Integrated Services Post (Posyandu) as Sociocultural Approach for Primary Health Care Issue

Pos Pelayanan Terpadu (Posyandu) sebagai Pendekatan Sosiokultural untuk Isu Pelayanan Kesehatan Dasar

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Abstract

The birth of Integrated services post (*Posyandu*) in 1980s is no doubt based on the effort of the Goverment of Indonesia to improve the health status of the population following the International call the Declaration of Alma-Ata (Kazakhstan) about Primary Health Care in 1978. The key concept of the declaration is community participation. In Indonesia specifically the community participation is called "*gotong royong*". Community plays an important role in the improvement of their own health. To involve community in the health care, the volunteer has to be recruited and trained to recognize basic health care issues. The idea is that the volunteers that called village health worker (*kader*) as part of the community would be much easier to deliver health programs because they are closer to them compare to the public health officials. This paper is intended to discuss *Posyandu* which is basically a sociocultural approach for primary health care as a strategy to improve the health status of Indonesian people.
Keywords: *Posyandu,* primary health care, sociocultural approach

Abstrak

Kelahiran posyandu pada tahun 1980-an merupakan usaha pemerintah Indonesia untuk meningkatkan status kesehatan masyarakat, mengikuti panggilan internasional, Deklarasi Alma Ata (Kazakhstan) tentang kesehatan masyarakat tahun 1978. Konsep kunci deklarasi tersebut adalah partisipasi masyarakat. Di Indonesia, partisipasi masyarakat disebut "gotong royong". Masyarakat memainkan peran penting dalam meningkatkan kesehatan masing-masing. Untuk melibatkan masyarakat dalam kesehatan masyarakat, relawan harus direkrut dan dilatih untuk mengenal isu-isu kesehatan masyarakat dasar. Gagasan mengenai relawan yang disebut kader (*village health worker*) tersebut diajukan agar relawan sebagai bagian dari masyarakat dapat lebih mudah menyampaikan program-program kesehatan karena lebih dekat dibandingkan pejabat kesehatan masyarakat. Di dalam artikel ini dibahas tentang Posyandu yang pada dasarnya merupakan pendekatan sosiokultural dalam pelayanan kesehatan masyarakat sebagai strategi untuk meningkatkan status kesehatan masyarakat Indonesia.
Kata kunci: Posyandu, pelayanan kesehatan dasar, pendekatan sosiokultural

Introduction

The establish of *Posyandu* in 1980s is no doubt based on the effort of the Goverment of Indonesia to improve the health status of the population following the International call that stated in the Declaration of Alma Ata (Kazakhstan) on Primary Health Care in 1978.[1] The key concept of the Declaration is community participation. In Indonesia specifically the community participation is called *gotong royong*. *Gotong royong* is Indonesia's original term that means working together to reach the result as wish including health status. Togetherness at community level is based on the spirit of big family. Community plays an important role in the improvement of their own health. To involve community in the health care at the widest sense, the volunteer has to be recruited and be trained to solve basic health care issues. The idea is that the volunteers that called village health worker (*kader*) as part of their own community would much easier to deliver health messages or programs because they were closer to them compare to public health officials.

Posyandu was born as the consequences of another Government program called *Pembangunan Kesehatan Masyarakat Desa* that was popular by its acronim PKMD. *Pembangunan Kesehatan Masyarakat Desa* or I may translated as Village Public Health Development (VPHD) that was initiated around 1975 was the effort of the Government

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of Indonesia to improve the health status of the community. The basic foundation in developing the program was based on reality that the socio-cultural history of the Nation inherited through generation called *gotong royong* and *musyawarah*. In referring to that, the concept of VPHD was developed by the spirit of familial relationship and helping to each other.[2] As written by Subekti M.D., MPH as the Director General Public Health Development (*Pembinaan Kesehatan Masyarakat*) at that time, the public health problem was very complex. Communicable diseases were still the number one enemy with high incidence and prevalence. Nutritional status especially for vulnerable under-five age group and pregnant women and lactation period were still under unsatisfaction condition. Safe and healthy drinking water, domestic waste disposal and sanitation were very bad. All those things were very close to poverty that mirrored on low level educational status, income, production, and consumption per capita. Also, there was strong relationship between social value and system of belief among ethnic groups were the factors that play important role in the health development.

As the government activity, VPHD was relatively new, although The Department of Health had identified that more than 200 locations or villages throughout the country already conducted various activities that had the same direction with VHPD. According to the report, at Central Java alone at that time already existed 400 locations as mentioned before. Those reality was the evidence that there was a real need on community side, and community has the capacity to conduct VPHD activities. The VPHD that developed sistematically by the government was actually to respond community desire and intention positively. Advance analysis showed that the important foundation of the Program is *gotong royong* principle that deeply rooted in Indonesia society.

Gotong royong and *musyawarah* are old custom that practiced widely in Indonesia. Family or community need identification and decision making process are reached by concensus is a usual practice in rural areas. Activities are conducted based on help each other principle and conducted within familial spirit. Those efforts are not only limited to solve daily problems but also encompass development programs and those that become mutual interest. The facts mentioned above are the basic cultural and history of VPHD.

This paper is intended to discuss that *Posyandu* is basically a sociocultural approach for primary health care as a strategy to improve health status of people.

Maternal and Child Health: The Classical Public Health Problem in Development

The highly complex, reciprocal relationship between health and development has received considerable attention within the academic community and among development planners and practitioners. Within societies, the development process affects individuals and groups differently. Child-bearing is one of the biggest health risks for women worldwide and women in the world's least developed countries are 300 times more likely to die during childbirth than those in developed countries. Globally, approximately 536,000 women continue to die needlessly each year. Countries of the WHO South-East Asia and the Western Pacific regions count for more than 44% maternal and 56% neonatal deaths globally. Risks to women's health are linked to the quality of life and to the relationship of women to their economy, society, and culture.[3,4] Concernity about the health of mothers and children has gathered momentum in Indonesia in the 1950s with the establishment of mother-child health clinics throughout the country and the implementation of a traditional birth attendant training program. Influenced by the 1987 Nairobi Safe Motherhood Initiative and especially because maternal mortality remained high, the Government of Indonesia in 1989 initiated a national workshop to seek intersectoral commitment to improve safe motherhood. The outcome of that workshop was a decision to train and deploy a large number of community midwives to villages. Since then, other measures to safe motherhood have been undertaken, including the provision of basic emergency obstetric and neonatal care services at the sub district (*kecamatan*) level and comprehensive emergency obstetric and neonatal care services at the district (*kabupaten*) level.[5] In addition, communities, providers, and related sectors were mobilized to increase the demand of communities for such care and the effective utilization of maternal and child health services.

The Making Pregnancy Safer Strategic Plan launched in 2,000 symbolized the Government's commitment to increase both the supply of and demand for emergency obstetric services.[5] Despite these measures, maternal mortality continues to remain high. Current political will, the availability of comprehensive strategies to reduce maternal mortality and the availability of cost-effective technologies for addressing obstetric complications have not yet had a significant impact on the reduction of maternal mortality. The problem is simply that the safe motherhood policies have not yet been optimally translated into action at the service and community levels.

The main causes of maternal mortality are postpartum hemorrhage (PPH), infection, eclampsia, and abortion. In general, PPH is the most common cause of maternal mortality in Indonesia, which is estimated around 42% of the total maternal mortality. PPH is unpredictable; it may happen to women who do not have any complaints during pregnancy. PPH can be more dangerous for pregnant women who has anemia problem in sudden and will be more dangerous for pregnant woman who has anemia problem. Evidences show that those obstetric complications cannot be handled by traditional birth attendance.[5]

There are three delays in getting treatment when complication occurred that lead to maternal deaths: First, delay in recognizing critical sign and in decision to seek care from health facility because of lack of decision making by pregnant woman for her health, socio-cultural factor, and ignorance on complications and its implications. Second, delay in reaching a health facility which may be caused by poor distribution of the health facilities, distance, and time to reach the health facility, limited transportation, and costs. The last, delay in receiving treatment at health facility which includes referral system, inadequate health equipment and medicines, limited well-trained health providers, and the availability of health providers in the health facility. Aside from the above factors, other factors that contribute to the unfavorable pregnancy are "four-too", i.e.: too young to be pregnant; too often, low spacing between pregnancy; too many children; and too old to be pregnant.

Posyandu

The growing of VPHD stimulates many community-based health endeavor (*upaya kesehatan berbasis masyarakat*) such as under-five weighing post, immunization post, village family planning post, health post, besides rural health insurance (*dana sehat*). Refer to the reality, in several places such as West Java it is designed to merge those endeavors into single program in order to make services easier. Besides, the basic idea is to provide full-service at one place so that it is easier for community to access (one-stop service). At the same time, many discussion held at international level about health improvement of the world population. In the international conference at Alma-Ata (1978), Primary Health Care (PHC) strategy was formulated. The key concept in the new strategy is community participation, a process by which people are enabled to become actively and genuinely involved in defining the issues of concern of them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing, and delivering health services and in taking action to achieve changes. In this case, communities play an active role on their own health services.[6-11]

In order to involve community in health services, the volunteers will be recruited and be trained to solve the primary health issues. The idea is the volunteers, called village health worker (VHW), will be much closer to their own community that will receive the service. In this strategy the VHW role is as communicator between health professional and community. It will reduce the communication gap socially as well as culturally. The idea then accepted in Indonesia promptly, whereas a project was conducted in Banjarnegara regency in early 1970s. The success of PHC strategy acceptance in Banjarnegara regency stimulated Government of Indonesia to apply VHW program at national scale on the first Five-Year Development Plan (1977 – 1984).

The Problem Approach in Public Health Development in Indonesia

Since 1982 Indonesia has National Health System (NHS) that arranged by the Department of Health. Through NHS, health development short and long term programs had been organized as good as possible in order to reach the goals in line with the NHS. Shortly, the NHS goals were the improvement of optimal health status through wide range, equal, and accessible health services, especially for low income people who live in rural or urban areas, and the enhancement of community participation actively within health endeavor.[4,9,12]

The Government recognized that to reach the goals stated in the NHS maximally, the role of social sciences could not be ignored. In order to solve the problems properly both at the levels and to assure the process of planning and implementation, monitoring and evaluation were on the right track is the area where social sciences could play their roles. All those things were appropriate with the principles of NHS that the components of subsystem input include population, community behavior towards health, environment, resource supply, and policy agreement.[12,13]

But in reality, there are many problems in implementing *Posyandu* as sociocultural approach for primary health care issues.[14] To the author's knowledge, there are three serious mistakes that underlie the implementation problem of *Posyandu*. The first is misconception about the meaning of "health".[15] This problem exists since the beginning of the program. Although the premise of *Posyandu* is from community to community program, but it could not be denied that the influence of health professional is very strong. The influence begins from the very basic thing i.e. the understanding about the meaning of "health".[15,16] Very often the health professional idea on "health" is in contradictory to community or lay person idea. Everyone, especially the health professional, engaged in the tasks of promoting health, starts with a view of what "health" is. However, there is a wide variety of this view, or concepts, of health. It is, important of the outset to be clear about the concept of health which we personally adhere to, and to recognize the differences from those of our colleagues and clients (community). Otherwise, we may find drawn into conflicts about appropriate strategies and advice that are actually due to different ideas concerning the end goal of health.

Secondly, there is a distortion of implementation of *Posyandu*. Philosophically, *Posyandu* program should cover not only the physical component of health but also mental and social components. In fact, the activity

in *Posyandu* mainly directed towards physical component only. The program only concern how to solve physical problem (ill-health), for instance how to improve or to increase the weight of the undernourished child without trying to find out and to solve the root cause of the problem. The child health program should follow the scheme on growth and development for instance the balance between age, bodyweight, and child intelligent. Although actually *Posyandu* has to extent the activity to the wider components (mental and social), but the mindset of the Government until the grass-root level still trapped into narrower view.[17-18] The third problem is about misunderstanding on the organization of *Posyandu*. Politically, the organization of *Posyandu* is under the Ministry of Home Affairs (*Kementerian Dalam Negeri*), health sector only one of several component in the organization. But, in practice public health center (*Puskesmas*) as the frontline of health sector becomes the main component and many other sectors rely heavily on this sector. Consequently, the performance of *Posyandu* in general is far from the early expectation as a community organization that reflects community empowerment and participation that indicated by strong sense of ownership.

Conclusions

Posyandu essentially is the socio-cultural manifestation of Primary Health Care approach that actually developed since 1970 but in 1975 WHO officially accepted. In the Declaration of Alma Ata (1975), Primary Health Care is formulated as follows: "Essential health care on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individual and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process". Compare with Community Development this PHC formulation obviously has five similarities, i.e. emphasized on community participation and initiatives from community itself; resources utility from community itself; character and mental building; intersectoral approach; the role of rural personnel (in PHC is rural health worker). Due to distortion from the original idea the performance of *Posyandu* in general is still far from the expectation.

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