Development

Community mobilization and empowerment for health
Darmayanti Saludung

The present article traces the history of “dana sehat”, a scheme of social funding devised in Indonesia three decades ago which has proved to be of particular significance as a means of inducing communities to accept responsibility for decision-making on the development of health care.

In response to the inadequacies of the official health services in Indonesia during the 1960s, a scheme known as dana sakit (funds for the sick) was proposed by Dr Gunawan Nugroho for a poor community near the Panti Waluyo Hospital in Solo, whereby the sick were to be supported by the healthy. Unfortunately, there was little public response and the scheme failed.

Birth of “dana sehat”

In 1969, within the framework of a community development programme introduced by the hospital, a campaign was conducted to clear drains and so prevent flooding. This activity was well understood by the people, who received allocations of wheat in exchange for their participation. The programme also included women’s courses, health and nutrition education, care for infants and preschool children, and family planning, and dana sakit was reintroduced under the name dana sehat (health funds). Members of the scheme paid a monthly fee of 0.5% of average family income, equivalent to US$ 0.06, which was deposited in a credit cooperative whose revolving capital was thus augmented. Members of the cooperative borrowed money at low interest, thus further increasing the fund.

A household survey was organized on education, family size and income, expenditure on food, and the use of herbal remedies, cigarettes and medical care. The resulting baseline data made it possible to give meaningful information to people about the aims of dana sehat and the prospects for affordable health care.

Discussions between health workers and the community indicated that, using available facilities and resources, the short-term objectives of dana sehat should be to provide simple, practical and inexpensive health care appropriate to the local situation, and to maintain adequate health standards. For the longer term it was

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The Sirkandi initiative

A young medical graduate went to Sirkandi, a poor village deriving its income mainly from palm sugar, where he initiated a "dana sehat" programme similar to that in Solo, 200 kilometres distant. Using a health centre situated 5 kilometres away as his base he developed a comprehensive community health programme, including a prepaid health scheme, relying on voluntary health promoters who had been trained to provide primary health care and home care. Active community participation was sought in public meetings and discussions with community leaders. A loan from the health centre helped the community to build a small dam for improving the irrigation of the village’s rice field, resulting in a 25% increase in yield. The community became aware of its potential, activity increased rapidly, and malnutrition became rare. Surrounding villages, observing these achievements, emulated them, and health officials in the area recognized the value of "dana sehat" as a support for government health programmes.

Primary care was provided by a nurse-midwife and voluntary health promoters. Children aged under 5 years were weighed regularly, and mothers received advice on nutrition, immunization, hygiene, sanitation and family planning. Decisions on priorities, plans and actions relating to the programme were made by the committee, which consulted the health workers on the feasibility of its proposals.

Environmental improvement projects helped to raise health standards, as did vegetable growing and the raising of rabbits and goats. Better health meant that clinic bills were reduced and resources were released for further developmental activities.

Expansion

Various private bodies and government agencies asked Dr Nugroho to introduce dana sehat to their health professionals and administrators, and a training programme was therefore organized. The trainees were exposed to field situations and were encouraged to find solutions to the problems they encountered and to mobilize resources for implementing them. They were asked to conduct a survey, talk with community leaders, and observe community life. The structure of the programme evolved as a reflection of the problems that arose, which were tackled in order of priority. It soon became clear to the trainees that solutions could not be imposed but had to be worked out with the people in order to ensure their cooperation.

The present author visited the dana sehat programme in Solo on several occasions and was able to set up a similar scheme on the outskirts of Semarang, where the
people could not afford to pay for health care. Various charity organizations became interested and a training programme was established for them. Many different types of dana sehat scheme were devised because there were no standard procedures to follow.

Because interest in dana sehat diminished after the initial enthusiasm, a national seminar on the subject was convened in 1988 with Dr Nugroho as consultant, to which government agencies and private bodies were invited. A committee was appointed to define the concept of dana sehat and to draw up procedures for its application. The Foundation for Health Development was created with the role of promoting dana sehat and providing a training programme for people from all parts of Indonesia. Seminars were conducted in many areas. Schemes were devised for various occupational groups, including farmers, church members, schoolchildren and their teachers, vendors and tricycle operators. Their main purpose was to help people to pay for services, which were usually provided by government health centres and dispensaries or by private hospitals. Schemes were also designed to provide a framework for community health development, using the slogan “How to live a healthy life”. Attention was directed at requirements for water, food, shelter and income-generating activities.

The Foundation for Health Development was consulted by the government on the use of dana sehat as a mechanism for mobilizing local resources in support of state health programmes. By 1995 some 7 million people were benefiting from dana sehat schemes.

In Central Java the dana sehat concept was applied in an effort to improve the health status of roughly a million people in the Wonogiri Region. The following criteria were used as indicators of healthy lifestyles in families:

- at least four visits per pregnancy for prenatal care;
- participation in family planning;
- weighing of children aged up to 5 years at least eight times a year;
- every person possessing a toothbrush;
- no alcohol consumption;
- weekly participation in a mosquito eradication programme;
- eating three meals a day;
- availability of latrines and potable water;
- having a herbal garden or access to essential drugs;

Vector control by the community

In the early 1970s there was an outbreak of what was suspected to be dengue fever in the vicinity of the Panti Waluyo Hospital. The “dana sehat” committee sought medical advice. A rapid survey revealed that the mosquito vectors of the disease were breeding in water that had accumulated in old tyres, bamboo growth and garbage. A cleanup campaign was organized, and the numbers of people with the disease declined during the following months.
– active participation in a dana sehat scheme.

Contributions ranged from $0.22 to $0.30 per person annually, which was within the reach of the average family. The schemes increased the coverage of the state health system and made health services affordable. There are indications that the health of the people in Wonogiri is improving: the infant mortality rate is now 18 per 1000 live births, which compares favourably with the national figure of 58/1000, and there is relatively little malnutrition among children aged up to 5 years.

Dana sehat offers a practical framework enabling communities to act in the interest of achieving and maintaining good health. It requires participation by government and the private sector, with decision-making power in the hands of the communities. It uses local resources for financing health care and community development. Honest, committed leadership is required, whether individual or collective, to guide communities in their struggle for a better life.

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How to make the most of village health promoters

Attia Z. Taha

In a rural area of Bangladesh the methods used by village health promoters and the time available to them for their intended tasks were inadequate. Poverty and illiteracy in the community exacerbated their difficulties. Ways of tackling these problems are discussed below.

During 1990 the first steps were taken to establish a health development project in Bangladesh’s Ukhaia subdistrict, with a predominantly rural population of approximately 122,000 people. Health and social services were minimal and high morbidity and mortality rates were associated with preventable diseases. The main aims were:

- to improve the curative, preventive and promotional aspects of the health system;
- to train 200–250 community health workers as village health promoters over a five-year period;
- to foster socioeconomic development by supporting income-generating projects.

Roles

In April 1994, almost two and a half years after the health development project began to be implemented, the performance was assessed of the 28 male and 27 female village health promoters who had by then been trained. The priorities for action at this time were to distribute health cards and, in order to prevent diarrhoea and intestinal infections, to motivate families to install and use sanitary latrines and tubewell water. Each village health promoter was expected to provide health education by visiting 150 houses per month as well as health posts and schools. Certain houses in the community were also used as centres for health education. All the village health promoters spoke to both individuals and groups. Blackboards were used in schools and health posts by about a quarter of them, and a similar proportion used posters and leaflets.

It was intended that the village health promoters should provide comprehensive primary care, including:

- education on personal hygiene, the management of diarrhoea and the use of latrines;
- mother and child care;
- immunization;
- house registration and the distribution of health cards.

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Community leaders said that the village health promoters were widely accepted by the population. The activities of the village health promoters as reported by both themselves and the community leaders involved:

- visiting houses to distribute health cards and educate people about personal hygiene, sanitation and the prevention of communicable diseases;
- providing health care for mothers and children, including immunization;
- motivating families to buy and install slab latrines;
- vaccinating poultry.

**Coverage**

A sample of 300 households in the project area, 60 in each of five villages, was compared with a similar sample in a nearby control area. Mothers who had at least one child aged under 5 years were interviewed by women who had been trained for this work. The views of community leaders were sought in focus group discussions in four of the five selected villages on such matters as the kinds of activities performed by the village health promoters, the adequacy of the time they spent on health activities, and the needs and expectations of the communities. A structured questionnaire dealing with these and other matters was used in interviews with a total of 15 village health promoters in the same five villages and two additional ones.

In the project area it was found that 183 of the sample of 300 households had been visited by a health worker, 61% of the visits having been made by village health promoters. The failure to reach the target number of home visits by the village health promoters was evidently attributable to the scattered distribution of the households, the lack of transport, and the difficulties of travel during the rainy season. In the control area only 136 households were visited by a health worker. Of the 40% or so of households in the project area which received health education on personal hygiene, sanitation and the use of tubewell water, some 60% were covered by village health promoters.

There were sanitary latrines in 53 of the households in the project area sample, and one-third of these had been constructed by families responding to encouragement given by village health promoters. Unfortunately, household latrines were little used by family members, especially children. Tubewell water was used for domestic purposes by a higher proportion of households in the project area than in the control area, but even so half the households in the project area lacked a water supply of this kind and continued to rely on polluted ponds, rivers and canals.

Only about 7% of the village health promoters gave practical demonstrations. Role-playing, storytelling and other effective methods were not employed. The time spent on health activities by village health promoters, which averaged 3.5 hours a day, was considered too short by half of them and by two-thirds of the community leaders. The principal difficulties and constraints affecting the village health promoters’ work were said by both them
and the community leaders to be as follows.

- People were so poor and illiterate that they were unwilling to pay for health cards and were uninterested in health education.

- It was impossible to visit all the targeted households in the prescribed time because they were so scattered.

The efforts made did not, on the whole, succeed in inducing people to abandon unhealthy practices. The community leaders and village health promoters responded by suggesting:

- the creation of income-generating projects;

  Because the people were extremely poor they did not regard health education as a priority. The development of income-generating projects should be given urgent attention in conjunction with health and sanitation programmes.

- the establishment of health posts with essential equipment in villages lacking health facilities;

- the appointment of a female doctor to supervise female village health promoters and to help in the training and continuing education of village health promoters;

- the involvement of village health promoters in literacy work with both adults and children.

Towards increased effectiveness

Among the factors influencing the effectiveness of the village health promoters were the criteria used to select them, their initial and in-service training, the planning and logistics of their work, and the degree of community participation in the project. Village health committees were involved in the planning and implementation, and in the supervision and evaluation of the these workers, who were confronted by constraints and difficulties comparable with those reported from other parts of the world. Full evaluation of the project would require a functioning health information system and the use of simple health indicators.

Because the people were extremely poor they did not regard health education as a priority. Major factors determining their poverty were the shortage of cultivable land, the high rate of illiteracy and the large sizes of families. Resources such as chalk, blackboards and posters were inadequate, and the well-tried teaching methods of role play, storytelling and demonstration were neglected by the village health promoters. The target of 150 home visits a month for each of them proved impossible to achieve because the communities were so scattered and there were no means of transportation. With a view to improving health promotion the steps outlined below are desirable.

- The number of houses to be visited by each village health promoter should be reduced from 150 to 90–100 a month, thus allowing more time to be spent on health education. Clearly, this requires increased numbers of village health promoters.

- Village health promoters should be encouraged to use more effective techniques, given the high rate of illiteracy in the population. Training in these techniques for health promoters is essential.
The development of income-generating projects should be given urgent attention in conjunction with health and sanitation programmes.

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Health in the community
Through research and direct support of countries, WHO actively promotes community involvement in health aimed at enabling people to take responsibility for decisions concerning their health and to make their health services more effective. Community involvement in health now seems to be widely accepted in most countries. It finds its expression in such ways as ensuring equitable and rational distribution of resources for health; mobilizing funds from local, national and international sources; and making good use of the knowledge and experience available within the community.