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A Limited Report On Child And Family Welfare In Indonesia

By

Myranawati
One of the main objectives of child and family welfare in Indonesia is directed towards mother and children. I'll try to formulate it in the following words. Mother should be brought safely through their pregnancy, labour and puerperium and consequently securing the infants to be born and brought up in a favourable condition, freed from its hazards and enjoying both the physical and mental needs for their physical and mental developments.

One of the crucial problems of health in Indonesia, as it may probably be encountered in other developing countries, is the extremely high morbidity and mortality rate among mothers and infants. There is a report that infant mortality rate is estimated to be in the range of 100 - 110%. This comprises the greatest part of number of deaths in young children under the age of 5 years. Some observers claim, that this figure is lower than the actual fact, since report of death cases from deliveries conducted by village midwives are not available. 75% of all deliveries in rural areas are conducted by them. There is a reluctance among the population and the village midwives to report death cases to the authorities in charge with.

Specifying the death figures among children under 5 year of age, dr. Anna Alisyahbana is giving the following distribution:

- perinatal death: 43.9%
- fetal death: 12.1%
- early neonatal death: 31.8%

Reported as taking the highest toll of lives is Tetanus infection (1.6,2%), other infection (7.7%) and asphyxia (24.1%) being the next.
2.

Figures as reported by Dr. Anna Alisyahbana is collected from her observation at Ujung Berung, a village some 20 km from Bandung.

Among the contributory factors leading to high infant mortality rate is the poor care of women during pregnancy, and the unskillful management of their labour. Health condition, especially during pregnancy in developing countries - related closely to the social and economic states of the women or their family, which is generally not favourable as malnutrition, bad housing, overcrowding always accompany the condition. Multiparity or diseases already affecting the women before they become pregnant, may worsened their health during pregnancy, and consequently enhance the risk of mortality.

To mention a disease which is so prevalent among the Indonesia mothers is anemia. This anemia will become severe, since labour is always accompanied by bleeding. Probably the most frequent cause of mother's mortality after deliveries is the preexisting anemia. Anemia become more and more important as a cause of death since post partum hemorrhage is almost always not properly handled by village midwives.

A problem other than infant's death is the low birth weight which is very prevalence in Indonesia. It is estimated to be in the range 13-20% of all babies born.

Due to the low level of education of the general population, especially among women, there is inadequate understanding and insufficient awareness of health problems. Superstitious beliefs inhibit attempts to improve health conditions by modern means. Although the development of Indonesia's economy shows great promise, at the present stage where annual income per capita is still low, it will be very difficult to raise sufficient funds for development in the health sector and for better food and nutrition intake.

Other factors ..........
3.

Other factors having close relation to the current health situation in Indonesia are, among others, the poor environmental sanitation, inadequate safe water supply (only 12% of the total population receiving safe water supply up to 1979), poor housing condition with overcrowding, insanitary excreta disposal (only 12% of the total population have sanitary excreta disposal) and inadequate drainage system.

THIRD FIVE YEAR PLAN

The first and the second five year plan have been implemented, and since 1979 - 1984 the third five year plan is on its way. This goal, reflected in the third five year plan, will be achieved through the following main objectives:
1. reduction of morbidity and resultant disabilities
2. improvement of the nutritional status of the community
3. equitable supply and utilization of health services
4. improvement of environmental health services, facilities, maintained and developed by the community
5. improvement of community's awareness of healthy living, participation and self-reliance to improve their health status.
6. development of family welfare, encouraging the small size type of family.

In order to reach the above mentioned objectives, the activities carried out for the improvement of health services, are based on the following policies:

a. low income groups in community either in villages or in the cities have priority in the provision of health services
b. health services give special emphasis to preventive measures and the promotion of health itself.

c. intensification of medical services delivered through ambulatory care.

d. Health Care ........
d. Health Care Delivery System is design to provide services that are evenly distributed to the population, with active participation of the community. This include traditional medicine when its effectiveness has been proved.

Delivery of health services is carried out through Health centres and its referral system. It is expected that at the end of the Third Five Year Plan the system will be able to deliver, evenly distributed comprehensive health services that are effective and efficient, with community participation and acceptance. Thus, everybody has easy access to health services, whereby provident health problems will be reduced.

During the Third Five Year Plan, emphasis will be laid on an overall and purpose full development will cover planning, education and training and utilization of health workers.

Efforts, undertaken provide sufficient and effective drugs payable by the community at large. For this purpose, drug regulation and drug management will be developed.

The most ideal place for labour, is still the well equipped hospitals. But these items are only available in big cities, so that a system of referral should be instituted. Severe cases are to be referred there.

Labour at home still bear the dangers of the same, especially when it is conducted by village mid-wives. This is to be reduced by educating those village mid-wives, giving them the knowledge of hygiene and diagnosing labour complications and consulting actual mid-wives in case of encountering difficulties.

A routine procedure to stop the post partum bleeding is the parenteral administration of ergometrin and drugs of the like. It is very advisable that the know how of this routine procedure is to be taught to village mid-wives and a resultant reduction of number of post partum bleeding is secured.
Up to April 1979, 56,772 indigenous midwives have been trained in hygiene and other aspects of health especially those related to mother and child health. Beside their contribution in mother and infant care, these indigenous midwives are also equipped to disseminate health messages to their clients, to identify symptoms of communicable diseases and to refer them to the Health Centres. This training has contributed to the alleviation of infant and maternity mortality rate caused by unhygiene deliveries.

Before closing this short account, mention on breast-feeding will be made. It is more a culture rather than nutritional, that mothers in the rural area are breast-feeding their infants, in a manner which greatly differs from that done by their counterparts in cities. These rural women are breast feeding their infants during the days as they are doing their work, and at night from 6 p.m until 6 a.m the next day. The latter is done due to the absence of electricity in most rural area.

Ladies and gentlemen, this report may be very short. But I do hope that it will be sufficient and providing a little bit material to formulate the role of communication to be played in child and mother welfare.

Thank you very much.