CULTURALLY DISTINCT COMMUNITIES

1. Culturally distinct communities (CDCs) are defined as groups of people who live or wander in dispersed, isolated areas, adhere to sociocultural systems distinct from mainstream Indonesian society, and are often viewed as "left behind." The term isolated is understood in terms of both geography and culture, while "left behind" is defined according to measures of human development, such as, health, education, housing, clothing, and livelihood. It is difficult to identify CDCs on the basis of official lists or through reference to official census records; the census does not provide ethnic information and ethnolinguistic maps are incomplete and obsolete. The process of identifying CDCs requires in-depth interviews with organizations or groups associated with CDCs, including Government ministries, non-governmental organizations (NGOs), and missionary or church groups, and consultations with community members at the subdistrict level, in areas that have been identified as geographically isolated and are most likely to have CDCs vulnerable to change.

2. The Health and Nutrition Sector Development Program (HNSDP) is essentially neutral with respect to CDCs. There will be no adverse effects from the project. Although the HNSDP does not specifically address CDCs and their issues, some components of the HNSDP are national in scope, therefore, a certain amount of contact with CDCs is inevitable. However, it is impractical to identify all CDCs prior to beginning the HNSDP, and a basic strategy is needed to address traditional and sociocultural issues of CDCs prior to HNSDP implementation. Parallel HNSDP interventions are intended to help modern medical personnel become sensitized to CDCs and their traditions, and to raise awareness among CDCs about modern nutrition and health practices without disregarding their traditional practices and beliefs.

3. CDCs tend to use health centers much less often than mainstream Indonesians, because of (i) difficulty of geographic access that entails high costs, both in terms of money and time; (ii) the availability of health centers and the adequacy of their facilities, i.e., beds, drugs, medical equipment, blood supplies, etc.; (iii) the treatment they receive from health center personnel, including village midwives, who are often not adequately trained, or culturally sensitized to deal with CDCs; (iv) a lack of education and awareness of nutrition and health issues; and (v) an adherence to traditional healing and birthing practices based on a combination of animistic and spiritual beliefs associated with childbirth and sickness.

4. Most CDCs live in isolated areas of low population density, and many isolated communities are not accessible by road. In mountainous or highland areas where access is very difficult, outreach activities may occur infrequently, if at all. In certain parts of Indonesia, particularly in the inaccessible highlands of Irian Jaya, public health service providers are only located in the subdistrict capitals. In the remote areas, health care is provided through a network of missionary and church organizations. The isolation of these villages coupled with the limited interaction with mainstream Indonesian society makes it hard for an indigenous woman to leave her village, family members, and familiar surroundings to deliver a baby in an unfamiliar and uncomfortable health center or hospital, that may be far away and over difficult terrain. Most pregnant women also need to be accompanied by family members, but health centers in rural isolated areas generally do not have facilities to accommodate family members. Ability to pay also plays a major role; most CDCs cannot afford to lose a day's work to travel to a health center or hospital, nor can they usually afford to pay the fees for an examination, for

medication, or for a midwife to deliver a baby. They tend to prefer to self-medicate using traditional medicinal herbs or to consult traditional healers and birth attendants.

5. Subdistrict health centers are unpopular postings for health personnel, most especially for trained midwives. These health centers tend to be in isolated areas with few opportunities for career enhancement. As a result, younger, newly trained midwives, with little experience, tend to be assigned to isolated areas. In the absence of family links, most midwives do not develop a bond with the community in which they have been placed, find it increasingly difficult to perform or commit to their work, actively interact with the community, and tend to leave before their tour of duty is complete. Generally, midwives that come from the area or a neighboring village tend to perform better and have a higher retention rate than those who do not.

6. Research and observation have shown that health center personnel tend to treat patients in a brusque, impersonal, and even discourteous manner. Indigenous peoples are viewed culturally by mainstream society as "base, unhygienic, and primitive" and are treated accordingly by health center workers. Health promotion materials and operational manuals are generally centrally produced, do not account for sociocultural or religious sensitivities, and in many cases, have actually served to offend certain cultural groups. The obvious lack of respect for traditional beliefs, and the discourteous and even scornful treatment of women on behalf of health service personnel continues to perpetuate the fear and unwillingness on behalf of indigenous women to seek medical attention and use modern health centers or hospitals, especially for deliveries.

7. Partnerships need to be developed between Government health services and appropriate NGOs, missionary, and church groups to provide better services to the CDCs. To overcome the problems of access to the health centers experienced by isolated CDCs, additional resources should be provided for suitable modes of transportation for health center personnel, especially the midwife. The HNSDP will encourage public sector providers to work as much as possible with the grassroots network already in place, rather than competing with it, in the outreach campaigns, and in the efficient delivery of health services. Moreover, the complete participation of the community will be vital to the project in order to satisfy specific locally identified needs.

8. An international and domestic consultant, with knowledge of local indigenous languages, will be recruited to identify concentrations of CDCs and to conduct a study of the existing sociocultural barriers that impede CDC utilization of health services. The consultants will develop a plan, in close consultation with the community, that will take CDC issues, beliefs, and concerns into consideration and incorporate them into the HNSDP's project interventions in health and nutrition in CDC areas. The HNSDP will support the development of a training program for cultural sensitization of health personnel, with a particular focus on midwives, to increase understanding of CDCs, their traditions and sociocultural norms to encourage the utilization of services by, and the effective delivery of services to CDCs. The primary aim is to ensure that health care, and particularly maternal health care, is made a priority of CDCs and of health service providers in areas that serve CDCs. Vigorous social marketing and information, education, and communication campaigns, culturally acceptable to the community, will have an important role to play.