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Lessons for the developed—from the Third World

*Pembinaan Kesejahteraan Keluarga* is a nationwide women’s organization in Indonesia with strong government backing, which works for family welfare, community development, and a decent standard of living. It encourages community self-help and is heavily involved in health care. The author suggests that some of the features of the country’s health education programme, which uses the organization to disseminate information, might advantageously be adopted in the design of a community-based, culturally appropriate health education and support programme in the USA.

Indonesia comprises 13,677 islands and in 1984 had a population of about 160 million. Approximately half of the people are under 20 years of age and some 80% live in rural areas. There are about 300 ethnic groups and some 365 languages and dialects are spoken. Islam is the religion of 90% of the population, the remainder being Christians, Hindus, or Buddhists.

Women constitute about half the adult population. Problems experienced by them include low income, illiteracy, marriage when very young, and some social and cultural values unfavourable to them. The task of educating women about child health is made difficult by these circumstances.

During the current five-year development plan the Ministry of Health aims to decrease the infant mortality rate through the integration of programmes in immunization, maternal and child health, nutrition, diarrhoeal disease control, and family planning. Implementation occurs at village level, where multiple health service posts are set up every 1–2 months. Several services are offered: the weighing of children; the plotting of the weights on growth charts; discussion of the charts with the children’s mothers; giving the mothers information on nutrition, diarrhoea control, and child health; and family planning. Volunteers from the Family Welfare Movement (*Pembinaan Kesejahteraan Keluarga*) and paid staff from local health department clinics provide these services.

**The Family Welfare Movement**

This is a nationwide organization of women at all levels of economic status in both rural and urban areas. It is a voluntary grass-roots body working for community development, improved welfare, and a decent standard of living. Since mothers hold the central role...
in the family, the Movement's programmes focus mainly on them. The long-term goal is to attain a just and prosperous society. Each woman's efforts to improve her home and community are seen as also improving the whole country's well-being.

The Movement began in the 1960s at the provincial level when teachers and others concerned with the social welfare of women began to encourage their participation in literacy classes. The initial approach emphasized women's knowledge and strengths. The leaders identified women's individual expertises, e.g., in herbal medicine, and encouraged each woman to share her knowledge with others. In 1968 the government's literacy programme became available at village level and many members of the Movement participated in it. In 1972 the Ministry of Home Affairs recognized the value of the Movement's activities in rural development and recommended that it should reach out to new locations. In 1981 it was made a component of the Ministry's rural development programme and given a small annual budget to cover travelling expenses, the purchase of books and training materials, and the renting of meeting places.

Programmes are implemented in the villages by kaders, who are lay women trained in areas such as health, nutrition, home projects, and agriculture. Ten basic programmes provide the framework used by villages to design their activities. The programmes relate to:

- housing and home economics;
- education and handicrafts;
- health;
- promotion of cooperatives;
- protection and conservation of the environment;
- domestic planning.

The socializing that occurs at meetings of the Movement appears to be widely enjoyed. The Movement's song is sung at some meetings, and there is a song for village children, one verse of which includes the words "I am a healthy child, my body is strong because my mother was diligent when I was a baby. I was given breast milk, immunizations and nutritious food".

A rotating loan game called Arisan is frequently played: a group of women agree to participate weekly for a specified number of weeks; each week they donate a fixed sum of money and one participant's name is randomly selected as the winner. A winner's name is not subsequently included in the draw but she continues to make her contribution. The result is that each participant wins once. Winning a large sum of money enables each woman to make a major purchase without having to borrow.

In general, officials and their wives at each administrative level oversee both state and Family Welfare Movement activities at the levels below. The organization and
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hierarchical structure of Indonesian society appear to be well understood by all.

Through an outsider's eyes

It was felt that a developed country like the USA might benefit from the experience of programme-planning gained in Indonesia. Our aim was to describe a national health education programme that utilizes an existing community organization, the Family Welfare Movement, for the dissemination of information, and to consider which concepts discovered in the Indonesian model might be applicable in efforts to improve the health of low-income families in the USA who are not English-speakers. It is conceivable that the health of families who traditionally do not attend health education classes, and for whom the United States health care system is not culturally appropriate, could be improved with the help of lay health workers and organizations associated with the appropriate cultures.

Our exploratory study was conducted in various settings in Indonesia over a period of six weeks during July and August 1986. Data were collected through interviews, Public Health Nursing determined the schedule, the persons to contact, and specific locations. The proposed sites represented a convenience sample based on the availability of health staff and interpreters and reflected the focus on public health nursing and the Family Welfare Movement.

Interviews

The interview settings included offices, restaurants, homes, meeting-halls, clinics, vehicles, boats, aeroplanes, and forest clearings in West Java, East Java, and Nusa Tenggara Timur. In total, 88 interviews lasting between 20 and 90 minutes were conducted. Fourteen people were interviewed more than once over a period of days. Notes were taken during the interviews. The interviewees included health officials and administrators, public health nursing administrators, non-Indonesian health consultants, nurses, midwives, physicians, leaders of the Movement at provincial level, members of the Movement at neighbourhood and village level, and mothers.

Participant observation

The author's degree of involvement during participant observation varied from passive to moderately active. Passive participation occurred at a women's meeting for reading of the Koran, a literacy class, a nursing graduation ceremony, and visits to health posts and clinics where maternal and child health care was provided. Moderately active participation, a combination of being an outside spectator and an active participant, was possible at several meetings of the Movement, at clinics, and during home visits. In villages visited with representatives of the Movement from the capital, people lined the streets, military formations turned

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out, children’s choirs performed, and numerous health workers attached to the Movement appeared in uniform.

The 26 instances of participant observation took place during home visits with health workers, non-health activities of the Family Welfare Movement, health activities in health posts (posyandus) of the Movement, formal meetings of the Movement, community clinics (puskesmas), and a tuberculosis control clinic, in an orphanage, and at a nursing school graduation.

Findings

How and why is the Family Welfare Movement a viable, active, well-attended organization in some areas of Indonesia? Several cultural elements appear to

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Field notes

Notes were taken during interviews and participant observation and were added to as soon as possible afterwards. The author’s reactions and feelings were recorded so that their influence on the research could be taken into account.

Data analysis

The analysis started by classifying the data in categories such as “showing initiative” and “encouraging teamwork”. Several categories were then grouped together; for example, both “showing initiative” and “encouraging teamwork” are characteristics of “effective leadership”. “Effective leadership” was again grouped with other characteristics such as “community participation”, both of which were considered to be “factors contributing to successful programmes of the Movement”.

After having thus classified the data, analysis was undertaken by identifying different characteristics which led to similar results, or one characteristic which seemed to lead to different results. In that way, recurrent themes were identified, such as “the role of women”.

Societal organization. The hierarchical structure of Indonesian society was a dominant characteristic that contributed to the successful functioning of the Movement. This was demonstrated by the many volunteers who devoted long hours to the Movement’s programmes; they did so partly because of the obligation that came with status in the hierarchy. Women at any given level appeared to comply readily with the expectations of those at the next higher level.

Role of women. As a result of their involvement in the Movement, women have gone beyond the kitchen and field to express themselves in village politics. Thirty years ago women were afraid to venture from their villages; now they think nothing of visiting the nearby town and health centre. This increase in women’s self-confidence
strengthens the Family Welfare Movement, and in turn more women are favourably affected. Women, and particularly mothers, have always been highly esteemed in Indonesian society, and this is undoubtedly one reason for the success of the Movement.

It was noticed that officials and leaders of the Movement who visited villages were greeted by both men and women but that the meeting halls were filled only with women. During events organized by the Movement, men helped with logistical tasks but the limelight and prestige were reserved for the village women, the men remaining on the sidelines. All this emphasized the importance of women to the well-being of the family and the village.

Leadership of the Family Welfare Movement. The ability to motivate people was frequently mentioned as an important quality in leaders. Interestingly, the word “motivator” was used by the Movement’s leaders to describe their main function. The leaders delivered speeches that were clearly designed to motivate volunteers to take action. The mother was presented as the most important person in the family: she made the home, homes made the country.

Village health workers. The kaders’ challenge is to bring information to the remote villages, facilitate the implementation of development and health programmes, and motivate residents to participate in and accept the new programmes and ideas. Some of the most helpful characteristics of village health workers are dedication, willingness to work and take responsibility, and pride in the tasks done. Literacy and an ability to learn are important, although some interviewees claimed that a high level of motivation was more so. Kaders with strong interpersonal skills understood people’s questions and imparted information in a manner that allowed villagers to assimilate it easily. Such kaders were able to relate to villagers as “insiders” and respected their beliefs and traditions.

Motivational factors in the Family Welfare Movement. Motivating village women and
Kaders to participate in development programmes was a recurring theme in interviews with members of the Movement and officials of the Health Department. Women were motivated to participate in the Movement’s activities by the prospects of affective rewards, cognitive rewards, social change, togetherness, competition, and tangible rewards.

Affective rewards consisted of feelings of importance, pride, status and prestige resulting from being a kader. Cognitive rewards included the opportunity to participate in classes on agriculture and other subjects, to learn to solve problems, and to learn skills for the home.

The opportunity to participate in efforts to bring about social change motivated a number of participants. The most frequently mentioned motivational factor was that of togetherness; the enjoyment of group activities such as praying, reading the Koran, and celebrating holidays together was included in this category.

Tangible rewards were rare. In fact, the policy in most places was to encourage voluntary participation and self-help without remuneration or tangible incentives. However, two responses indicated tangible items as motivating factors. The products resulting from an activity of the Movement, e.g., craft or food items, motivated one participant. The other instance of material gain involved the promise of electrical power for a whole village.

Lessons for the USA

The study reveals both culture-bound and cross-cultural characteristics pertinent to the health education model that uses the Family Welfare Movement in Indonesia. Culture-bound characteristics may not be relevant to the USA; they include the organizational structure of society and the Movement, the degree to which community self-help is practised, and the role of women.

The organizational structure includes a hierarchical pattern such as does not exist to the same extent in the USA. Nevertheless, there may be some communities or ethnic groups in the USA in which there is a hierarchical structure with role expectations that would encourage participation in a group like the Family Welfare Movement: the bottom-up planning and implementation philosophy is a model worth considering. Since the Movement is affiliated to both the Health Department and the Directorate-General of Rural Development, the result is a programme concerned with all aspects of individual and family life, from agricultural skills to health and hygiene. In general, programmes in the USA address

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specific issues and exclude related ones. The USA should examine the benefits of an integrated programme, as seen in Indonesian health and rural development efforts.

Gotong royong differs from the more self-interested orientation found in the USA: the transient nature and relative isolation of the nuclear family make community
self-help unlikely, at least to the extent practised in Indonesia. Nevertheless, the volunteer spirit exists in some parts of the USA and could be harnessed to implement programmes similar to that of the Family Welfare Movement.

The role of women in Indonesia is sufficiently different from that of their United States counterparts to suggest that the creation of a group like the Family Welfare Movement in the USA may not be possible: an organization modelled on the Indonesian Movement might look quite different there.

Several elements that contributed to success in Indonesia are parts of human nature that may transcend cultural boundaries and thus may be applicable in the planning of community interventions elsewhere. These elements include leadership and kader qualities and motivational factors. Leadership and kader qualities may deserve attention when personnel are selected for health and social programmes in the USA.

Factors that motivated participation in the Movement may not all be applicable in the conditions of the USA. However, most such factors cross the boundaries of culture. Perhaps, in populations that are cognitively orientated, the cognitive rewards would be more likely to motivate than the affective or competitive rewards. The motivation of sharing and enjoying group activities and experiencing a sense of togetherness could be highly motivating in the USA, where many families live in relative isolation. Such sharing and social support could be particularly rewarding for recent immigrants, and could provide a forum for culturally appropriate health education.

The Indonesian maternal and child health education programme, which disseminates information via the Family Welfare Movement, has some characteristics that might be useful in designing a community-based, culturally appropriate health education and social support programme in the USA.

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Reference


Editor’s Note

The Chief Executive Officer of the Indonesian Family Welfare Movement (PKK), Mrs Kardinah Soepardjo Roestam, wrote about her experiences for World Health Forum’s Round Table on ‘Leadership in health’ in the last issue (World health forum, 9: 167–169 (1988)). The Family Welfare Movement was awarded the Sasakawa Health Prize at the 41st World Health Assembly in May 1988 (see WHO Notes & News section in this issue, p. 471).