Development

Community mobilization and empowerment for health
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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 sakti (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 sakti 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.

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*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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