Participation of Community in Health Development Based on Local Genius in Indonesia

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Abstract: This study aims to analyze the role of local wisdom in building community participation in health development in Ujungjaya district of Sumedang Regency both the outcome and process of participation. Triangulation of interviews, observation, and documentation in data collection support qualitative research. Data processing procedure with display, reduction, conclusion and triangulation. The participation of community of Sumedang Regency both in the form of outcome and process from start of mind, energy, skill and social could happen because of local wisdom. Therefore, the increase of community participation in the activities of alert villages, health cadres and posyandu, local wisdom should be used as a driving force. To measure the success of participation and the process of implementation of community participation, the criteria and indicators of success not only refer to the quantity and quality of participatory output and processes but also pay attention to the achievement of the policy objectives and targets as well as the extent to which local wisdom was concerned.

1 INTRODUCTION

The development of the State administration paradigm begins the paradigm of the old State administration, the paradigm of administration of the new State, the paradigm of new public management, the paradigm of new public service and governance. The old State administration paradigm pioneered by Wodrow Wilson, F.W. Taylor, Max Weber, Henry Fayol. The main focus of the administration of the old State was public service by government organizations (Dernhart and Dernhart, 2003). The main values developed was effectiveness, efficiency, and rationality.

The New State Administration paradigm emerged in the 1970s. In 1971 there was a conference that produced a collection of papers "Toward a New Public Administration: The Minnow brook Perspective". George Frederickson presented a paper entitled "The New Public Administration". The New State Administration paradigm developed that the performance of public administration was not only judged by the achievement of economic value, efficiency, and effectiveness but also on the value of "social equity" (Frederickson, 1980). Because the state administration is committed to realizing humanitarian and equity values, Frederickson rejects the view that administrators and state administrative theories must be neutral and value-free.

New Public Management paradigm (NPM) emerged in the 1980s and strengthened in the 1990s. The basic principle of the NPM paradigm was to run state administration as it moved the business sector. NPM paradigm proposed by David Osborne and Ted Gaebler (1992) in the concept of "Reinventing Government". Osbone and Gaebler suggested to inject the entrepreneurial spirit into the state administration system. The public bureaucracy has to use steering rather than rowing. By way of "steering", the government does not directly work to provide public services, but to the extent possible submit to the community. The role of the state was more as a facilitator or supervisor of public affairs.

Paradigm New Public Service (NPS) was a concept that was raised through the writings of Janet V. Dernhart and Robert B. Dernhart entitled "The New Public Service: Serving, not Steering" was published in 2003. NPS paradigm intended to "counter" administrative paradigm that became the current mainstream of the New Public Management paradigm that was principled "run government like a business" or "market as a solution to the ills in public sector".

According to Dernhart (2008), the NPS paradigm saw the importance of the involvement of many

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actors in the conduct of public affairs. In public administration what was meant by public interest and how public interest was realized was not only dependent on government institutions. Public interest must be formulated and implemented by all actors, both government, business, and civil society. This view make the NPS paradigm was also called the Governance paradigm. In this paradigm, state managers are not only the public sector but also the private sector and civil society (civic organizations, NGOs, and communities). Thus, based on the paradigm of governance, development became a joint task between the public sector, private sector, and civil society.

This study was based on the paradigm of governance, that development was a task between government, private and community, especially reviewing community participation. Nevertheless, this study used the paradigm of the new State administration that science was not value-free. This study is expected to develop a new variant of the governance paradigm with the basis of the values of Sundanese.

In Indonesia, the awareness that development were a common task between the public sector, the private sector and civil society was not well established. Development was only seen as the main task of the public sector. Therefore, the private sector and civil society should be encouraged to become the main actors of development through the engineering of development programs. The development result in the new order era (until 1998) was only enjoyed about 2 percent of the total population of Indonesia. The implication of Indonesian society was apathetic when asked to participate in development.

Thus, the purpose of this study was to analyze the role of local wisdom (Sundanese Values) in building community participation in health development in Ujung Jaya District, Sumedang Regency, both the outcome (form) and process of participation.

2 DEVELOPMENT PARADIGM

Viewed from the perspective of community participation, the development paradigm was divided into the paradigm of modernization (Smelser, 1964; McClelland, 1961; Rostow, 1960), dependency paradigm (Prebisch 1953; Baran 1957; Frank 1967; Dos Santos; 1971), ecological paradigm (Gardner and Lewis, 1996; Hoogendijk, 1991; Adams, 1993), basic needs paradigm (Streeten, 1981), liberation paradigm (Freire, 1975), endogenous paradigm (Friedman, 1992).

Development paradigms affect the praxis of community participation in development as the object of this study. Development paradigms will affect the types of community participation, such as the authoritarian approach (where the development program was planned and implemented solely by the government without the involvement of the community), the tokenism approach (development programs were planned by the government while the people would participate in their implementation in terms of energy, funds), and participatory approaches in which local communities make decisions and take full responsibility in planning, implementing, monitoring and evaluating development programs with government and NGO support (PMD-JICA and PSKMP-UNHAS, 2000).

Participation can be studied from both the output perspective and from the process perspective (Kulozu, 2014). In its development, the target of research changed from participation as output to process (Kulözü and Takeli, 2014). To analyze community participation in the implementation of health development need to formulate the success of participation and successful practices of participation.

From the perspective of output, participation can be assessed from output (forms) of community participation in development implementation. Huraerah (2011) details the forms of community participation into participation of ideas, power (energy) participation, participation in property, skills participation, and social participation.

From the perspective of the process, participation could be seen from how participation in the process of decision making and planning, participation in implementation, participation in supervision, and participation in utilizing the results (Nasution, 2009); citizen control, power delegation, partnership, concessions, consultation, information, therapy, and manipulation (Arnstein, 1969). There was even an opinion that integrates the participation of outputs and processes such as the level of community participation proposed by Mardikanto and Soebiato (2012), namely: providing information, consultation, joint decision making, acting together, and providing support.

Kulozu (2014) had successfully analyzed some of the criteria used to measure the success of participation and participation practices. The terms which were used to refer the success of participation and participatory practices, and were commonly used to define success (Buchy and Hoverman, 2000; Chess and Purcell, 1999; Innes and Booher, 1999; Koontz and Craig, 2006), are effectiveness (Rosener, 1978), efficiency (Brand and Gaffikin, 2007), and equity

(Fung and Wright, 2001). While effectiveness refers to the ratio of targets set to outputs achieved, efficiency refers to the ratio of inputs to outputs. Equity, on the other hand, means ensuring actions do not affect some less favorably than others. Although some scholars used just one of these terms to define the success of participatory practices, Warburton (1997) argues that all three concepts should be employed (cited in Buchy and Hoverman, 2000). Following Warburton (1997), Coglianese (2002) argues that when evaluating the success of participatory practice, researchers should focus on the effectiveness, efficiency and equity of the decisions made during the participatory process.

Study Ohama et al. (2002) carried out with a central focus on capacity building of local society with its structural and functional uniqueness to analyze self-organizing capability of local community and institution building of local society by capturing the uniqueness of each local society as a social venue for project development. They shift in thinking of the goal from national economic growth to individual happiness and capacity building at various levels for its attainment; the change in terms of agent for development from the market and the state to the community and individual; the reverse in the approach from top down to participatory approach and that based on universalism to that respects the uniqueness of each local society.

This study not only examines the outcome of participation but also the participation process focuses primarily on the role of local wisdom in the process of community participation in health development in Ujungjaya District, Sumedang Regency. The Community of Ujungjaya District of Sumedang Regency was unique in its participatory process of implementing the Sundanese values that distinguish it from previous studies.

3 METHODOLOGY

As the decentralization policy, some government affairs were handed over to the Regions and villages, including health affairs. Sumedang as one of the regencies in West Java Province Indonesia had the authority to manage health. Similarly, gradually the affairs also became the authority of the village. In this study analyze how the participation of villagers in Sumedang regency. Case study on community participation in health development, the target of research selected by Ujungjaya district.

Ujungjaya District had an area of ± 7,573.62 ha which was divided into 9 (Nine) villages, namely:

Table 1: Area villages in Ujungjaya district.

No	Village	Area (Ha)	Sum of Dusun	Sum of RW	Sum of RT
1.	Ujungjaya	1.194,61	3	9	39
2.	Palasari	251,12	3	6	20
3.	Sukamulya	314,24	2	4	15
4.	Kudangwangi	472,81	2	6	23
5.	Palabuan	191,88	3	6	17
6.	Keboncau	1.022,07	2	6	25
7.	Sakurjaya	1.361,95	2	5	16
8.	Cipelang	1.173,25	3	6	18
9.	Cibuluh	674,82	3	10	41

Source: Profile of Ujungjaya District, 2016.

Ujungjaya District had one Puskesmas (Community Health Centers) and two sub Puskesmas. Health facilities and infrastructure are illustrated in table 2 below. The population of Ujungjaya District is 35,354 people spread in 9 (Nine) villages like table 3 below.

Table 2: Health facilities and infrastructure in Ujungjaya district.

No	Village	Total								
		Integrated Service Post	Village Health Post	Sub Pus Kes mas	Pus Kes Mas	Hospital	Clinic/ Medical center	Doctor practice	Pharmacy	Drug Store
1.	Ujungjaya	4	1	0	1	0	0	1	1	1
2.	Palasari	3	1	0	0	0	0	1	1	0
3.	Sukamulya	2	1	1	0	0	0	0	0	0
4.	Kudangwangi	2	1	0	0	0	0	0	0	0
5.	Palabuhan	3	1	0	0	0	0	0	0	0
6.	Keboncau	5	1	0	0	0	0	0	0	0
7.	Cipelang	3	1	0	0	0	0	0	0	0
8.	Sakurjaya	4	1	0	0	0	0	0	0	0
9.	Cibuluh	6	1	0	0	0	0	0	0	0

Source: Profile of Ujungjaya District, 2016.

Table 3: Distribution of population in Ujungjaya district: Based on gender and age group.

No	Village	Population			Sum of family	Age			
		man	Woman	Sum		< 15 year	15-56 year	>57 year	Sum
1.	Ujungjaya	3.723	3.830	7.553	2.586	1.824	3.261	1.421	6.524
2.	Palasari	2.200	2.136	4.336	768	2.038	1.477	1.097	4.612
3.	Sukamulya	1.183	1.235	2.418	1.242	847	1.154	801	2.802
4.	Kudangwangi	1.393	1.455	2.847	1.068	471	2.970	720	4.161
5.	Palabuan	1.223	1.086	2.309	798	859	1.162	849	2.870
6.	Keboncau	2.110	2.111	4.221	986	1.142	1.571	1.340	1.142
7.	Sakurjaya	1.724	1.747	3.471	1.006	766	2.022	903	3.691
8.	Cipelang	845	874	1.719	656	603	771	922	2.296
9	Cibuluh	3.220	3.260	6.480	3.276	1.954	2.663	1.814	6.431
Sum		17.620	17.734	35.354	12.386				

Source: Profile of Ujungjaya District, 2016.

Area, health facility, and population of object and subject research, it could be concluded that health development in Ujungjaya district required public participation. Community participation by utilizing the values of Sundanese as local wisdom was required when members of the community who were in pain could not be handled by the health personnel and facilities in Ujungjaya District.

This case study to analyze community participation in health development both in output and process of participation. In the form of process, it was studied about process (community participation in strengthening of alert village, community participation in strengthening and fostering health care, community participation in posyandu activity) with outcome in the form of mind, energy, property, and skill and skill. The informants consisted of village administrators who, posyandu managers, village health cadres, village apparatus, BPD representatives, Puskesmas Health Promotion Program Implementers, Sub Program Section and District Activities.

Primary data were collected by using interview and observation technique while secondary data was collected through documentation study, especially the legislation. Data was processed by data reduction procedures, data presentation, conclusions. The technique of examination of data harmony with triangulation both triangulation data source and data collection technique. Qualitative analysis is used to analyze the data obtained.

4 RESULTS AND DISCUSSION

Health development in Indonesia (especially Sumedang Regency) had been faced with the problem of unequal distribution of basic health services, especially the problem of unequal distribution of health facilities and personnel. In the face of this problem the Indonesian government issued a policy on the health sector that was the Program Desa Siaga (the alert village program).

The Desa Siaga Program was expected to address the inequalities of health facilities and personnel as well as the provision of health services to the community through Village Health Post (Poskesdes) and Integrated Service Post (Posyandu). In the implementation of the alert village (Desa Siaga) program, village leaders were set up and established village health cadres.

Village alert and village health officials were the partners of government health workers in implementing health development in Indonesia at the rural level. With the presence of alert village officials and village health cadres, health-care duties were not only performed by government health workers. The village officials in charge and village health cadres do most of the health-care duties at the village level.

In Sumedang Regency, there were three activities to increase community participation in health development, namely: (1) strengthening of alert village officials, (2) strengthening and guidance of health cadres, and (3) posyandu. The reality of the field shows that participating in general as well as board and / or village health cadres were still low. In fact they did not understand what the criteria of success as the caretaker of the village alert, health cadres, and posyandu board. This fact was similar to Akadun's (2011) research that community participation in musrenbang implementation was only formalism because the community generally rarely gave their opinions in the activity-even if there were proposals of program from certain community group, finally in document of regional development planning did not emerge the development programs. Whereas according to Kulozu (2014), before

evaluating the level of community participation or community groups, should need a common understanding how to assess the success criteria of participation.

4.1 Community Participation in Strengthening Desa Siaga

Desa Siaga according to the Ministry of Health RI was a village whose inhabitants had the readiness of resources and the ability and willingness to prevent and solve health problems independently in order to realize Healthy Village. Desa Siaga was expected to bring the basic health services closer to the community, face the health threats and problems, develop surveillance and health information systems based community, create clean and healthy living behaviors.

In terms of output, community participation could generate knowledge about various forms of health problems faced by the community, increasing the competence (minimal knowledge) of health of community members, and handled members of the community who experienced the pain and social solidarity. The first two were prevention efforts for people to maintain health in their lives, while the third was a curative action and the fourth is a side effect.

Results of interviews with village administrators it was revealed that the activity of village alert management was funded by the district but the study of documentation had no budget for the activities of alert village empowerment in both districts and villages. Thus, the activities of village administrators were funded by the board and donations from the community. Activity activities of alert village administrators can be self-funded by them because they were *guyub* (mutual cooperation) and *nyambungan* (exchange resource, money, materials in turn).

From the process point, the participation of the community in the strengthening of alert villages was due to the activities of a small group of community members as drivers. The social system will require actors to mobilize community participation in activities. Therefore, the community needs to be given the opportunity to participate. The same thing Slamet proposes in Theresia et al. (2014: 207), one of the main elements of the growth and development of community participation was the opportunity given to the community to participate.

In terms of participation process, Desa Siaga management through surveys of village around and the results were presented to the speakers at the time of the activity of the Desa Siaga management. When conducting village surveys, administrators interacted directly with community members to explore problems and find solutions together. This direct interaction was the key to success in carrying out development programs including increasing community participation in development. This field reality was supported by Adisasmita's opinion (2006: 51-52), face-to-face experience in the field was the key to increasing community participation in implementing development programs.

4.2 Community Participation in Strengthening and Development of Health Cadres

From the point of output of community participation in strengthening and fostering activities of health cadres, health problems faced by the community, cadre presence on activities, knowledge of sanitation and healthy environment and nutrition, social solidarity. Apparently, the forms of community participation at the village level both quantitatively and qualitatively were considered small and trivial. However, the form of community participation in the health sector when all villages in Indonesia do so will have a major impact on improving the level of public health at the national level.

Information from primary data sources (from community members) on the conditions, needs and attitudes of local communities towards government health programs was important data for program evaluation and future health programming. Diana Conyers in Huraerah (2011: 118) said that one of the main reasons why community participation was important that community participation was a tool for obtaining information about the conditions, needs and attitudes of local communities without the ones presence of development programs and projects that will fail.

Likewise, in the process of community participation in health activities was essential so that health programs could reach every member of the community directly. The process of community participation was a direct face-to-face process that was culturally an integral part of the human life process of Indonesia itself. These processes of community participation in a face-to-face manner result in the output of participation in the form of social solidarity something that has been almost lost from the social system of modern society.

Community participation in the strengthening and fostering of health cadres needs to be encouraged because according to Adisasmita (2006: 36) with the following considerations: (1) they understood the

reality of the social and economic environment of society; (2) they were able to analyze the causes and effects of various events occurring in society; (3) they were able to formulate solutions to overcome problems and obstacles faced by the community; (4) they were able to utilize the development resources they have in order to achieve the development goals; (5) community members with efforts to increase the willingness and ability of human resources would eliminate most dependence on the outside world.

The reality of the field also showed that community participation in strengthening and fostering of health cadres is also gradually able to manage activities to fulfill their own needs. It is expected that in the future the government will give concessions (Arnstein, 1969) to the community to make proposals for development programs to meet the needs of the people themselves.

Community participation both outputs and processes in strengthening and fostering health cadres in Ujungjaya district Sumedang District can occur because based on the values of Sundaness. The values were *"Kudu silih asah, silih asih, jeung silih asuh", "Kacai jadi saleuwi, kadarat jadi sagolak", "Sareundeuk saigel, sabobot sapihanean", "Sabilulungan", "Rempug jungkung sauyunan", "Kaluhur jujur ngabantu, kagigir ngais tarapti, ka handap cekas ngabina".* The meaning was the Sundanese should be aware that the implementation of development will provide optimal benefits if done in mutual assistance and with the spirit of togetherness. The same weight bears, the same light is carried. Through this spirit is expected to grow the understanding that the social capital of society is the main capital in development, while the financial capital sourced from government assistance is a stimulant capital.

4.3 Community Participation in Posyandu Activities

Community participation in Posyandu activities both in the form of ideas, energy, property, skills, social was very important for the achievement of the goals of the Posyandu activities. Participation of the minds of the people was very important because according to Diana Conyers in Huraerah (2011: 118), community participation was a tool to obtain information about the conditions, needs and attitudes of local communities, without the ones presence of development programs and projects will fail. Energy participation was needed to support the success of an activity (Hamidjoyo in Obrianto, 2012: 28). The participation of property could facilitate efforts for the achievement of the needs of the people who need help (Hamidjoyo in Obrianto, 2012: 28). Sumedang community participation in Posyandu activities in the form of output, such as health conditions and problems in the community (thoughts), the presence of mothers in the activities and the availability of facilities and infrastructure posyandu and food supplement (energy), knowledge about toddler maintenance, environmental health, and nutrition (skills), clean environment and social solidarity (social).

Community participation in Posyandu activities in processes such as discussion (thoughts); attend activities, prepare posyandu facilities and infrastructure, make additional food (energy); socialization of knowledge in stages (skills); consecrated work (social).

Community participation in Posyandu activities both from as a process and product was one form of *guyub* (mutual cooperation) the members of Ujungjaya community. Pasaribu and Simanjuntak in Huraerah (2011: 116) reveal, social participation given by people as a sign of mutual cooperation, for example *arisan* (cooperation in collecting resources, cooperative), *layad* (visit the deceased person in the event of death), *kondangan* (attend wedding invitation in the event of marriage), nyambungan (exchange of resources or power).

5 CONCLUSIONS

The participation of Ujungjaya district community of Sumedang Regency in the form of process and product from start of mind, energy, skill, and social can happen because of local wisdom. Local wisdom in the local culture (Sunda) is known as the guyub, layad, nyambungan. Therefore, increasing the participation of the community in the activities of Desa Siaga, health cadres and posyandu, guyub, layad, nyambungan must be used as a catalyst or driving force. To measure the success of participation and the process of implementation of community participation, the criteria and indicators of success are not only related to the quantity and quality of participatory forms and processes but must also pay attention to the achievement of the policy objectives and targets as well as the extent of paying attention to local wisdom.

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