Tackling health problems in remote areas with CSR

When we think about the remote areas of Indonesia, immediately we think about the lack of infrastructure, low education levels, poor communities and a lack of medical facilities. Their beautiful surroundings, clean environment and local wisdom are often told like a fairy tale, and are easily superseded by the negative news. Then, there comes the blame on everybody, i.e. local government and companies operating nearby.

One of the most common health problems in remote areas is rooted in poor sanitation and hygienic behavior. This also happens in urban and densely populated areas in Indonesia. The Health Ministry in 2014 reported that child mortality (age 0-59 months) is 44 in 1000 babies, largely due to diarrhea. Other data show that 40 percent of Indonesian people do not have proper sanitation facilities. It is believed that the improvement of sanitation practices and hygienic behavior is a key to reducing mortality. For that, the ministry issued Regulation No. 52/MENKES/SK/IX/2008 on a national strategy for community based total sanitation. This regulation emphasizes five key elements: stop using inappropriate toilets, like rivers and back yards, wash hands with soap, use safe drinking water, responsibly manage garbage and manage domestic waste water well.

We know that in remote areas, there are lots of reasons why the five aspects mentioned above are happening. Lack of water, lack of knowledge about health, lack of good personal habits and mismanaging garbage are some of the causes that require an integrated approach.

The past administration in Indonesia endeavored to improve the condition, through three strategies: demand creation, creating enabling environments and increasing the supply of sanitation infrastructure. Whilst the above strategies are well defined and executed, why then has the situation not been significantly improved? Lack of consistency in program implementation has often been the cause of ineffectiveness. Changes in government and personnel often shift priorities. We are hoping the current government will pay attention to this essential aspect, which is crucial to future human equality.

Courtesy of IBL

A nurse checks a tuberculosis patient for further treatment.

Courtesy of IBL

A mother pays avid attention to a health staffer offering maternal and infant education in Waa Banti, Tembagapura, Papua.

There has been a lack of cross-sector coordination in tackling various health issues, including malaria, tuberculosis and HIV/AIDs. So, who can play a pivotal role in all those cases? Is it the government's responsibility only? Today, many would say "the private sector and corporate social responsibility [CSR]". My next question is: Do those mentioning CSR actually understand its true meaning?

Corporate Social Responsibility (CSR) is a term that has become popular in the last decade, but unfortunately has been interpreted variably and is often misleading

Companies that are operating in remote areas can contribute significantly to improving health conditions in partnership with the government and NGOs. Their contribution is not merely through physical infrastructure, but also through educating local people about healthy life styles. Many companies are taking leadership in this area, through various programs including sanitation, medical facilities, clean water provisions and garbage management. Other companies take active roles in education about public health, reproductive health and other medical services.

Examples about companies' programs related to health are numerous, and the list is getting longer year by year, which is a good trend. But then such terminology has been misinterpreted by stakeholders, as though companies are the only source of help. Even worse, companies become a target of threat in the name of CSR. Health, like many parts of human life, is the responsibility of all elements of society. The private sector is one among several partners in development. Solutions to any health issues, regardless of location, should be tackled through multi-sector partnerships.

In the last decade, there have been massive contributions from private sector companies that improved health conditions in remote areas. Mining companies, oil and gas companies and plantation companies ranked highest in terms of contributions to basic medical facilities. Consumer products manufacturers often conduct CSR programs addressing healthy life styles. Service industries tend to empower communities through education and health campaigns.

How interesting the CSR dynamic is these days. There are a wide range of drivers, including gaining a social license to operate, marketing, public relations or simply compliance to regulations. Some experts say CSR is still a relevant term for community care, while others think CSR should be more inclusive and sustainable.

Companies must secure human resources that come from surrounding areas. If the areas are prone to contagious and/or endemic diseases, business operations can be disturbed due to high absence rates and low productivity. Moreover, good future clients are grown up from healthy communities. If companies do not empower their communities, there will be less of a client base, less buying capacity and higher rates of insurance claims and all of this means less profit.

In conclusion, in today's business world it is not enough to be seen as a good citizen. The business mind-set focuses on sustainability and hence they must turn challenges into benefits for all. Let us put social and environmental benefits into our core business. The health sector is a never ending area where profit goes along with people and their environment.

(Yanti Triwadiantini)

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Empowering Puskesmas through Pencerah Nusantara

Young university graduates take part in the yearlong Pencerah Nusantara (PN) program to provide education to rural communities, including those in far-flung and hard-to-access areas to foster a health paradigm.

Courtesy of CISDI

Using V-Scan, a health staffer checks a pregnant mother in Lesan Dayak Village, Kalimantan.

A mother fumigates a newborn. It sounds weird, doesn't it?

But it does still happen in a remote area in Ende, East Nusa Tenggara. In Ogotua, Central Sulawesi, there are mothers who hang their newborns under trees. And there are many other similarly 'odd' stories in off-the-beaten-track places in the country.

Some of the above exemplary baby-delivery traditions may captivate those fond of archaic and exotic things and prompt them to ask why they do it. Fumigating newborns is believed to free the baby of evil spirits; while hanging the infant under a tree is intended to expose the neonate to sunshine.

The old custom-related stories that spread from word of mouth, however, are considered improper by modern schools of thoughts on health.

"Medically, the traditions pose a high risk and we believe many villagers do not understand it," said Anindita Sitepu, program director of the Center for Indonesia's Strategic Development Initiatives (CISDI), which manages PN.

"We do not prohibit them from using the old ways of baby delivery but we tell them how the tradition can be potentially harmful to the infants and give them better alternatives," she said.

"Many do it due to ignorance and in such cases, it is our obligation to solve it and give them other alternative ideas," she said.

PN is an extension of the Millennium Development Goals (MDGs) program, with health as the focus area. With a vision of improving the welfare of Indonesian people, PN aims to empower community health centers (Puskesmas) across the country and to build a health paradigm among communities.

Carefully selected teams, with each comprising a young doctor, a midwife, a nurse, a nutritionist and a specialist in health issues from various backgrounds, carry out yearlong voluntary work in the respective targeted regencies.

The targeted locations for the three-year program that kicked off in 2013 and will end this year are Mentawai Islands, West Sumatra; Karawang, West Java; Pasuruan, East Java; Berau, East Kalimantan; Toli-toli, Central Sulawesi; Sigi, Central Sulawesi; and Ende, East Nusa Tenggara.

As Anindita Sitepu put it, the old traditions were one of the challenges facing PN teams, especially when it came to implementing their task of providing preventative services, part of the impactful functions of Puskesmas.

How frequently the 'weird' birthing traditions are seen varies from one region to another.

In Kelay district, Berau regency, such ancient ways of baby delivery have been gradually decreasing over the past few years thanks partly to continued efforts by the local health office and friends of PN, which started three years ago through education and counseling, according to Arnel Panimpa, head of the Kelay Puskesmas.

Building more Puskesmas

Arnel said the unusual ways of giving birth in Berau were closely linked to people's livelihood activities, conducted deep in the forest, leaving them further away from health facilities and services.

Currently, Berau, one of the PN-targeted locations, has one standard Puskesmas, situated in Kelay, about 100 kilometers from the regency or two-and-a-half hours by land.

Its targeted medical service coverage is 14 villages in the region, of which six are exceptionally hard to reach due to geographical challenges. "To provide mobile Puskesmas services, we have to take what we call *ketinting* [long boat] to reach one of the six villages and we have to stay the night there."

"Along with friends from Pencerah Nusantara, we discussed the problems, with the end result of proposing to build two more standardized Puskesmas as a breakthrough solution to the severely challenging access problem," he said in a phone interview.

PN has received overwhelmingly positive responses from young university graduates but of the many applicants, only a few male doctors are interested in the program. Among the few was Shaftan Dostur from Banda Aceh, who took part in the first generation in 2013.

Shaftan said that he had his own views on his profession as a doctor, which led him to decide to stop working at a hospital and join the program. He said being a doctor should be seen in a broad perspective in terms of medical activities, which should not be confined to treating patients in hospitals but the "most challenging and important thing is how to prevent people from being ill."

"Sick people do not only have to bear treatment costs but also become unproductive. Many rural people in remote areas face difficult access to medical facilities and services. This is why I joined the program in 2013," he said.

He added that he knew about the geographical challenges facing volunteers carrying out their tasks in hinterland areas but said "the real challenge was greater than expected. What helped us in this regard is that we work in a team".

Brakeless 'ojek'

Disclosing the severely rough and challenging roads in the field, Anindita, who joined site visits to all locations during the assessment phase, said, "In hilly Lindu, most *ojek* [motorcycles taxi] are brakeless and they use their legs to stop the vehicle because the roads are muddy. So you can imagine, I took a brakeless *ojek* on a long and winding up-and-down road, with ravines on my left and right side," she said.

According to Shaftan, villagers in Kelay have a tradition of leaving their village to go to the forest to work on the land, which also poses another challenge for the team, especially because "we cannot set a schedule for meeting with them as we expect. Therefore, we have to make adjustments to suit their schedule. They usually return to their village on national days, during harvest season and rainy season".

He said the one-year experience in the field had made him "more aware that promoting health and preventing people from being sick are more beneficial to people than healing".

Anindita said that local Puskesmas were only one of the partners that CISDI established relationships with to execute the program as it involved many aspects, some of which required academic expertise, such as the University of Indonesia's School of Medicine and School of Psychology that helped in the recruitment phase.

"We [also] partner with GE which provides funds for the program's operation. Partners are needed in every phase of implementation."

She disclosed that in the field, its partners included local regional administrations, health offices, NGOs, etc. "We are not 'picky' when it comes to partners. The important thing is as long as we have the same vision, values, and ethics, then go [... We] are equally open to the public and avoid exclusivity [...] we are a social movement. There is no significant challenge in this regard [...] because they need us [...] and all support us," she said.

According to her, partnerships will continue despite the end of three-year program because "partners are given room to give input according to their capacity in targeted locations that they support. We hold a leaders' meeting once in every six months, with leaders of the team and partners invited to attend and we also share info updates on the movement through a newsletter," she said.

"I think Pencerah Nusantara is one of the best practices. It is very good. Alumni of Pencerah Nusantara now work in hospitals everywhere and some of them move to other institutions, which is good in terms of talent development," said GE's CEO Handry Satriago.

"Another essential thing is impact. They provide education to villagers on how to give birth in a medically healthy way. Hopefully, this will change the mindset of mothers, who, for example, cut their own babies' umbilical cords, making them highly susceptible to infection, etc," he said.

The year 2015 marks the end of the Pencerah Nusantara program in the seven targeted locations, as well as the handover of the program to the respective targeted Puskesmas.

According to Anindita, the issue of handover is part of the program's design, which has been thought out since the beginning, to ensure the program's sustainability.

"Planning, implementation, monitoring, evaluation and handover were all well considered from the start. Why would we complete the implementation of the program, which is intended for the community, but then not know the continuation? That would pose a risk to the community," she argued.

"So, first, second and third generations of PN should be seen as united, complimenting each other.

The first generation of PN focused on assessment of need, the second on implementation of intervention and the third on handover, she said. "All make a synergy. Each team in the respective generations has different persons but essentially, they are the same," she said.

(Sudibyo M. Wiradji)

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