Women's impetus in community and health development

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Women in Indonesia are playing an increasingly large part in economic activity and community development. Moreover, they are making a significant beneficial impact on the nation’s health, most notably, perhaps, by helping to secure financial resources. The present article describes some of the ways in which women are working to improve the well-being of the Indonesian people.

In modern Indonesia, women are assuming an increasingly important economic role in addition to their domestic responsibilities. Over 40% of the country’s workforce of 86 million consists of women. Recognizing their importance in national life, the government has established the State Ministry for Women’s Affairs with the aim of fostering their well-being and harnessing their potential for the benefit of all. Considerable progress has been made, notwithstanding shortages of funds, facilities and trained personnel at the grass-roots level.

Community development projects

Management and leadership training programmes for women are being conducted, and self-help is considered vital in community development projects, which have the following characteristics.

- Women whose work is primarily in the home are being trained in handicrafts and other skills with a view to selling produce in local markets.

- Integrated health posts or posyandu are being developed in hamlets, villages and neighbourhoods. Questions of water supply, sewage and garbage disposal, and the quality of house construction are being addressed. Health service interventions are underpinned by health education, and communities obtain technical support from their local health centres. Communities are encouraged to provide finance to meet their own requirements in the health field.

- A special effort is being made to eliminate illiteracy. Reading materials contain messages on health, hygiene, sanitation, environmental cleanliness, and economic and agricultural subjects.

- A religious and cultural basis is considered to be necessary for the development of socially responsible attitudes and behaviour in relation to health and other matters.

Action by wives of civil servants

All Indonesian civil servants and their families enrol in the state health insurance scheme, which is funded by a levy of 2% on basic salaries. Members are entitled to free treatment, including the provision of drugs, at government health centres and hospitals. Dharma Wanita, an organization of the wives
of civil servants, has signed a memorandum of understanding with the scheme whereby a programme of health promotion and disease prevention is being set up.

In Jakarta, where the scheme has almost a million members, surveys have been conducted on disease patterns, utilization of the health services, and related matters, and the findings have led to the initiation of health education projects and the holding of seminars on self-care. Attention is given to the prevention of communicable diseases such as conjunctivitis, worm infection, and AIDS, and of non-communicable diseases, among them heart diseases, diabetes mellitus and hypertension.

**Village-based health insurance and care**

*Dana sehat* is a village-based health insurance scheme in which funds or marketable commodities are gathered in accordance with the tradition of mutual aid within the communities, known as *gotong royong*. The prime movers may be local leaders, local government staff, people working in nongovernmental organizations, including women’s organizations, and ordinary members of local communities. Over 4000 villages have *dana sehat* schemes, covering about a million households. Some examples follow.

- In the village of Pejaten, Bali Province, the scheme comes within the village cooperative movement. The population is about 3000 and most of the adults are engaged in brick and tile production. The scheme was started by 78 villagers in 1976, when funds were raised by holding concerts and other means. In 1978 the entire village decided to join and the monthly levy was fixed at 30–40 tiles per family. The headman coordinated the marketing of the tiles and the money obtained was spent on drugs for the village clinic, where free treatment and referral to the subdistrict health centre, three kilometres away, were given. In 1982 the contribution system was changed so that each household began paying the equivalent of US$ 10 a year. The accumulated capital has made it possible to extend credit facilities for purposes of latrine construction, cattle raising, education and so on.

- A pilot prepaid community health programme was inaugurated during 1987 in Kerambitan Subdistrict, Bali Province. The target population comprised some 30,000 people in 15 villages. A survey indicated that 57% of the people desired only basic outpatient care, 5% wanted only inpatient care, and 27% preferred a combination of both. A preference emerged for a programme providing access to both public and private facilities. On these grounds it was decided to provide basic services, referral services and inpatient care, using the personnel and facilities of the two sectors. The running of the programme is greatly helped by the existence of the traditional *banjar* or hamlet organization and Pem-inaan Kesejahteraan Keluarga (PKK), the Indonesian Family Welfare Movement.

- In 1988 a *dana sehat* movement was started in Candidoto Subdistrict, Central Java Province, with a potential membership of 49,000 people. The basic ideas were promoted, focus group discussions were held, meetings were arranged with village representatives, an operational plan was formulated and contributions were collected. Management of the scheme is in the hands of a village cooperation unit. The PKK has
played an important role, especially in encouraging families to participate. The monthly payment is Rp 100 per person, 25% of which is retained for village activities connected with the scheme.

- In Jakarta a scheme is in preparation for the benefit of home handicraft workers and small-scale traders and food manufacturers. The initial steps being taken by health providers are similar to those outlined above for the Candirotto Subdistrict.

- A scheme started in 1988 in the Sungai Puyuh Subdistrict, West Kalimantan Province, is run largely by women. The monthly contribution is Rp 300 per individual and members are allowed to borrow at an interest rate of 1% per month.

Village polyclinics where women can give birth are maintained, managed and financed by local women’s organizations. Dharma Wanita is involved in similar work, whereby rooms are provided by families in village houses for this purpose. The patients, accompanied by family members, have the opportunity to use the accommodation before, during and after delivery. Charges are made to cover the costs of maintenance, hygiene, sanitation, delivery, health education, demonstration of supplementary feeding, referral and so on.

In the light of the above observations it is worth drawing special attention to the following points.

- Education on the equality of men’s and women’s roles should begin in childhood, and perceptions on the differentiation of tasks and functions between the sexes should be adjusted to reflect the concept of equal rights.

- As regards the collaboration between Dharma Wanita and the state health insurance scheme, it is important that the health education programme be well planned and based on needs and demands, and that the service provided should match the information issued about it.

- Proper basic and referral services should be provided in return for financial contributions from communities, and a clear statement of financial matters should be available to all citizens.

- Nongovernmental organizations, especially those of women, have shown tremendous dedication, especially in the establishment of village health insurance schemes.

Women, acting individually, in small groups or through major nongovernmental organizations, now play a vital role in the development of health care in Indonesia. They are in a good position to disseminate information on health insurance, and educational programmes on this subject should therefore be directed at women’s organizations. With a view to expanding community health insurance schemes, studies should be made on the perceptions, attitudes and knowledge of women in this field. Finally, it is necessary to improve the services provided under such schemes, to understand the constraints and problems they face, and to formulate action programmes based on mutual aid.