HEALTH PROMOTION IN INDONESIA

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1. PURPOSE OF ASSIGNMENT

The writer was engaged to extend the efforts of WHO in supporting the Government of Indonesia in building its technical capacity in health promotion in the 21st century. The work establishes the deficiency in the Ministry of Health’s ‘natural’ capacity to sustain health promotion and the resources needed to carry out the programmes on a national level.

The launch pad for health promotion in Indonesia was the 4th International Conference on Health Promotion, hosted by the Government of Indonesia. The operationalization of the Jakarta Declaration (1997) into National Health Promotion Policy subscribes to the global directions of the Organization and sets priorities in health promotion and strategies to:

- promote social responsibility for health;
- increase investment for health development;
- consolidate and expand partnerships for health;
- increase community capacity and empower the individual, and
- secure an infrastructure for health promotion.

2. EXISTING SITUATION AND THE MAIN PROBLEMS FACED

Indonesia is still undergoing a major process of social, political and economical changes since late 1997. The Government Act No.8/1995 shifting the centralized government system to a decentralized structure became effective in 1999. The introduction of the Republic Law No.22 for local autonomy and fiscal equalization was also passed. The Ministry of Health acted on this opportunity to accelerate its new policy framework – “Healthy Indonesia 2010” by focusing on four areas: (1) New health paradigm, (2) Professionalism, (3) Decentralization, and (4) Community-managed care (JPKM) in 1999.

The unpreparedness and lack of directions given to the management and staff to undertake new roles and responsibilities of a decentralized health system have created a big gap in efficiency and productivity within the Ministry of Health (now known as Ministry of Health and Social Welfare). The Centre for Health Education (PPKM) is now the Directorate of Health Promotion (DHP) under the Directorate General of Community Health. In the midst of the organizational changes, the management and staff encountered many operational challenges and constraints relating to job insecurity, the unknown destiny of the Ministry, the uncertainty of managerial functions and the unstable social environments, unavoidably affecting the productivity of the weakened workforce. The former PPKM, with its traditional, vertical management structure of health education programmes, is now experiencing chronic deficiency in implementing its current activities with a horizontal approach. There is a lack of systematic development of an infrastructure in DHP to undertake the new role as the “service” provider in the decentralized structure where central level is no longer the ‘supply’ side. Throughout this transition period, confusions and conflicts were experienced, which delayed the implementation of the plan of action for the WHO biennium 2000-2001.
The writer was concerned with some of the issues on how the existing health programmes from other donor agencies can be integrated into one system, including the WHO plan of action under the DHP management structure. The issues are:

- how to set an agenda for health promotion principles and strategies to be diffused throughout the health care system and the broader public health arena;
- how to develop goal and target setting as a strategic approach to planned change as it is a technical exercise in predicting future trends in health status indicators;
- how to draw out common threads and challenges facing health promotion in the holistic approach of the health care system;
- how to scan activity to focus on areas with global, regional and national cross-cutting programmes like RBM, TB, STD/HIV/AIDS, Safe Motherhood (MPS) and tobacco control, and
- how DHP can move towards a participative role, as opposed to representative approach, if it is to create health promotion in the integrated health care system.

The writer does not have all the solutions at this stage due to limitations of manpower, health sector reform and minimal practice of project management skills. The operations of the projects have revealed the following problems associated with project implementation and barriers in the sustainability of health promotion discipline.

1. **Technical Expertise**

   The present situation has not developed a sound health promotion methodology. There is limited technical knowledge among health professionals on health promotion discipline. The only technical expertise on health promotion is provided by WHO. Health promotion is presently conducted on a micro level with short-lived strategies under social mobilization, advocacy and community development. The comparative advantages of cross-cutting programmes with cross sectors have not been seriously focused and it is essential for them to move beyond the traditional, bureaucratic “top-down” frameworks and ways of thinking. To gain success in the health promotion programmes, DHP needs a balanced mix of both “bottom up” and “top down” planning and actions with a continuous process of feedback. The lack of professional learning skills on how to manage health promotion programmes should be addressed immediately.

   It is the first time for DHP to receive regular funding from the WHO biennium 2000-2001 to develop its capacity in health promotion. The availability of funds has provided incentives for conducting health promotion activities but not having the know-how to integrate the strategies with other ongoing health programmes. The former ‘piggyback’ approach with other health programmes is not appealing to health professionals because of “extra” workload, lack of control of funds and multi-skills requirement. The shortcomings of multi-skilled and multi-professional education of health professionals also delay the process of developing the health promotion methodology. So far, only three staff members from managerial position have received short course training on health promotion in Australia, sponsored by the World Bank under the Child Health and Nutrition Programme. However, two of them are no longer with DHP.

2. **Management**

   One major obstacle to health promotion is the lack of appreciation on the part of many directorates within the Ministry and among WHO non-health promotion staff of what health promotion is and what it can do. The lack of basic health promotion literacy prevents national and
international donor agencies from fostering the necessary integration of health programmes with the health promotion discipline. Intersectoral management is weak and it is evidenced that they need to move beyond the traditional management style to face the challenges of decentralization and become the agents of change.

To remove some of the barriers under a passive management style, it is necessary to find proactive leaders at all levels to support the health promotion discipline. This can be best attained by appealing to them through enlightened self-interest collaboration. Management will need to be provided with tools; training skills in the application of theories into actions to diffuse the methodology of the health promotion framework throughout the Ministry beyond the central level to the districts and sub-districts. These can become generic tools and national standard operation procedures can be established. Constant review is applied to solve some of the major problems in the development of a standard methodology in DHP and to encourage management to focus on the best practice of producing health promotion activities (and not because of availability of funds) based on national health needs and priorities.

Collaboration with international and national institutions can be effectively applied to expedite training of staff with a conventional approach. The present mindset of a standard prescription of advocacy, behavioural change and empowerment guidelines for health promotion programme are too superficial and, therefore, development of scientific and practical knowledge is essential. There is a gap between knowledge and action. Development of strategic plans and management by objectives approach can only be overcome with acceleration of training of professional staff in health promotion. National training institutions, such as Puskiat and the University of Indonesia School of Public Health, are sought to design a curriculum suitable for adults learning in health promotion at the operational level.

(3) Programme Management

Part of the capacity building of DHP is directed to design programme goal and proposed target instead of routine output and outcome approach. Many a time, “hands on” training is given to develop better understanding of health promotion, being an art and science, and it needs to monitor and respond to the ‘dynamically’ changing needs of the environments. Programme management is critical to ensure that the goals and targets are achieved and not objectives alone. Continuity of pilot projects is essential for the sustainability of the programme but this is impossible because budget is not included in the central health budget. When WHO funds are exhausted, the project stops and this method does not provide sustainability to the programme. The low practice of monitoring and evaluations of pre- and post- tests of projects needs revitalization of evaluation knowledge and evaluation practice to determine baseline data for future project planning. It has been difficult to lobby donor agencies to integrate health promotion activities in their programmes because health promotion has never been considered as an important discipline. The writer has temporarily suspended ‘selling the idea’ of health promotion to donor agencies until the infrastructure is fully revitalized with improved management skills, capacity and capability to undertake the additional workload.

Donor agencies are prepared to collaborate with communities at provincial and districts levels. For example, Yogyakarta has received a direct grant from the World Bank to set up a Health Promotion Coordinating Board and this has yet to be developed and implemented because of the lack of technical and social skills in building the infrastructure by the local health education centre (PKM).

In this respect, WHO can play a more active role and expand its technical assistance and services directly with the provinces/districts and provide extra budgetary funds to evolve new strategies under the health promotion programme.
3. ACTIVITIES UNDERTAKEN

The writer has complemented her responsibilities with her terms of Reference, together with the WHO biennium 2000-2001 Plan of Action.

(1) Operationalization of Jakarta Declaration

The operationalization of the Jakarta Declaration has been done through the following activities:

(a) Assisting DHP in the work plan of the paradigm shift to achieve national health promotion policies, as endorsed in the Jakarta Declaration, as well as supporting the national social movement of “Indonesia Sehat 2010” (Healthy Indonesia 2010).

(b) Assisting DHP in the development of networking and coalition structure in collaboration with USAID (JHU) with WHO as partner of the “Demand Generation/Health Promotion” Board.

(c) Increasing technical resources from WHO guiding principles and action research on health promotion settings.

(2) Development of health promotion settings

(a) Health promotion at the workplace (12-month project)

– A needs assessment was conducted at PT Kem Food, a meat packing factory of 300 workers and staff. Health priorities were identified with activities focusing on (i) correct lifting technique to avoid bad back and hernia. (ii) Introduction of physical activity three times per week led by appointed leaders with two sessions to accommodate workers on shift. (iii) Implementation of a smoke-free workplace policy. Ongoing support from WHO and DHP included the visit of Mr Alan Landers to the factory to strengthen the ongoing advocacy campaign for tobacco control and adherence of the smoke-free workplace policy.

– Development of a generic manual for health promotion in the workplace is based on the WHO framework.
- The transfer of technology on health promotion discipline has been diffused specifically on the determinants of workers’ health in the workplace. Health promotion framework was disseminated to the community relating to environmental, organizational, community and societal factors as well as personal lifestyle. It was unfortunate that when the pilot project was completed, DHP did not have funds for continuity of the programme to start the ‘multiplier’ effect with other workplaces.

(b) Health promoting schools
- To launch health promoting schools as the entry point for the WHO Mega Country Health Promotion Network and the expansion of the national school health programme, an action research study was conducted to measure the capacity of the government to support HPS.
- A rapid assessment and action planning process (RAAPP) was conducted in three phases (assisted by WHO and EDC Atlanta). The third phase will coincide with the national workshop for the local school health programme in November 2000 to include global strategies and implementation with local specifics.

(c) Health promoting hospitals
- This was not initiated due to shortage of manpower and not included in the biennium.

(3) Development of sustainable partnerships

The development of sustainable partnerships with NGOs, donor agencies, public/private sectors and the business community in health promotion activities was initiated but not actively pursued because partners prefer to have affiliation with WHO as the regulating body but not with the Ministry due to its lack of credibility. WHO, being a technical agency, the intermediary role is not always effective when it comes to negotiations without implementation. Therefore, some of the projects were not successfully sustained. Activities conducted were:

- Development of an advocacy kit for Partnership in Health Promotion soon to be field-tested via the distribution system of the Indonesian Chamber of Commerce and Industry. The kit is based on the profile of best practice and good governance of partnership in the local language.
- Development of a workshop for NGOs to receive structured learning on health education and promotion at the community level, including negotiation skills and management of change.
- Application of the five strategic elements of the Ottawa Charter as the basis for NGOs to plan comprehensive health promotion advocacy activities.
- Empowering NGOs with knowledge and skills training workshop to complement existing programmes with cross-programmes and cross-sector management interactions.

(4) Development of health promotion infrastructure and resources

- The development of health promotion infrastructure and resources is in process with the adoption of the “China model” for health promotion infrastructure. A consultant is assisting DHP to conduct a rapid situational analysis and implement the project in early January 2000.
• Assisting in the development of capacity building of the Health Promotion Forum formalizing its professional organization. Introduction of internship to first year students from the School of Public Health as the mechanism to provide the Forum with manpower to support its services, practical community participation and development. Likewise, students can also apply for internship with DHP, an incentive for students to appreciate their chosen career path as well as earning accreditation for their course of study.

(5) Development of health promotion advocacy - education and training materials.

Since there was no budget to develop education and training materials for special events, materials received from SEARO/WHO HQ were reproduced in the local language by DHP. These included:

• **World Health Day 2000** – The theme of “Safe Blood” was translated into the national language with a description appropriately designed for local conditions. Training workshops on the importance of blood screening, voluntary blood donation and its users were organized. Assisted the Green Crescent in producing strategic, promotional messages on the steps of quality control and quality assurance of blood banks.

• **World No Tobacco Day 2000** – “Tobacco Kills – Don’t be Duped”. The lack of funds for the event did not provide opportunities to develop short- or long-term materials for education and training. MoH addressed the event on a piecemeal basis rather than as trends for future target and goal setting. NGOs produced their own IEC materials based on the same theme. The “World No Tobacco Day” had a low key commemoration. The impact of the tobacco control advocacy campaign came from the SEAAT Flame events funded by SEARO and distributed to NGOs to conduct their activities in five provinces. The campaign was successfully launched.

(6) Technical support for training DHP staff in health promotion

• National training for health promotion has not started due to internal restructuring and organizational changes. It is planned to send three staff members to attend the VicHealth Summer Course on health promotion in February 2001.

(7) Responsibility for all health promotion-related activities

Focal points for tobacco control activities and other specific health programmes related to health promotion discipline have been established as follows:

• **INO HIS 001- Guidelines for 100% condom use in high-risk groups**

This project is the first cross-cutting programme between CDC and the Directorate of Health Promotion sharing roles and responsibilities at cross sector level. This approach has initiated collaboration and understanding between sectors of planning strategically to produce effective communication resources on common objectives and adoption by other agencies.

• **INO NCP 002**

• **Expected Result No. 1- Develop national strategy for tobacco control**

Close facilitation is provided to the Ministry in producing its first draft of the National Strategy for Tobacco Control. An international consultant from SEARO is assisting the national consultant in finalizing the document, including the FCTC document.
• Expected Result No. 2 – Regulations for the control of tobacco consumption

Government Regulation PP 81/99 has been implemented but law enforcement of its 42 chapters on tobacco control is very weak. The synergy and priority given to TFI are weak due to the lack of authority and responsibility in enforcing policies already mandated. A seminar is planned for January 2001 for members of Parliament (PDR) Komisi VII (Health Sector) to disseminate and diffuse the innovation of FCTC and TFI strategies to improve their understanding of tobacco and health issues.

(c) Expected Result No. 3 – Pilot anti-smoking education programme for school children and youths

This project is undertaken by the Ministry of National Education under the Health Promoting Schools setting. There is an ongoing anti-smoking campaign on “Youth under 18 without Tobacco.” This is funded by the White Cigarette Association to support the Ministry of National Education. The tripartite collaboration among WHO, MONE and the Association needs close scrutiny because of its common programme objectives but with different agenda. It can be taken as a comparative advantage for the Association to misconstrue the intention and develop its advertisement and promotion strategies for the public perception that WHO is in partnership with them.

(d) INO RHR 001 – Expected Result No. 6 – Development of IEC materials for providers on safe motherhood/reproductive health

Technical assistance was provided to Family Health in collaboration with DHP in designing and developing IEC materials for easy understanding and practice by health providers on the safe motherhood initiative. Close supervision was given on the strategies of IEC framework with emphasis on integrated marketing communication on how to influence behavioural change and made applicable to local intellectual perception and practice in the community.

(e) INO CEE 001 – Expected Result No.1 – Enhanced leprosy elimination campaign

CDC has minimum use of DHP to assist in the preparation of their IEC resources to improve public health education and promotion on leprosy and its health implications. The WHO consultant for this project is collaborating with DHP to enhance existing IEC resources according to local specifics to improve the public perception and acceptance of patients with leprosy.

(f) INO RBM 001 – Rollback malaria/ACT malaria

Technical assistance on health promotion has been provided since late 1999 for RBM. The Sub-directorate for VBD is also the focal point for ACT Malaria. An ambitious cross-cutting training programme at national and international levels is in process to collaborate with ACT Malaria for conducting a four-week workshop on “Broadening Involvement Team Training for Malaria Control.” Technical assistance is provided for the three components in Unit III out of five units and this covers:

– Health promotion at community level.
– Partnership in health promotion
– Rapid Assessment and Action Planning Process (RAAPP)

(g) Activities from SEARO

SEAAT Flame campaign

Close supervision was provided and activities relating to the South-East Asia Anti-tobacco campaign with Ministry and NGOs were facilitated. This event was held for ten weeks in five provinces. The limitations of communication and involvement have made it impossible to include
measuring tools to assess the effectiveness of the campaign activities and feedback from the organizers for future improvement, repetition or deletion. However, the regional solidarity campaign had made an impact in Indonesia, especially with the media communications, as a number of countries from SEAR participated in the tobacco control campaign.

_Tobacco control advocacy visit by Mr Alan Landers_

The visit of Mr Alan Landers to conduct tobacco control advocacy presentations was successful with almost daily coverage on tobacco issues. It also coincided with the Pall Mall case of luring young girls to ‘take off their clothes’ competition with monetary reward and signing up of brand change of cigarettes on site. Technical resources on ethics, consumer protection and code of conduct relating to tobacco issue was shared with the Ministry and the media to strongly advocate compliance of Health Regulation PP81/99 by the tobacco industry.

_Making pregnancy safer_

An advocacy kit for “Making Pregnancy Safer” was developed for launching by the Director-General of WHO and the President of Indonesia. A health promotion component is integrated into the MPS initiative for promoting the use of skilled workers, improvement of the health system, introduction of effective hospital referral methodology and increased public health education. This aspect was also covered by the media in the neighbouring countries.

_CDC - INO CPC 001-Dengue haemorrhagic fever_

Participated in the external review of dengue haemorrhagic fever, conducted by WHO HQ/SEARO and CDC Atlanta. The report revealed a shortage of IEC materials with public health education messages on behavioural change and source reduction. Income generation of selling the ‘tempolo’ fish as the predator of mosquitoes took priority than dissemination of objectives to the communities of source reduction to decrease the prevalence of DHF. The follow-up programme planning for DHF should include a health promotion discipline.

4. **CONCLUSIONS AND RECOMMENDATIONS**

4.1 **Conclusions**

Considering the positive outcomes of WHO assistance in capacity building and development of health promotion discipline, the Ministry is confident of meeting its challenges in spite of the unstable political, social and economical environments. The management and staff should not become complacent and staff fall back to the traditional, vertical approach of health education believing that the approach is the same for health promotion. The prompting question is: can the management and staff remain limited in this traditional, top-down management approach in the process of decentralization?

Given the priority of the health paradigm shift to improve the health status of the population, the inadequacies felt by the management and staff regarding their performance in health promotion activities can prevent them from being proactive. The question is: How can cross-fertilization of manpower and resources be achieved within the Sub-directorates to produce an integrated health promotion discipline with other interdisciplinary activities and strategies at national, regional and international levels?
Considering the constraints and challenges the Ministry is encountering, health promotion activities and strategies have been implemented to the best of its capability. The availability of a technical assistant to support the Ministry to focus on capacity building in health promotion under the leadership of DHP has accelerated the level of priority in health sector reform. The benefits of health promotion are long-term and, because of this, it is critical that the ongoing activities are capable of surviving short-term changes in the current political climate and resource distribution. Health promotion is institutionalized now and it should not be bureaucratized. It is important to continue with the strong linkages and alliances for its survival. The short-term impact evaluation should also be used to demonstrate the worthiness of health promotion efforts in the activities and strategies conducted so far. Health promotion should not be seen as a new or separate discipline but as a necessary and timely consideration of public health.

4.2 Recommendations

Given the existing situation in health promotion at the central level, the following recommendations are proposed:

(1) Training and further education

Training of staff is a key issue in health promotion. Current training materials from WHO are limited for health promotion initiatives. Development of manuals and guidelines for health promotion practice with local specifics is necessary for creating a baseline for systematic training. Good facilitators and trainers are crucial for disseminating health promotion concepts, strategic planning, principles of health promotion application, monitoring and evaluation and for enriching the training programme. Mindful of the shortcomings of health promotion practice, it is recommended to recruit international, regional and national resource persons to provide further education training for health promotion and education information. These basic knowledge and skills equip individuals with better understanding of health promotion development, empowering them with interactive participation in health promotion action and decision-making processes.

(2) Formulation of strategic planning for health promotion at national level

Intersectoral collaboration and cooperation with integration of health programme planning, production of education and health promotion technical resources based on national standard operation procedures and technical advisory role (service oriented) in line with decentralization function. The regulation of health promotion, education and practice in all health programmes should ensure adoption of an integrated and comprehensive system in the new health sector reform.

(3) Expansion of capacity building on human resource

Expanding the roles and functions of health professionals for career opportunities development in becoming future health promotion practitioners. This action will ease the shortage of health promotion providers and a career diversification for some of the health providers.

(4) The role of WHO in health promotion

Continued provision of long-term technical assistance in health promotion development in Indonesia is highly recommended in order not to lose the advantages already achieved. This is in compliance with WHA resolution WHA42.44 on health promotion, public information and education for health and the outcome of the five international conferences on health promotion (Ottawa Charter
1986, Adelaide 1988, Sundsvall 1991, Jakarta 1997 and Mexico 2000). The global commitment to the Health Education and Health Promotion Five-Year Plan of Action (1998-2002) adds to the workload of the Ministry in addition to its national health priorities. The Ministry has identified four approaches to strengthen capacity building in health promotion. These are:

- Bottom-up organizational approach to develop technical expertise in health promotion with training, skills and knowledge beneficial to individuals and, more importantly, to DHP and the wider community.
- Top-down organizational approach to enable other sectors to be more responsive to existing and emerging health issues adopting health promotion strategies resulting in enhanced capacity building.
- A partnership approach involving collaboration and strengthening the relationships between public and private sectors with WHO playing a catalytic role.
- Strengthening community actions and participation in the development of a systematic health promotion framework.

The continuation of WHO technical assistance will require a long-term staff position to provide short- and long-term programme planning implementation of international, regional and national strategies for health promotion throughout the life span of the health system. Indonesia already has a focal point for WHO Mega Country Health Promotion Network and further expansion of global health promotion networks will, no doubt, require a very solid foundation for the health promotion infrastructure.

### 5. ACKNOWLEDGEMENTS

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