the empowerment process properly and only 14.3% included the less criteria.

The results of the analysis using the Chi-Square test with a Fisher's Exact value of 0.230 > α (0.05) means that marital status is not significantly related to the ability of village midwives to carry out community empowerment processes.

The education level of the majority of respondents was D-III as in Table 3. It is known that those who carried out the empowerment process with good criteria were 56.9% and those who included less criteria were 43.1%. Whereas for D-IV education there were 66.7% with good criteria and for Midwife Education Program (P2B) education there were 57.1% which included good criteria.

Table 1. The Relationship between Age and the Ability of Midwives in Villages to Conduct Community Empowerment Processes, Pidie Jaya District in 2010

UMUR	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	n	%	n	%	n	%
≥ 35 tahun	13	44,8	16	55,2	29	100,0
< 35 tahun	34	64,2	19	35,8	53	100,0
Jumlah	47	57,3	35	42,7	82	100,0

Table 2. The Relationship between Marital Status and the Ability of Village Midwives to Conduct Community Empowerment Processes, Pidie Jaya District in 2010

Status Pernikahan	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	n	%	n	%	n	%
Menikah	41	54,7	34	45,3	75	100,0
Belum Menikah	6	85,7	1	14,3	7	100,0
Jumlah	47	57,3	35	42,7	82	100,0

Table 3. The Relationship between Education and the Ability of Midwives in Villages to Conduct Community Empowerment Processes, Pidie Jaya District in 2010

Pendidikan	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	n	%	n	%	n	%
D – IV	2	66,7	1	33,3	3	100,0
D - III	33	56,9	25	43,1	58	100,0
P2B	12	57,1	9	42,9	21	100,0
Jumlah	47	57,3	35	42,7	82	100,0

The results of the Chi-Square test with a continuity correction value of 1.000 > α (0.05) means that the respondent's education level is not significantly related to the ability of village midwives to carry out community empowerment processes.

The relationship between tenure and the ability of midwives in villages with working periods of > 6 years and < 3 years both carried out the community empowerment process well at 61.5%. In Table 4 shows that the working period of 3-6 years is 68.6% including good criteria and 31.3% including poor criteria. This means that the ability to carry out the empowerment process does not only depend on the length of time working which shows the more experience that has been lived.

According to the results of the Chi-Square test with a Pearson Chi-Square value of 0.500 > α (0.05) it means that the respondent's tenure is not significantly related to the ability of village midwives to carry out community empowerment processes.

Employment status, both as civil servants and PTT, also had no effect on the ability of village midwives to carry out community empowerment processes. Although many respondents have occupied positions as civil servants, the empowerment process that was carried out was not much different. Table 5. It is known that there are 56.9% of midwives in civil servant villages who are in the good criteria, while 43.1% are still in the low criteria in carrying out the community empowerment process. Likewise for Midwives in Villages with PTT status there are 58.8% including good criteria and 41.2% are still lacking in carrying out the community empowerment process.

According to the results of the analysis using the Chi-Square test with a Continuity Correction value of 1.000 > α (0.05) it means that the employment status of the respondents is not significantly related to the ability of midwives in the village to carry out the community empowerment process.Midwives in the village are expected to live in the village where they are placed, with the aim of bringing access to services closer to the community. However, in reality, although most of them live in the village where they work, it is not related to the community empowerment process. In Table 6. seen 57.9% including good criteria and 42.1% including less criteria.

Table 4. The Relationship between Tenure of Service and the Ability of Midwives in Villages to Conduct Community Empowerment Processes, Pidie Jaya District in 2010

Masa Kerja	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	n	%	n	%	N	%
> 6 tahun	28	61,5	25	47,2	53	100,0
3 – 6 tahun	11	68,6	5	31,3	16	100,0
< 3 tahun	8	61,5	5	38,5	13	100,0
Jumlah	47	57,3	35	42,7	82	100,0

Table 5. The Relationship between Employment Status and the Ability of Village Midwives to Conduct Community Empowerment Processes, Pidie Jaya District in 2010

Status Kepegawaian	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	n	%	n	%	N	%
PNS	37	56,9	28	43,1	65	100,0
PTT	10	58,8	7	41,2	17	100,0
Jumlah	47	57,3	35	42,7	82	100,0

Table 6. The Relationship between Residence and the Ability of Midwives in Villages to Conduct Community Empowerment Processes, Pidie Jaya District in 2010

Tempat Tinggal	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	n	%	n	%	N	%
Di desa ini	44	57,9	32	42,1	76	100,0
Di luar desa	3	50,0	3	50,0	6	100,0
Jumlah	47	57,3	35	42,7	82	100,0

The results of the Chi-Square test with a Fisher's Exact value of 1.000 > α (0.05) indicate that there is no significant relationship between the midwife's residence in the village and her community empowerment process.

The results of the analysis using the Chi-Square statistical test, it is known that the psychological condition of the village midwife that is significantly related to the community empowerment process is the attitude and motivation variables. The attitude variable of the midwife in the village has a Continuity Correction value of 0.045 <α (0.05) and work motivation with a Continuity Correction value of 0.024 <α (0.05). Shows a significant relationship. Whereas knowledge with a Fisher's Exact value of 0.131 > α (0.05) is not significantly related to the ability of midwives in the village to carry out community empowerment processes.

If we pay attention to the data in Table 7, it can be explained descriptively that the relationship between the knowledge of the Village Midwife regarding the development of Desa Siaga, there are 60% of respondents who have good knowledge can also carry out the empowerment process well, however there are still 40% of respondents even though they have good knowledge, but have not been able to carry out the empowerment process properly. While respondents who have less knowledge, but are already able to carry out the empowerment process properly there are 28.6% and logically that with low knowledge they are certainly not able to carry out the empowerment process as much as 71.4%.

Table 7. The Relationship between Knowledge and the Ability of Midwives in Villages to Conduct Community Empowerment Processes, Pidie Jaya District in 2010

Tingkat Pengetahuan	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	n	%	N	%	n	%
Baik	45	60,0	30	40,0	75	100,0
Kurang	2	28,6	5	71,4	7	100,0
Jumlah	47	57,3	35	42,7	82	100,0

Table 8. Correlation between Attitudes and the Ability of Midwives in Villages to Conduct Community Empowerment Processes, Pidie Jaya District in 2010

SIKAP	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	n	%	n	%	n	%
Mendukung	25	71,4	10	28,6	35	100,0
Kurang Mendukung	22	46,8	25	53,2	47	100,0
Jumlah	47	57,3	35	42,7	82	100,0

Table 9. Relationship between work motivation and the ability of village midwives to carry out community empowerment processes, Pidie Jaya district, 2010

MOTIVASI	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	n	%	n	%	N	%
Tinggi	33	68,8	15	31,3	48	100,0
Rendah	14	41,2	20	58,8	34	100,0
Jumlah	47	57,3	35	42,7	82	100,0

The relationship between attitudes towards the empowerment process and the ability of village midwives to carry out the empowerment process is shown in Table 8. There were 71.4% of respondents who were supportive but could carry out the community empowerment process well, but there were 28.6% of respondents who were supportive but had not been able to carry out the empowerment process properly. In fact, what needs to be paid attention to intensively is that there are 53.2% who are less supportive, of course they have not been able to carry out the empowerment process properly.

Furthermore, the psychological condition of village midwives can be seen from their work motivation as Village Alert facilitators in Table 9.

In Table 9. shows that midwives whose work motivation as facilitators for Desa Siaga development are high with the empowerment process being carried out include good criteria, namely 68.8%. Meanwhile, midwives with low work motivation only 41.2% of respondents were able to carry out the empowerment process properly. However, there are still 31.3% of respondents who have high work motivation but cannot carry out the empowerment process properly. In fact, there are still 58.8% of respondents who have low work motivation and are automatically unable to carry out the community empowerment process in the development of Desa Siaga.

3.2 The Relationship between Involvement in Social Activities and the Ability of Village Midwives to Carry out Community Empowerment Processes

The results of the analysis with the Chi-Square test show that the variable involvement in social activities that significantly affects the ability of midwives in the village to carry out community empowerment processes is their activeness in community activities with a Continuity Correction value of 0.040 < α (0.05) which means significant. Meanwhile, activeness in social organizations is not significant with a Continuity Correction value of 1.000 > α (0.05). This means that the activeness of respondents in social organizations is not significantly related to the ability of village midwives to carry out community empowerment processes in developing Desa Siaga. However, descriptively it can be seen in Table 10.

Table 10. The Relationship of Activeness in Social Organizations with the Ability of Midwives in Villages to Conduct Community Empowerment Processes in Pidie Jaya Regency in 2010

Keaktifan dalam Organisasi Sosial	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	n	%	N	%	n	%
Aktif	1	33,3	2	66,7	3	100,0
Kurang Aktif	12	63,2	7	36,8	19	100,0
Tidak Aktif	34	56,7	26	43,3	60	100,0
Jumlah	47	57,3	35	42,7	82	100,0

Table 11. The Relationship of Activeness in Community Activities with the Ability of Midwives in the Village to Carry Out the Community Empowerment Process in Pidie Jaya Regency in 2010

Keaktifan dalam Kegiatan Masyarakat	Bidan di Desa Melakukan Proses Pemberdayaan Masyarakat					
	Baik		Kurang		Jumlah	
	N	%	N	%	n	%
Aktif	32	68,1	15	31,9	47	100,0
Kurang Aktif	14	45,2	17	54,8	31	100,0
Tidak Aktif	1	25,0	3	75,0	4	100,0
Jumlah	47	57,3	35	42,7	82	100,0

If we pay attention to the frequency data descriptively in Table 10. it can be explained that 43.3% of respondents who were not active in social organization activities could not carry out the empowerment process properly, in fact there were 66.7% of respondents who were active but were unable to carry out the community empowerment process in developing Desa Siaga.

In addition, involvement in social activities can be seen from the level of activeness in community activities as shown in Table 11. It can be seen that 68.1% of respondents who are active in community activities can properly carry out the community empowerment process and there are still 31.9% of respondents who are active in community activities but have not been able to carry out the empowerment process properly.

4. DISCUSSION

4.1 Individual Characteristics

The midwife's age affects the work experience of the midwife, and affects the community's trust in the ability of the midwife in the village. As a result of experience and maturity of the soul. In addition, the ability to work is more influenced by encouragement from external factors, such as facilities and infrastructure, and awards in the form of separate compensation for the performance of midwives [45]. The marital status of health workers can encourage these health workers to more easily enter the scope of various social activities held in the community. The results showed that almost all midwives in the village, namely 91.5%, were married. This marital status can increase the knowledge of the midwife in the village regarding reproductive health and child care which is obtained on a daily basis so that the process of exchanging experiences between the community and health workers is easier and smoother. Education is a measure of the extent to which a person's knowledge of the knowledge he has acquired. A person's education affects his perspective on himself and his environment. The higher the education of health workers, the wider the knowledge of these health workers, so that the higher the work ethic they have. The length of time a midwife has

worked in a village can be identified with the amount of experience she has. The more experience a person gains while working, the midwife's knowledge also increases, with this knowledge and experience midwives can adapt to the job they are carrying [46]. Employment status can be a benchmark for the level of employee welfare, and can bind the employee to work in the institution he occupies. Midwives in the village have been able to carry out the empowerment process well. This means that employment status is not related to the ability of village midwives to carry out community empowerment processes. The midwife's residence in the village [47-57]. Access or range of residence to workplace is an important thing to note. Due to the long travel time spent on the trip, it can affect the performance of midwives.

4.2 Psychological Conditions of Midwives in the Village

In order for the community empowerment process to run well, of course training is not only for health workers, but more importantly community leaders who serve as role models for the community can understand the philosophy of Desa Siaga development which is solely for the benefit of all levels of society. From the results of the interviews it is known that the readiness of the village midwife as a facilitator is 23%. The village midwife still needs support from various related parties in the village, and even unpreparedness as a facilitator, because 12% is due to their limited ability to empower the community. Therefore, it is this readiness as a facilitator that needs to be improved so that the attitude of the village midwife supports the community empowerment process in the development of Desa Siaga. If the midwife in the village has not met her physical needs, then her motivation is low even though acting as a facilitator is her job as a health worker in the village [58-64]. Therefore, it is necessary to have facilitative supervision from the Guidance Team at the sub-district or health center level, not just instructive supervision which will add to the burden on midwives in the village.

4.3 Involvement in Social Activities

Being active in social organization activities has no significant relationship with the ability of village midwives to carry out community empowerment processes in the development of Desa Siaga. One form of participation of health workers is their active participation in community activities. The results showed that the level of activeness of the village midwife in community activities was significantly related to her ability to carry out community empowerment processes.

4.4 Ability of Midwife in the Village to Conduct the Community Empowerment Process

The ability of midwives in the village to carry out the community empowerment process with several stages by helping the community find problems, carry out analysis, determine priorities, find solutions to problems, take concrete actions, and evaluate activities in the development of Desa Siaga.

The results of the study showed that a small proportion (4.9%) of the abilities of the Village Midwife included good criteria in helping the community find problems. This includes the nominal group technique, with the Delberg technique (Delberg Technique), where problems are determined by a group of people who do not have the same knowledge about the subject matter being discussed. Because of this knowledge dissimilarity, the process of finding existing problems cannot be carried out easily. Desa Siaga can be the executor in carrying out one of the actions, namely conducting an analysis of existing data, assisted by the Midwife as the facilitator. The results showed that the ability of midwives in the village to help the community perform data recapitulation and analysis well was 53.7%, this was not as optimal as expected. So that special assistance is needed for the community, such as on the job training which is carried out by midwives on an ongoing basis and the results are controlled together continuously to see how far the community is able to carry out proper analysis independently without depending on the midwife's instructions. Duties and functions of midwives as facilitators must explain the extent of problems that can occur in all age groups, the nature of problems that can result in death, and the magnitude of the impact/risk of these problems which will eventually lead to Extraordinary Events (KLB). Because the determination of different knowledge is hampered, midwives need understanding to be more applicable and to provide learning information that is easily understood by the community, so that the community can determine the priority scale of the various problems they face. Nurses and paramedics, in this case the midwives in the village, make decisions using a

decision-making method based on four things, namely based on experience, based on existing standards/procedures, based on education or theory possessed and consideration of more skilled people [65]. The results of this study indicate that the ability of midwives in the village to help the community find solutions to problems is only 52.4% which includes good criteria.

The ability of midwives in the village to help the community take concrete actions is only 57.3% which is included in the good criteria. This is because midwives in their implementation are only as facilitators and the community as the main subject of the empowerment process, so that the actual actions taken are highly dependent on the potential, situation and conditions of the local community. In the process of evaluating community empowerment programs, it can be slow and long, one might even say that it never stops completely. The results showed that only 56.1% of the ability of village midwives to help the community carry out evaluations included good criteria. This is in accordance with the description of the health education program by Marry Arnold, said to be a spiral picture, which gives an illustration that one result influences the other (Machfoedz and Suryani, 2007), this shows that if the planning process is good, then the implementation process is good, as well as the process at the next stage, namely evaluation. It often happens in the program evaluation process, where certain things that are part of community empowerment can only be successful and achieved several years after the activity is completed [66]. So that for the empowerment process, the implementation of the evaluation has not yet reached the output to be achieved, but for the time being we are still evaluating the process that is being carried out towards the next empowerment process.

4.5 Relationship between Individual Characteristics, Psychological Conditions and Involvement in Social Activities with the Ability of Midwife in the Village to Conduct the Community Empowerment Process

The results of the statistical analysis stated that there was no significant relationship between individual characteristics and the ability of village midwives to carry out community empowerment processes. Thus, whatever the characteristics of the midwife in the village, it is an asset to be able to facilitate the community so that they are empowered to behave healthily. The results of the analysis of the psychological influence of village midwives on the community empowerment process show that attitudes and levels of motivation are significantly related to the ability of village midwives to carry out community empowerment processes, while knowledge is not related to the ability of village midwives to carry out community empowerment processes. The results of the analysis of the psychological influence of village midwives on the community empowerment process show that attitudes and levels of motivation are significantly related to the ability of village midwives to carry out community empowerment processes, while knowledge is not related to the ability of village midwives to carry out community empowerment processes [67-74].

4.6 Design of Efforts for Increasing the Capacity of Midwife in the Village to Conduct the Community Empowerment towards an Active Alert Village in Pidie Jaya District

Increasing the knowledge and understanding of village midwives regarding their duties and responsibilities as village midwives, increasing the positive attitude of village midwives towards the Community Empowerment Process in Village Alert Development, increasing the work motivation of village midwives as Village Alert facilitators, increasing the activity of village midwives in social organizations , Increase the activity of midwives in the village in community activities, Increase the activity of midwives in the village in community activities.

5. RESEARCH LIMITATIONS

The results of this study cannot describe the sustainability of the development of Desa Siaga as a whole, because the unit of research analysis is only the midwife in the village, even though to develop Desa Siaga in a sustainable manner requires the involvement of all stakeholders and components of society to play an active role according to their duties and functions.

In addition, this research only describes the ability of midwives in the village in the community empowerment process without taking into account the difficulties with the social, cultural and economic conditions of different

communities, of course, a different approach is needed. Precisely this community approach strategy is the key to the success of community empowerment programs.

6. CONCLUSION

Midwives in the village with the most individual characteristics aged less than 35 years, married status, Diploma-III education, with a working period of more than 6 years and most have become civil servants and live in the village where they serve.

The knowledge of village midwives about the development of Desa Siaga is 91.5% good, but the attitudes of village midwives towards the community empowerment process in developing Desa Siaga are more unsupportive, namely 57.3% and those who support 42.7%. Meanwhile, midwives in villages who have high work motivation as facilitators for Desa Siaga development are 58.5% and those who have low motivation are 41.5%.

The level of activeness of the Village Midwife in social organizations, such as TP activities. PKK in the village, TP. PKK in sub-districts, and the activities of religious organizations, are still very low at 3.7%. While the level of activeness of village midwives in community activities still needs to be increased because 57.3% are active, 37.8% are less active and even 4.9% are not active.

Only 57.3% of midwives in the village can carry out the community empowerment process well, while 42.7% are still considered unfavorable. Of the 6 (six) stages of the empowerment process, only 70.7% help determine priorities. Other processes such as helping to carry out data analysis, helping to find solutions to problems and helping to take concrete actions as well as helping to carry out evaluations are only around 50% which are considered good criteria, even helping to find problems is only carried out well by 4.9% of village midwives.

The relationship between individual characteristics, psychological conditions and involvement in social activities with the ability of village midwives to carry out community empowerment processes Efforts to increase the capacity of village midwives carry out a community empowerment process to achieve Active Alert Villages in Pidie Jaya District.

CONSENT AND ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Author has declared that no competing interests exist.

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