Chapter V. LIFE IN THE COMMUNITY OF SUKAMISKIN

The present chapter embarks on a description of daily life in Sukamiskin. It describes the data both available in existing resources and collected among the people of the research population, *i.e.* the residents of the community of Sukamiskin, and the sample population comprised of the selected household heads. In addition, a general description will be presented on the plural medical system, operational in Sukamiskin. Furthermore, the collected geographic, socio-demographic and economic characteristics of the research area are presented as an overview of the community life in Sukamiskin. This chapter concludes with an outline of the plural medical system available in the research area which comprises a traditional, a transitional and a modern medical system, which are related to the different systems of health information and communication in the area.

5.1 Study and Sample Population

5.1.1 Official Statistical Data of Sukamiskin

On the basis of an estimation of the total population living in the 30 districts and 151 urban communities of Bandung, the average population for each village amounts to 16,262. Arcamanik, representing one of the districts of Bandung, encompasses four communities with a total population of approximately 69,313 inhabitants, as estimated in 2013. The official data for Arcamanik District indicate a substantial increase in population size compared to the previous year. In 2012, the population living in Arcamanik District comprised approximately 68,519 people of which 34,795 were male and 33,724 were female. In 2013, the population increased to 35,198 male and 34,115 female inhabitants at a population distribution rate of 92,18/km2 (*cf. BPS Kota Bandung* 2013).

Residing in 14 hamlets and 83 neighbourhoods as indicated in Table 3.1, the inhabitants of Sukamiskin as one of the urban communities of the district of Arcamanik were selected as the research population of this study. According to the data of 2013, the population of Sukamiskin amounted to 20,379 people with a density rate of 9,000 persons/ha, while the total number of households was 6,528. From the research population, 125 households comprising a total of 617 household members were chosen as the sample population which provides the basis for the quantitative household surveys conducted in the research area.

Gender and age composition

In September 2013, the population of Sukamiskin was composed of 10,242 males and 10,137 females. Among the 617 respondents, the male (52%, n=321) slightly outweigh the female (48%, n=296), as highlighted in Table 5.1.

Table 5.1 Gender of the Household Members of the Sample (N=617)

No.	Gender	N	%
1	Male	321	52
2	Female	296	48
	Total	617	100

Source: Household Survey (2012-2014).

In the research area, the male inhabitants are commonly playing a leading role in the household as all 125 household heads of the sample are male. The highest percentage is found in the age

group of 41 to 45 years (27.2%, n=34), and the lowest percentage in the age group of 26 to 30 years (0.8%, n=1). Table 5.2 presents the age distribution of the household heads of the sample.

Table 5.2 Age of the Household Heads of the Sample (N=125)

No.	Age	N	%
1.	26–30 years	1	0.8
2.	31–35 years	8	6.4
3.	36–40 years	14	11.2
4.	41–45 years	34	27.2
5.	46–50 years	22	17.6
6.	51–55 years	18	14.4
7.	56–60 years	16	12.8
8.	61–65 years	6	4.8
9.	66–70 years	3	2.4
10.	71–75 years	3	2.4
	Total	125	100.0

Source: Household Survey (2012-2014).

The age categories of all household members of the sample range between 0 to 5 years and 86 to 90 years. Since the maximum life span in Indonesia is estimated to be above 65 years of age, respondents aged 61 and older have been identified as ‘seniors’, while respondents in the age group of 86 to 90 years have been identified as ‘elderly’.

Table 5.3 Age and Gender of the Household Members of the Sample (N=617)

No.	Age	Male	Female	Total	
		n	n	N	%
1.	0–5 years	36	27	63	10.2
2.	6–10 years	24	24	48	7.8
3.	11–15 years	32	20	52	8.4
4.	16–20 years	28	28	56	9.1
5.	21–25 years	31	27	58	9.4
6.	26–30 years	28	26	54	8.8
7.	31–35 years	17	13	40	6.5
8.	36–40 years	16	27	43	7.0
9.	41–45 years	32	30	62	10.0
10.	46–50 years	24	24	48	7.8
11.	51–55 years	19	14	33	5.3
12.	56–60 years	17	5	22	3.6
13.	61–65 years	7	5	12	1.9
14.	66–70 years	5	9	14	2.3
15.	71–75 years	5	2	7	1.1
16.	76–80 years	0	1	1	0.2
17.	81–85 years	0	1	1	0.2
18.	80–90 years	0	3	3	0.5
	Total	321	296	617	100.0

Source: Household Survey (2012-2014).

Representing a minority of the sample, the seniors include: 12 respondents of 62 to 65 years of age (1.9%); 14 respondents of 66 to 70 years of age (2.4%); 7 respondents of 71 to 75 years of age (1.1%); 1 respondent of 76 to 80 years of age (0.2%); and 1 respondent of 81 to 85 years of age (0.2%). The age group of the elderly amounts to a total of three respondents (0.5%) (*cf.* Table 5.3).

Although the number of males of the sample is larger than the number of females, females appear to have a longer lifespan than males, as also indicated in Figure 5.1.

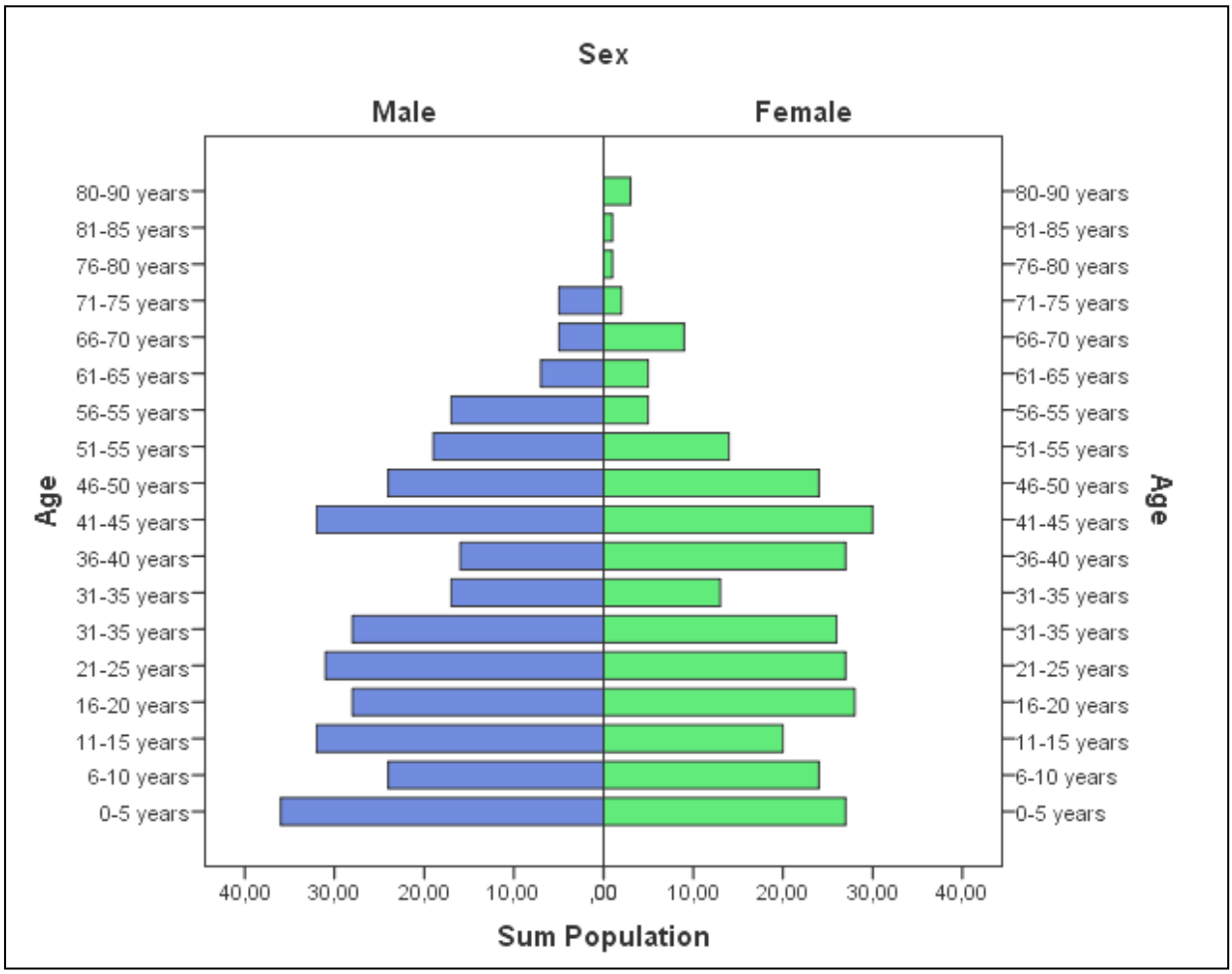


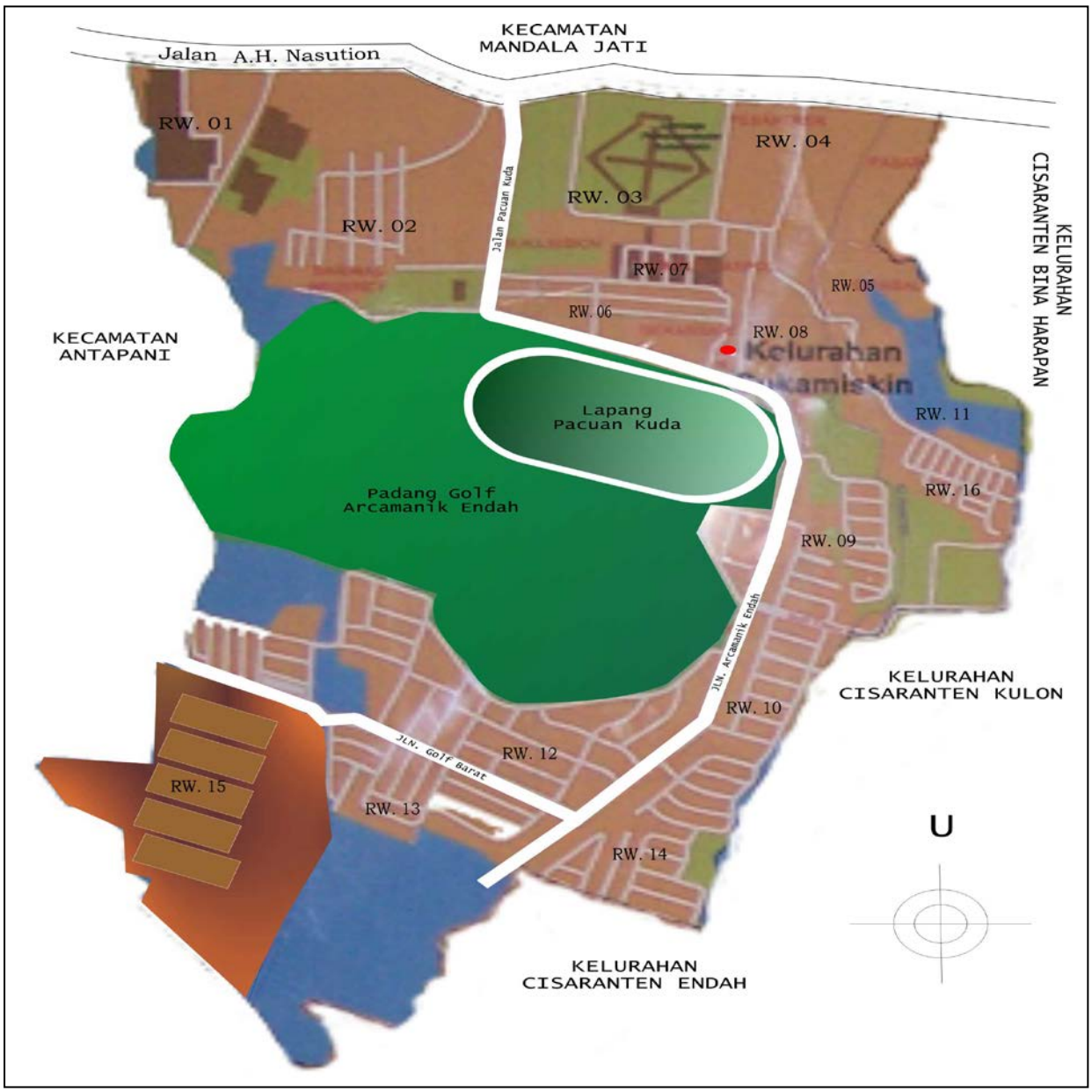
Figure 5.1 Age of the Household Members distributed over Gender of the Household Members of the Sample (N=617).

5.2 Geography and Location

5.2.1 Environment of Sukamiskin

Sukamiskin is an urban community of the Arcamanik District which is located in the eastern part of Bandung and surrounded by Bandung District in the north, Rancasari District in the south, Ujung Berung District in the east and Antapani District and Mandalajati District in the west. The area of Arcamanik District covers 512,99 ha and is located at approximately 700 metres above sea level. In total, Arcamanik District comprises four urban communities, *i.e.* Cisaranten Kulon, Cisaranten Bina Harapan, Cisaranten Endah and Sukamiskin.

Sukamiskin derives its name from the words '*suka*' meaning 'market' and '*miskin*' meaning 'perfume' or 'fragrance'. Hence, the meaning of Sukamiskin refers to 'a market where people used to sell many different perfumes' which is also interpreted as 'people in Sukamiskin should behave well'. Around 127,162 ha of the land of Sukamiskin, mainly characterised by dry lands and plains, is used agriculturally while another 69 ha is utilised for public facilities and a number of regional and central government institutions.



Map 5.1 Map of the Arcamanik District based on the Regional Distribution Pillars of Citizens in 2013.
Source: *Kelurahan* Arcamanik (2013).

These include: (1) *Lembaga Pemasyarakatan*, the Correctional Facility Grade I A in Bandung; (2) *Lembaga Pemasyarakatan Wanita*, the Women's Correctional Facility Grade II A in Bandung; (3) *Lembaga Pemasyarakatan Juvenile*, the Juvenile Correctional Facility Grade III in Bandung; (4) *Rumah Penyimpanan Barang Sitaan Negara*, Store house for the State Confiscated

Goods; and (5) *Balai Monitoring dan Spectrum*, Bureau for Monitoring and Spectrum. The local government of Sukamiskin employs six government administrators, *i.e.* civil servants, and one intern.

Illustration 5.1 The Village Office of Sukamiskin.
Photograph by W. Erwina (2013).

The six civil servants are: the *Lurah*, ('Head of the village'), the Secretary of the *Lurah*; the Head of the governmental section; the Head of the developmental economy and law section; the Head of the social section; and the Head of the service section.The *Lurah* of the administration in Sukamiskin governs in coordination with the leaders of neighbourhoods and hamlets in the area. Neighbourhoods and hamlets represent the community, rather than the governmental associations which are formed by the government in order to maintain harmony among the communities.

Illustration 5.2 The Middle Class Housing Area in Sukamiskin.
Photograph by W. Erwina (2013).

Local leaders are elected by the members of the respective communities. The Ministerial Regulation of Internal Affairs (*Permendagri*) No. 7/1983 about Neighbourhood and Hamlet Associations established the average number of families in each neighbourhood at 30 to 40.As a consequence of population growth, the number of hamlets in Sukamiskin increased from 16 hamlets in 2011 to 17 hamlets in 2013 thereby adding one hamlet to the village. The number of neighbourhoods increased accordingly from 83 neighbourhoods in 2011 to 88 in 2013. Following the increase in population size over the last years, several hamlets, *i.e. RW* 2 and *RW* 11, have been in fact split into new neighbourhoods. Similarly, fractions of *RW* 13 have been combined into a new hamlet, *RW* 15.

5.2.2 Public Facilities in Sukamiskin

The area of Sukamiskin is covered by 1.5 km of street; 14.70 ha of rice and other fields; 1.6 ha of public buildings; 1.2 ha of green lines; 1 ha of chemical industries; and 0.6 ha of other features. Throughout the research area, properties of land can be distinguished on the basis of two different types of land status: (1) land with a certificate which amounts to 208.89 ha; and (2) land without a certificate which amounts to 2.27 ha. The certificates of land are divided into three categories: (1) property right certificates: 95.728 ha; (2) building concession right certificates: 65 ha; and (3) using right certificates: 48.168 ha. The different public facilities which are available in Sukamiskin offer services of education, health, religion, sport and entertainment. In general, the educational facilities in Sukamiskin provide the community with 12 years of compulsory education, as regulated by the Indonesian Ministry of Education. The different types of educational facilities in Sukamiskin include seven kindergarten and preschool facilities, six primary schools, five secondary schools and four senior high schools (*cf.* Table 5.4).

Given the different educational facilities available in Sukamiskin, the establishment of a library as well as its activities is usually enabled by the government. The purpose of setting up a *Taman Bacaan Masyarakat* (TBM) ('Community Reading Corner') is: '*to provide reading materials for the community and to cultivate an enthusiastic reading habit. This establishment provides reading materials, such as books, magazines, tabloids, newspapers, comics and other multi-media materials which are placed in a room for reading, discussions, book reviews, writing and other similar activities, and is supported by the manager who acts as a motivator*' (*cf.* Kemendikbud 2013: 5).

Table 5.4 Educational Facilities in Sukamiskin in 2013

No.	Type of Facility	Building	Pupils/Students	Teachers/Lecturers
1.	Kindergarten	7	289	29
2.	Primary School	6	1.927	173
3.	Secondary School	5	3.183	176
4.	Senior High School	4	666	36
5.	University	-	-	-
6.	Educational Institution	-	-	-
7.	Courses	5	298	17

Source: Annual Report Sukamiskin (2013).

The *Taman Bacaan Masyarakat* (TBM) ('Community Reading Corner') not only offers reading materials and information to the community, but also organises a number of activities, such as the Children's Reading Society, from which the community benefits. Other activities aim at

stimulating the general interest in reading and at supporting the eradication of illiteracy through providing general access to the educational services (*cf.* Departemen Pendidikan Nasional 2008). The *Taman Bacaan Masyarakat* moreover acts as a means of accessing health information in printed form, such as magazines, newspapers, books, dictionaries, encyclopaedias, manuals and directories, as well as in electronic form using personal computers which are also available in the 'Community Reading Corner'.

The *Pondok Baca Arcamanik* refers to the 'Community Reading Corner' in Arcamanik which has been set up in an effort to stimulate the people's interest in reading and learning as well as to meet the need for information in the community [1].

In general, it is the target of any *Taman Bacaan Masyarakat* (TBM) ('Community Reading Corner') to combine their collection of information and materials with the mass media, such as television and radio, as well as with other learning tools. In this way, it is able to encourage community participation by organising activities, such as: drawing for children; camping; organised tours to the Zoo; and storytelling (*cf.* Illustration 5.3).

Illustration 5.3 *Taman Bacaan Masyarakat* ('Community Reading Corner') in Arcamanik. Photograph by W. Erwina (2010).

Apart from educational facilities, the available health care facilities in Sukamiskin aim at the realisation of a healthy community by means of offering the community members access to their health care services. Throughout the research area, the modern health care services are provided by a network of health care institutions and medical practitioners, including doctors and paramedics. These services are complemented by commercial pharmacies and traditional medicine stores.

First-line health care in Sukamiskin is generally provided by one of the 17 available *Pos Pelayanan Terpadu* (*Posyandu*) ('Integrated Health Posts') [2]. These *Posyandu* are located in each hamlet and provide weekly programmes and activities for both infants under the age of five and seniors. The *Pos Pelayanan Terpadu* (*Posyandu*) ('Integrated Health Post') are operated by a number of employees at the community health centre and representatives from the *Pembinaan*

Kesejahteraan Keluarga (*PKK*) ('Empowerment of Family Welfare Movement') and by the appointed workers in the *Pos Pelayanan Terpadu* (*Posyandu*) ('Integrated Health Post').

In addition to the *Pos Pelayanan Terpadu*, the inhabitants of Sukamiskin are generally able to obtain health services at the *Pusat Kesehatan Masyarakat* (*Puskesmas*) ('Community Health Centre') of Arcamanik which acts as a focal health care institution providing modern health services to the entire population of Arcamanik District (*cf.* Illustration 5.6). The centre offers the services of doctors, dentists and midwives as well as a pharmacy and represents a major centre for dental and oral care in Bandung. Since the government subsidises the fees for health care, residents who are covered by the community health insurance, *Jaminan Kesehatan Masyarakat* (*JAMKESMAS*), may be entitled to receive treatment free of charge. Besides the *Pusat Kesehatan Masyarakat* (*Puskesmas*) ('Community Health Centre'), other health care facilities in Sukamiskin include the *Yayas an Bahtera* and *An-Nur* Clinics.

At the time of the research, health care in Sukamiskin was being provided by six doctors, three obstetricians, two paediatricians and three dentists. There was one veterinarian available for the area. While there is no hospital in Sukamiskin, the residents in need of specialist medical treatment may consult the Bandung City Hospital or the *Ujung Berung Hos*pital which are the nearest hospitals in the area. Furthermore, the *Badan Kesehatan Ibu dan Anak* (BKIA) ('Mother and Child Care Agency') which is available in Sukamiskin, serves the special purpose of improving and promoting Maternal and Child Health (MCH) by monitoring pregnant and delivering women, as well as infants. With the overall aim of providing a better and qualified life for the future generation, the BKIA manages family planning programmes, makes arrangements during pregnancy to provide mother and child care and monitors the development of the population. In addition, the public facilities also include the *Keluarga Berencana* (KB) ('Family Planning Programme') with a birth control programme which was introduced by the government in an attempt to control the population growth rate. Every productive couple is expected to participate in the programme by using contraceptives, such as pills, condoms, intra-uterine devices (IUD), vasectomy, tubectomy or injections. The provision of infrastructure to programmes for family planning is fundamental to the maintenance and support of the birth-control services. The modern health care facilities available in the research area also include a local organisation which offers programmes for activities regarding the dissemination of health information, such as the gathering of mothers from hamlets, neighbourhoods, prayer groups and others [3]. Table 5.5 provides an overview of the various modern health care facilities available in Sukamiskin, Arcamanik District.

Table 5.5 Modern Health Care Facilities in Sukamiskin in 2013

No.	Type of Facility	Total	Additional
1.	Hospital	0	
2.	Mother and Child Care Agency (*BKIA*)	1	
3.	*Puskesmas*	1	*Puskesmas Aracamanik*
4.	Clinics	2	*Yayas an Bahtera* and *An-Nur*
5.	*Posyandu*	17	each RW (RW 01 -RW 17)
6.	Medicine Store	5	Al-Ma'soem, Waluya, Arcamanik, Eradica, Umiyah
7.	Traditional Remedies Store	1	Al-Ma'some

Source: Annual Report Sukamiskin (2013).

Table 5.6 Religious Facilities in Sukamiskin in 2013

No.	Type of Facility	Total	Additional
1.	Mosque	20	RW 01 - RW 17
2.	*Mushola*	11	RW 01 - RW 17
3.	Church	1	LP Sukamiskin
4.	*Vihara*	-	-
	Total	32	

Source: Annual Report Sukamiskin (2013).

Apart from the religious facilities, indicated in Table 5.6, a number of sports facilities which have been established in Sukamiskin by the government of the West Java Province since 2013 are available in the research area (*cf.* Table 5.7).

Illustration 5.4 The Great Mosque of Sukamiskin.
Photograph by W. Erwina 2012.

Illustration 5.5 Information Board of *Puskesmas* Arcamanik.
Photograph by W. Erwina (2010).

The continuous development of sports facilities has formed part of the preparations for the National Sports Week, *Pekan Olahraga Nasional*, held in 2016 in Bandung. In addition to sport facilities, the residents of Sukamiskin also use other available facilities in order to undertake sport activities.

Table 5.7 Sport Facilities in Sukamiskin in 2013

No.	Type of Facility	Total	Additional
1.	Badminton	3	*RW* 02, *RW* 06, *RW* 14
2.	Table Tennis	21	School and*RW*
3.	Volleyball	8	School and*RW*
4.	Basketball	3	School
5.	Tennis	3	School
6.	Golf	1	Renovated
Total		39	

Source: Annual Report Sukamiskin (2013).

5.3 Socio-Demographic and Economic Structure

5.3.1 Age, Gender, Family and Household Composition

Almost half of the 617 respondents of the sample (48.5%, n=299) are registered as 'monogamously married', while similarly half of the sample (45.2%, n=279) are registered as 'single', as such accounting for a rather equal balance between the monogamously married and unmarried respondents. Furthermore, several cases of polygamy or marriage with more than one woman at the same time are reported among the sample population. About 10 (1.6%) of the respondents maintain their polygamous marriage. The amount of 'widowers', *i.e.* male respondents, who have lost their wives and have not remarried, amounts to 1.6% of the sample (n=9) (*cf.* Table 5.8).

Table 5.8 Marital Status of the Household Members of the Sample (N=617)

No.	Marital Status	N	%
1.	Married (monogamous)	299	48, 5
2.	Married (polygamous)	10	1, 6
3.	Single	279	45, 2
4.	Divorced	2	0, 3
5.	Widow	18	2, 9
6.	Widower	9	1, 6
	Total	617	100, 0

Source: Household Survey (2012-2014).

The quantitative questionnaire which has been designed for this survey encompasses *i.a.* the educational background of the household head as the individual, who leads the family and takes full responsibility for it. Almost half of the 125 household heads of the sample (44.8%, n=56) are senior high school graduates and almost one-fifth university graduates (18 %, n=23). A relatively small amount (2.4%, n=3) of all household heads have no educational background (*cf.* Table 5.9).

In comparison, one-tenth (10.2%, n=63) of all household members of the sample have no educational background. This amount is in line with the number of household members aged five

years or younger. In addition, less than one-fifth (13.4%, n=83) of 617 household members of the sample have completed other forms of education, such as courses or training (*cf.* Table 5.10).

As regards the ethno-cultural background of all household members of the sample, it comprises a majority of Sundanese people (87.1%, n=538), followed by small groups of Javanese (8.6%, n=53), Batak (0.4%, n=3) and other ethno-cultural groups (3%, n=21).

Table 5.9 Educational Level of the Household Heads of the Sample (N=125)

No.	Educational Level	N	%
1.	No education	3	2.4
2.	Primary School	21	16.8
3.	Secondary School	22	17.6
4.	Senior High School	56	44.8
5.	University	23	18.4
	Total	125	100.0

Source: Household Survey (2012-2014).

Table 5.10 Educational Level of the Household Members of the Sample (N=617)

No.	Educational Level	N	%
1	No education	63	10.2
2	Elementary school not finished	37	6.0
3	Elementary school finished	112	18.2
4	Secondary school not finished	29	4.7
5	Secondary school finished	88	14.3
6	Senior high school not finished	24	3.9
7	Senior high school finished	158	25.6
8	University not finished	7	1.2
9	University finished	16	2.6
10	Other	83	13.4
	Total	617	100.0

Source: Household Survey (2012-2014).

5.3.2 Occupation and Socio-Economic Status (SES)

In the research area, the following professions have been recorded: private workers (n=4.802); private employees (n=3.666); civil servants (n=1.515); merchants (n=631); military/police (n=358); tailors (n=86); doctors (n=41); entrepreneurs (n=28); drivers (n=21); farmers (n=13); and, notably the largest number, students and pupils (n=6.948) *(cf.* Annual Report Sukamiskin 2013). Among the 125 household heads of the sample, the most frequently reported occupation refers to the entrepreneur (20.8%, n=26) followed by labourers (13.6%, n=17) and servants (12%, n=15). As shown in Table 5.12, around 8.8% (n=11) of the household heads are employed in the private sector, while 4.8% (n=6) are teachers and 2.4% (n=3) are farmers (*cf.* Table 5.11).

Table 5.12 presents an overview of the different economic organisation which are found in the community of Sukamiskin. These institutions include *i.a.* cooperations as well as small and medium enterprises operating in the area. The economic institutions available in Sukamiskin provide a sound basis for a number of economic activities which are undertaken in the research area. Cooperations, for example, encourage and support the economic needs of the local population by granting loans at a relatively low rate.

Furthermore, the different institutions can be distinguished as home industries, mass industries, such as the garment industry PT Printex and other small enterprises, such as food stalls and repair shops.

Table 5.11 Occupation of the Household Heads of the Sample (N=125)

No.	Occupation	N	%
1.	Farmer	3	2.4
2.	Teacher	6	4.8
3.	Servant	15	12
5.	Religious Leader	2	1.6
6.	Entrepreneur	26	20.8
7.	Labourer	17	13.6
8.	Private Sector Employee	11	.8
9.	Unemployed	11	8.8
10.	Retired	11	8.8
11.	Other	17	13.6
Total		125	100.0

Source: Household Survey (2012-2014).

Table 5.12 Economic Organisations in Sukamiskin

No.	Type of Organisation	Total
1.	Cooperation	9
2.	Small & Medium Enterprise	32
3.	*Selapan* Market/Public Market	-
4.	Business Enterprise	-
5.	Supermarket (*Swalayan)*	7
6.	Food Stall	8
7.	Restaurant	1
8.	Kiosk/*Warung Kelontong*	79
9.	Street Vendor (*Pedagang Kaki Lima*)	39
10.	Bank	5
11.	Food Industry	1
12.	Handicraft Industry	3
13.	Garment Industry	1
14.	Printing/Silk-Screening (*Sablon*)	1
15.	Motorcycle/Bicycle Repair Service	14
16.	Car Repair Service	8

Source: Household Survey (2012-2014).

5.4 The Plural Medical System

5.4.1 The Traditional Medical System

According to official data of the World Health Organization (WHO 2002), the widespread and growing use of Traditional Medicine (TM) is part of a rapidly growing health system with economic importance. In Africa up to 80% of the population uses TM to help meet their health care needs. In Asia and Latin America, populations continue to use TM as a result of historical circumstances and cultural beliefs. In China, TM accounts for around 40% of all health care

services delivered. Also, 65% of the population in advanced countries make use of TM while 30% to 50% of the population consume herbal remedies *(cf.* Purwanto 2013). Additionally, the World Health Organization (WHO 2002) acknowledges the use of TM including herbal remedies for community health care and disease prevention in general, as well as for the treatment of certain ailments, such as chronic diseases, degenerative diseases and cancer. Provided that TM is used properly, it has been identified as safer than modern medicine, particularly with regard to a less frequent occurrence of side effects (*cf* Purwanto 2013). For many generations, the inhabitants of Sukamiskin have made use of TM, mostly in the form of traditional home remedies which are applied in virtually every household.

Throughout the research area, TM is largely used in the form of *ubar kampung* which refers to the use of local medicinal plants and fruits for the purpose of disease treatment using locally available Medicinal, Aromatic and Cosmetic (MAC) plants, such as *lalab* ('raw vegetables') and other useful plants.

In general, *lalab* ('raw vegetables') are widely known for their medicinal properties. In this respect, *lalab* represents an essential component of the daily diet of not only the inhabitants of Sukamiskin, but also of the Sundanese population at large which is often found on the menu of restaurants and food stalls. Throughout the research area, *lalab* are frequently cultivated at home and as such widely available. In this regard, the Sundanese people identify food, particularly the harvesting and consumption of food, as a potential cause for disease, rendering the prevention of disease by consuming safe and nutritious types of food as most important.

In addition, herbal medicine forms a significant part of the traditional medical system available in Sukamiskin and elsewhere throughout the country (*cf.* Slikkerveer 2006). The providers of herbal medicine generally adhere to the following principles: (1) herbal medicine is administered in accordance with the age and specific needs of each individual patient whereby it is possible that two patients with similar clinical conditions receive different herbal prescriptions; (2) herbal medicine is intended to restore the natural internal balance of the body; and (3) herbal medicine never relies on a singular chemical component, but on the whole composition of the various components of plants (*cf.* Vitahealth 2006).

The *Badan Pengawas Obat dan Makanan* (BPOM) ('Food and Drug Control Agency') of Indonesia distinguishes between three types of herbal medicine: *jamu,* standardised herbal medicine, and phytopharmacy (*cf.* Purwanto 2013). *Jamu* refers to mixed potions which are prepared on the basis of the medicinal properties of natural ingredients, mostly from plants, such as *i.a.* turmeric, curcuma, ginger or garlic where much empirical evidence is supported by research conducted in herbal medicine. Examples of the different ingredients and compositions of *jamu,* as they have particular medicinal properties, include the *mengkudu* or *morinda* which is known to be anti-cancerous and anti-bacterial; curcuma which has a restorative effect on hepatitis and gastritis; and garlic which is used against hypertension and obesity as well as for the prevention of antheriosclerosis (*cf.* Vitahealth 2006). Furthermore, *jamuberas kencur* can be administered to a child, who suffers from loss of appetite in order to enhance the appetite.

In 2013, the Ministry of Health adopted also several decrees with regard to health and traditional medicine, indicating a growing interest and recognition of various forms of indigenous or traditional and complementary and alternative medicine available in Indonesia. In particular, the Ministerial Decree No. 296/MENKES/SK/VIII/2013 announced the formation of the 'National Commission of Scientification of *Jamu'* which was introduced in 2012 (*cf.* Table 5.13). The 'Scientification Team' aims at disseminating recent information on *jamu* and herbal medicine to the general public. Similarly, the Ministerial Decree No. 299/MENKES/SK/ VIII/2013 announced the establishment of the 'National Workgroup on Traditional, Alternative and Complementary Medical Treatment'.

Table 5.13 Decrees of the Ministry of Health related to Traditional Medicine (2012)

No.	Decree	Concern
1	*Kepmenkes* 137/MENKES/SK/III/2012	Archive Classification Pattern
2	*Kepmenkes* 155/MENKES/SK/IV/2012	National Commitee of *Jamu* Scientification
3	*Kepmenkes* 182/MENKES/SK/V/2012	Exception to Information in Health Ministry Environment
4	*Kepmenkes* 378/MENKES/SK/X/2012	Ethnomedicine and Holistic Research in Indonesia
5	*Kepmenkes* 424/MENKES/SK/XII/2012	e-Health Working Group

Source: Ministry of Health (2012).

Health Law No. 23, 1992, however, recognizes the existence of Traditional Medicine in the form of herbal treatment. In this context, TM is defined as medicine which is derived from natural materials taken from plants, animals or minerals and of which the knowledge has been passed on from generation to generation. In this context, *jamu* is divided into three categories: (1) *jamu* as TM which has not yet been scientifically investigated on the basis of its active properties and potential to produce recognisable effects; (2) *jamu* as standardized herbal medicine which uses standardised seeds and other raw materials and in which practices such as cultivating, harvesting and processing are monitored continuously; and (3) *jamu* as herbal medicine which has undergone clinical trials. Following clinical trials which are conducted incessantly in order to improve the standard of herbal medicine, 13 out of 33 medicinal plants have so far been clinically approved and have been registered by the Ministry of Health, and can as such be used as components in modern medical treatment. In Central Java, for example, several medicinal plants have been categorised as standardised herbs and have been integrated into formal treatment services offered at public health centres.

In Sukamiskin, *jamu* (‘traditional herbal medicine’) is widely used by the local population and can easily be acquired in local stalls, *jamu* kiosks and *jamu* cafes as well as from *jamu* vendors (*cf.* Illustration 5.11). Most stalls offer types of instant *jamu* or instantly prepared *jamu* which are usually sold in packages produced traditionally in large amounts. The *jamu* kiosks commonly sell herbal remedies in the form of beverages which can be consumed on site or at home. Besides selling different types of herbal medicine, the kiosks also offer customers the possibility of inquiring about the different brands and benefits of *jamu*. The *jamu* peddlers are often middle-aged women, called *Tukang Jamu Gendong* or *Mbok Jamu Gendong*, who carry their bottles of *jamu* in a basket on their back and offer it either door-to-door or by using a bicycle to go around the community (*cf.* Illustration 5.6).

The *jamu* peddlers are respected for having a vast knowledge of the particular types of *jamu* with regard to the needs of their customers. While selling herbs, the *mbok jamu gendong* also represent sources of information on health, herbal remedies or *jamu* in particular, thereby meeting the health information needs of their customers. The knowledge maintained by the producers of herbal medicine is generally passed on from generation to generation.

Illustration 5.6 A *Tukang Jamu Gendong* selling her *Jamu* door-to-door.
Photograph by Sekar (2013).

By consequence, the community members who have received this kind of information and who experience similar disorders develop the desire to use the same herbal remedy. Although patients may in fact consume the same type and dosage of the remedy, the recovery rate is likely to vary among individuals, not least because of their different medical histories.

Illustration 5.7 *Jamu* in Sachets in the Form of Powder and Tablets.
Photograph by W. Erwina (2010).

The manufacturing of herbal medicine has developed into a home-based industry which provides many positive contributions to public health. Traditional herbal medicine is usually marketed

orally, *i.e.* information about herbal medicine is spread among the public through mouth-to-mouth promotion. Patients who have had a positive experience consuming *jamu* will share the information about the pain they have suffered prior to taking herbal medicine as well as about the healing process after taking herbal medicine with others.

Another component of the traditional medical system available in Sukamiskin refers to massage which is exercised by a *tukang pijat* ('masseur'). The massage is a method of applying pressure to some or whole parts of the body which are aching. The purpose of the massage is to improve blood circulation and to make the patient feel relaxed, thus facilitating the recovery of the patient. Different massage methods have been identified which are: (1) relaxation massage: massage focusing on blood circulation improvement and muscle relaxation; (2) treatment massage: massage focusing on physical trauma or injury to the muscles, tendons or ligaments; (3) sports massage: a combination of massages to enhance performance and to recover from injuries caused by physical exercise; (4) aromatherapy massage: massage combining therapeutic and essential oils while using a special massage technique to improve recovery, health and well-being in general; (5) reflexology: a massage technique involving the application of pressure on pressure points on the patient's feet to enhance energy balance in the body; and (6) oriental massage: massage intended to provide treatment in accordance with oriental forms of medical treatment, such as acupressure, *shiatsu* and *tui na* using meridian lines on the body to balance the inner energy (*cf.* Vitahealth 2003).

Apart from the different massage techniques which involve muscle treatment, physical traumas are treated with a special technique called 'bone workshop'. In Sukamiskin, fractures are commonly treated by bone setters, using a combination of traditional instruments and massage methods.

Illustration 5.8 Traditional Eye Acupressure Treatment.
Photograph by W. Erwina (2013).

Acupressure represents a traditional method of massage which involves the application of pressure on certain acupunctural points of the body. In contrast to acupuncture, however, the acupressure method relies on the use of fingertips rather than needles. In Sukamiskin, the method of acupressure which is generally available and affordable to the local community members has been used for the treatment of sight problems, such as myopia and far-sightedness by applying pressure on relevant neural points (*cf.* Illustration 5.8). While administering treatment, the acupressure therapist commonly tends to share his traditional health information on several topics, such as the prevention of a disease by consuming certain foods or avoiding certain conditions as well as treating an illness in a particular way. Patients are generally free to ask any questions relating to their health which can often be overheard by others in the room.

In addition to acupressure, the inhabitants of Sukamiskin use other traditional treatment methods, such as acupuncture and Reiki as well as therapies relying on the application of stings, white rice grains or leeches, as they all represent components of the locally available traditional medical system (*cf.* Figure 5.10). Usually, such forms of treatment are offered by alternative health care providers located in the area around Sukamiskin. Various forms of traditional medicine moreover include treatment administered by the *indung berang* ('traditional birth attendant'), although no *indung berang* has been practising in Sukamiskin since 2012. The role of the traditional birth attendant has since been occupied by the midwife, *bidan*, who is trained in modern medical knowledge of Maternal and Child Health (MCH) (*cf.* Ambaretnani 2012).

The members of the Islamic population group in Sukamiskin also act sometimes as providers of particular forms of traditional medicine including the administration of: (1) holy water as a therapeutic element; (2) *bekam*, also known as *badkesh, bahes, buhang, bentusa, kyukaku, gak hoi, hijama* as well as bruising or cupping, a treatment which is mentioned in Islamic writings and recorded in the *Hadith* of Bukhari (*cf.* Gray 2010); the method of bruising or cupping aims at smoothening the blood circulation and easing 'dirty' blood out of the human body; and (3) *rukiyah* which is a reference to *ruqyah* '*syar'iyah*' and means reciting the Al Qur'an verses or praying to Alla. The prayers are usually directed at the alleviation of illness which is suffered either by the one who prays, or by someone else. The treatment involves placing the ablutionary right arm on the affected part of the body or on the forehead of the patient, while spelling the name of Allah and reciting the *ayats*. Examples of *ayats* which are used during this kind of treatment are Al-Fatihah, Al-Baqarah, Ayat Kursi, Ali'Imraan, Al-A'raaf, Yunus, Thaaha, Al-Mu'minuun, Ash-Shaaffaat, Al-Ahqaf, Ar-Rahman, Al-Hasyr, Al-Jinn, Al-Ikhlaash, Al-Falaq and An Naas (*cf.* Gray 2010).

Traditional Health Care Providers in Sundanese Communities

Indigenous health care practitioners, who are considered to be rather versatile, are known as *paraji*or *paraji sakti*. The Sundanese people, commonly use the term *paraji* to refer to a person who helps to deliver a baby, and is usually called *indung beurang.* Likewise, a person performing a circumcision is referred to as as *paraji sunat* in the Sundanese language, whereas the profession is otherwise known as *bengkong*. In addition to the *ajengan* ('religious healer'), the shaman is a traditional healer with medical skills, who treats spiritual and supernatural diseases on the basis of the cultural knowledge received from the *tukang teluh*, an expert in creating occult diseases. Traditional health care across the Sundanese communities is also provided by the *paneluh, patah tulang* ('bone-setter') and *nyeri huntu* ('dental expert').

Generally, traditional health care providers tend to cast meditative spells during their treatment procedures which are rooted in the local systems of behaviour and belief. In the Indonesian Dictionary, *Kamus BesarBahasa Indonesia* (*KBBI*), a, *mantra* or *jampe* ('spell') is defined as a courtesy or a saying which produces magical effects, such as a curse or a blessing.

The dictionary of *Kawi*-Indonesia locates the origin of the term '*mantra*' in the *Sansekerta* meaning of prayer or *du'a* (*cf.* Sastrawijaya 1995). *Mantra* or *jampe* which are applied to the treatment of a specific type of illness, can differ over geographical regions. Meditative spells can moreover contain Islamic prayers which are the result of the process of acculturation between the local culture and the Islamic religion. According to data released by the World Health Organization (WHO 2006), around 4 billion people or 80% of the world population make use of herbal medicine.

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Illustration 5.9 Café *Jamu* Al Masoem in Sukamiskin. Photograph by W. Erwina (2010).

Recent research shows that out of 119 modern medicinal substances used in pharmaceutics, 74% are taken from plants and correlate directly with the traditional source (*cf.* Vitahealth 2006). Throughout the research area, people generally also acknowledge the efficacy of the traditional medical system in its original, indigenous form which promotes the use of traditional medicine Sometimes, the traditional herbal medicines are packed in modern sachets in order to facilitate the practical use in liquids, teas and pills, often sold by commercial vendors in *jamu* stalls, shops or cafes (*cf.* Illustration 5.11). Although these herbal medicines are processed in a modern way and packed in modern shapes for easy application by the patients, they are largely derived from traditional herbal ingredients, and are as such categorised as traditional medicines.

Some traditional forms of treatment, such as herbal remedies which are widely available to the community of Sukamiskin, are currently also analysed experimentally for their health benefits. The experimental study of the safety and benefit of medicines which are mainly derived from natural ingredients is known as phytopharmacy. These particular forms of medicines are preclinically tested on animals as well as on humans, so that the ingredients and the end-products can eventually be standardised and submitted to quality tests for wider formal utilisation by the general public *(cf.* Purwanto 2013). A number of herbal drinks, for example which are made directly from dried or fresh ingredients, are also sold in the form of capsules or powders to be prepared with hot water. The majority of herbal medicines which are sold in Sukamiskin originate from West Java and other parts of Indonesia, including Central Java and Madura. In the same way, other traditional medicines, such as *habatusauda,* are imported from countries such as China and Korea. The utilisation of traditional medicines, such as *jamu,* is also promoted through the mass media, in particular in newspapers, radio and TV.

5.4.2 The Modern Medical System

In 2004, the national health care system of Indonesia adopted the globally recognised approach to Primary Health Care (PHC) of the World Health Organization (WHO 1978) which was identified in 1978 in Alma Ata (Russia) as an appropriate approach to reach 'Health for All' in Indonesia. This approach has also been formulated in the Indonesia Vision (2010) as the new policy based on an integrated strategy of health care development which aims at achieving the following health development goals (*cf.* Indonesia Vision 2010):

1. *Health Efforts*
Health efforts are to be implemented through a number of activities including: the supply of health and nutritious services; prevention and elimination of disease; and provision of a healthy environment.

2. *Health Finance*
The objective of health finance relates to an analysis and intensification of the financial flows towards health care improvement available in the respective country. In Indonesia, strategies of health care development are usually financed by two sources: firstly, state and local budgets, *i.e.* financial resources from the central government, the provinces as well as the districts and cities; and secondly, public and private financial resources which include household and individual out-of-pocket expenditures as well as means from private companies and enterprises to finance non-government employees and institutions commonly used for communal health care activities.

3. *Human Resources*
Human resources for health care development are to be obtained through planning, analysis and design work as well as through specific information systems.

4. *Medicine and Health Provision*
Medicine and health provision aims at overcoming difficulties in the availability, distribution and affordability of medicine.

5. *People Empowerment*
The goal of people empowerment relates to the empowerment of communities through health promotion efforts, in the past known as community health education or public health education.

Table 5.14 Description of Modern Health Care Providers.

Health Care Practitioners	Doctors, Dentists
Nursing Personnel	Nurses, Midwives
Pharmacy Personnel	Pharmacists, Pharmaceutical Analysts, Pharmacy Assistants
Community of Health Workers	Health Epidemiologists, Health Entomologists, Medical Microbiologists, Health Extension Officers, Administrators of Health and Sanitation
Physical Therapists	Physiotherapists, Occupational Therapists, Medical Speech Therapists
Health Workers	Radiographers, Radiotherapists, Dental Technicians, Electromedic Engineers, Health Analysts, Opticians, Prosthetics, Medical Technicians and Transfusion Recorders

Source: PP No.32 1996 in Adisasmito (2007).

6. *Health Management*

Health management is to be achieved through effective health administration as well as the planning, execution, control, monitoring and accountability of the organisation of health caredevelopment.

Throughout the research area, patients are also interacting with a number of different modern health care providers (*cf.* Table 5.14). The development of the modern medical system has taken place in accordance with the development of the technologies and regulations concerning health care development. The concept of the National Health Coverage, for example, was introduced as a general concept of health insurance which is in line with Article 19 of Law No. 40 of 2004 concerning 'health insurance' on a national scale and on the basis of the principles of social insurance and equity (*cf* Republic of Indonesia 2004). In 2011, the Government of Indonesia passed Law No. 24 of 2011 concerning the *Badan Penyelenggara Jaminan Sosial* (BPJS) ('Social Insurance Organising Institution') which had been expected to be implemented in 2014, reaching the entire population of Indonesia (*cf.* Adisasmito 2007).

Official health policies in Indonesia also involve the establishment and operation of a health care system which ensures that patients are comfortable and satisfied with the medical treatment offered. In order to meet these requirements, the health care system in Indonesia is based on a network of health care providers on the supply side and people on the demand side, who make use of the services and materials offered by the providers.

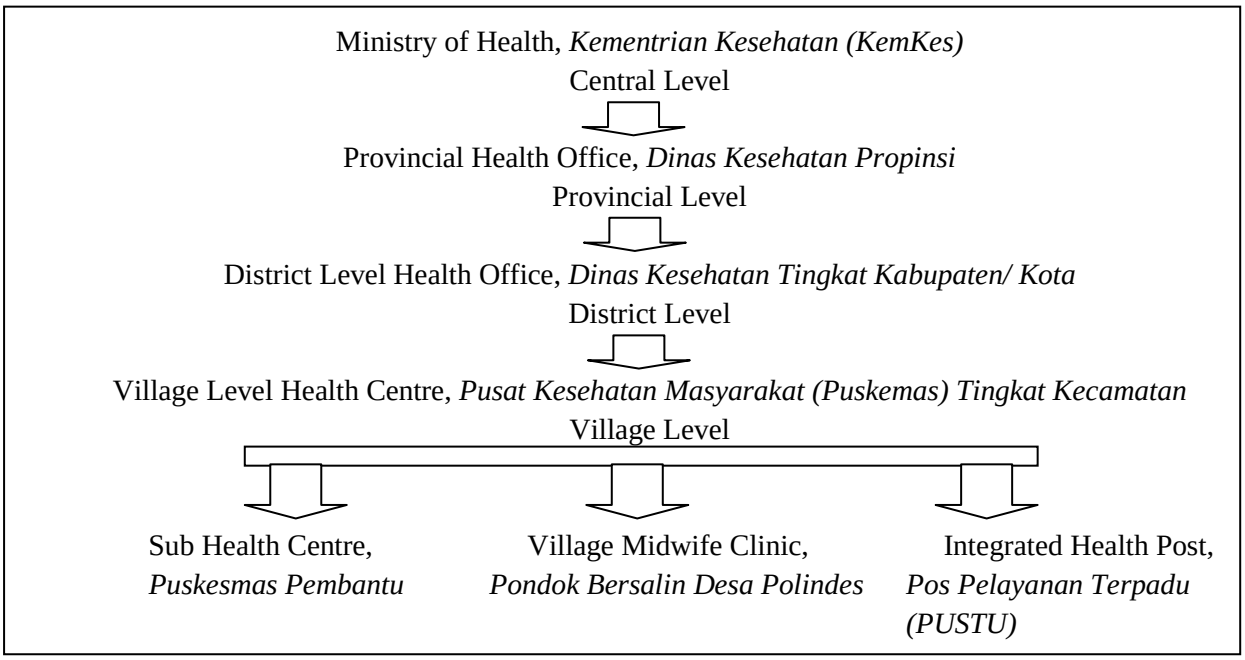

Figure 5.2 Organogram of the Modern Health Care System in Indonesia.
Source: Ministry of Health (2010).

In accordance with the Constitution of 1945, the National Health Care System was introduced in 1982 through a government decree which was adjusted in 2004 (*cf.* Rafei 2004).

The current health care system operates along well-structured lines of hierarchy and bureaucracy which include health centres at the local level, representing the main health agencies in every village. Figure 5.2 presents the structure of the National Health Care System of Indonesia.

Pusat Kesehatan Masyarakat (*Puskesmas*) ('Community Health Centre')

The *Pusat Kesehatan Masyarakat* (*Puskesmas*) ('Community Health Centre') was first introduced in 1971. In accordance with the strategy of 'Healthy Indonesia' adopted by the Ministry of Health in 2012 and the need for developing health sectors in the decentralised areas, the ministry implemented the idea of a public health centre at the local level. The concept of the 'Healthy Village' advocated in 2013 anticipates a future local society which lives in a healthy environment, exhibits healthy behaviour, is able to reach health services and ultimately has the highest degree of health (*cf.* Muninjaya 2004).

The public health centres operating at the local level not only function as a first contact point for patients to receive health care, but also act as centres and motivators for useful health development as well as for community and family empowerment. The basic health services which are provided by the health centres include not only Maternal and Child Health (MCH), general medical care, basic laboratory work and basic statistics, but also the provision of modern health information, including environmental sanitation, communicable disease control and health education for community groups. From all the services available, the representatives of the public health centre are entitled to implement the programmes which are most needed by the local communities.

Since 2010, various forms of health insurance available in Indonesia refer to *Asuransi Kesehatan* (ASKES) ('Health Insurance') which is allocated to civil servants (PNS), army employees (TNI) and police as well as retired civil servants and their families.

In addition, there is the *Jangkauan Programme Kesehatan* (JPK) ('Progressive Health Care Programme of *Jamsostek*') which is allocated to employees in the private sector and their dependants. The *Jaminan Kesehatan Masyarakat (JAMKESMAS)* ('Community Health Insurance') is allocated to the poor whereby the costs are covered by the state government, while the *Jaminan Kesehatan Daerah/Programme Jaminan Kesehatan Masyarakat Umum* (JAMKESDA/PJKMU) is allocated to the poor whereby costs are covered by the regional government (*cf.* Adisasmita 2014). The local health care system in Sukamiskin offers first-line care at the *Pos Pelayanan Terpadu* (*Posyandu*) ('Integrated Health Post') which is related to the *Pusat Kesehatan Masyarakat* (*Puskesmas*) ('Community Health Centre') in Arcamanik. In turn, the *Pusat Kesehatan Masyarakat* (*Puskesmas*) ('Community Health Centre') coordinates its activities, including the distribution of information and health promotion with the district and village offices as well as with schools in the area.

Notes

[1] The 'Arcamanik Reading Corner' was established in 2001 with the purpose to help less fortunate members of the community to improve their reading skills and to provide the community of Arcamanik with further access to information and knowledge. The reading corner is also used as a community centre and was labelled the 'second best reading corner' in the Province of West Java. Furthermore, the reading corner has engaged in a number of activities, such as *i.a.* the Astrocamp, in collaboration with the Astronomic Student Association of the Bandung Technological Institute (ITB); the Boscha Observatory; the Programme for Identifying Dangers of Fire with the Fire Brigade; and activities undertaken with the Centre for Environment Studies.

[2] The *Pos Pelayanan Terpadu* (*Posyandu*) ('Integrated Health Post') was established in almost all hamlets by the government in 1984 as the result of a 'Community Empowerment

Effort' (UKBM). Each *Posyandu* is linked to the nearest public health centre and aims at disease prevention as well as health promotion among the members of the community. The*Pos Pelayanan Terpadu* (*Posyandu*) ('Integrated Health Post') implements five priority programmes which include: Family Planning (KB); *Kesehatan Ibu dan Anak* (KIA) ('Maternal and Child Health'); Nutrition; Immunization; and Diarrhoea Prevention. The health posts frequently oversee the undertaking of activities organised by community volunteers, the so-called *kader kesehatan*, such as the toddlers' care which refers to a programme specifically designed for the development of toddlers, involving the administration of immunisation and vitamin A, as well as oral rehydration therapy (ORT) (*cf.* Adisasmita 2014).

[3] In the present context, the English term 'local institution' is used as a direct reference to the Indonesian term '*institusi lokal*'. The Great Dictionary of Indonesian Language, *Kamus Besar Bahasa Indonesia*, defines '*institusi lokal*' as: (1) an institution; (2) an agency which is built with reference to law, culture or customs, such as clubs, associations or social organisations; or (3) a building where the activities of a club or organisation are held. In general, the word '*lokal*' can either be translated directly as '*local*' or can be used to describe one particular region. In other words, a local institution can refer to an institution which is located in a particular region whereby the regulations and rules of that region do not apply in other regions. Hodgson (2006) explains that any interpretation of the term 'local institution' is etymologically in line with the description of the term 'local institution' in the Indonesian Language. On the basis of this definition, Hodgson (2006: 2) states that: '*Institutions are the kinds of structures which matter most in the social realm: they make up the stuff of social life. The increasing acknowledgment of the role of institutions in social life involves the recognition that much of human interaction and activity is structured in terms of overt or implicit rules.*' Following Hodgson's statement, a local institution can be defined as an institution which is involved in the structure of local community life and contributes to the improvement of community life towards a better future. The objective towards a better future firmly rests on processes of interaction among the individual members of the community.