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Analysis of Traditional Health Care in Three Primary Health Care in West Java Province, Indonesia, 2018

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Abstract

The National Traditional Health Care set up three objectives for its implementation at health care, whereby health staff were to be trained in traditional health and provide acupressure care, collect data, and register and provide technical guidance to traditional healers and guide individuals in the use of traditional medicine and herbs. This qualitative study aimed to analyze the implementation of traditional health care at three subdistrict health care: Ciomas, Ciawi, and Caringin in the Bogor District. Data were collected through document analysis, observation, and in-depth interviews. Each health care has trained staff in acupressure, but care is hindered by lack of room, and the community prefers to go to a traditional masseur. Data collection, registration, and technical guidance to traditional healers existed because of support from local funding. Individual guidance on the use of traditional medicine and herbs did not happen because of a lack of funding for home visits. Traditional health care at health centers focuses on the activity that is working, which is data collection, registration, and technical guidance by traditional healers.

Keywords: Accupuncture, primary health care, traditional health care

Introduction

The 2010 National Basic Health Research,[1] stated that 59.12% of people in Indonesia ever consumed an herbal drink. In 2013, National Basic Health Research,[2] reported that 30.4% of Indonesian households ever sought and used traditional treatments in a year. Most (77.8%) treatments were massage; reflexology, herbal drinks, aromatherapy, homeopathy, and spa treatments comprised 49%; acupuncture was 7.1% while hypnotherapy, meditation, and inner power were 2.6%.[2] The Statistics Indonesia reported that 20.99% of Indonesians practiced traditional care by self.[3] The reasons for households practicing traditional health care are a desire to stay healthy, wish to follow inherited traditions already in the family, dissatisfaction with western medicine, lower cost of traditional care, fear of undergoing an operative procedure, and belief that consuming medicines is dangerous. Several studies admitted that acupuncture could reduce pain and nausea, and certain herbs were proven as effective as cures for malaria, inflammation, microbes, and fever.[4]

In 2002, the World Health Organization (WHO) Southeast Asia Regional Office (SEARO) developed a strategy on the policy, safety, efficacy, access, and rationalization for the use of traditional health care, alternative, and complementary medicine.[5,6] The WHO recommendations were followed by the 2008 Beijing Declaration that comprised similar recommendations.[7] In 2009, the regional recommendations were brought to the World Health Assembly, whereby countries adopted the Beijing Declaration.[8] In 2008, Indonesia declared *jamu* (an herbal drink) as the brand of Indonesia, and

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this moment became the start of traditional health care in Indonesia.[9]

Traditional health care in Indonesia was under the Law No. 36/2009 Article 59 Paragraph 1[10], and because of its specificities and differences with western medicine, the Ministry of Health established a specific directorate for traditional care named Directorate of Development of Traditional, Alternative, and Complementary Health Care Services (the Directorate of Traditional Health Care Ministry of Health/THC MOH). The duties are to develop policy, set up norms and standards, create procedure, criteria, and evaluation indicators on traditional health care, alternative, and complementary care.[11] At the Third Conference on Traditional Medicine of the ASEAN countries in 2013, the Indonesian Minister of Health encouraged both the formation of partnerships in traditional health care with ASEAN countries and research to prove traditional health care scientifically.[12] Further, the Government's Regulation No. 103/2014 was issued as the legal protection for the development of traditional health care in Indonesia.[13]

In 2013, the WHO renewed the Traditional Medicine Strategy, which was to grow basic knowledge on traditional care; improve quality assurance, safety, and efficacy through training and education; create experts, and increase coverage through integrating traditional health care into the health care system.[10] Following the WHO, the Ministry of Health incorporated traditional health care into the National Strategic Development Plan, targeting 60% of health care in Indonesia that offered traditional health care by the end of 2018.[11]

To monitor progress, the Directorate of THC MOH set up three indicators to measure the traditional health activities at primary health care (PHC).[14,15] These indicators determined how the PHC provided traditional health care by trained staff; collected data on traditional healers in the working area, registering them, and providing technical guidance; and gave technical guidance to individuals on the use of traditional medicine and herbs (independent care).

In May 2018, the Directorate of THC MOH reported 3,471 out of 9,754 subdistrict health care (35.59%) in Indonesia provided traditional health care by 513 trained staff.[16] In West Java Province, 45 staff members from 1,050 subdistrict health care were trained in acupressure. Bogor District is the densest district in West Java with a population of 5,587,390 (2016). It obtained the opportunity to send staff from 3 of 101 subdistrict health care to be trained in acupressure. The trained staff members were from subdistrict health care in Ciawi, Caringin, and Ciomas.[18]

This study presents the analysis of traditional health care and the factors hindering its implementation at three subdistrict health care, namely Ciomas, Ciawi, and Caringin. The recommendations will serve as inputs for improvement.

Method

The system approach of Donabedian, was used as the theoretical framework for this study.[19,20] The inputs were the modalities to carry out activities on traditional health, and for each output of the process, indicators were established (Table 1).

The concept used for this study was the system approach concept, comprised of input, process, and output components. For the input component, the analysis was focused on the modalities used for running traditional health care, which are the local regulations, including the standards of procedures developed, staffing needs (number and capacity), funds that support the activities of traditional health care, equipment, and facilities available at the health care, and the number of traditional healers in the work areas of a health center.

For the process component, the study analyzed how traditional health care was carried out at the PHC, how the data was collected and registered, and what kind of technical support was provided by the health care staff to the traditional healers and the individual guidance is offered to the community (independent care), especially on the use of traditional medicine and herbs.

Table 1. Acupressure Care at Primary Health Care in Ciomas, Ciawi, and Caringin, 2018

Component	Ciomas	Ciawi	Caringin
Geographic location	Urban	Urban	Rural
PHC staff trained in acupressure	1, midwife, bachelor's diploma in health	bachelor's diploma in health	1, midwife, bachelor's diploma in health
Certified	Yes	Yes	Yes
Duration of training	7 days	7 days	7 days
Frequency of training	1	1	1
Year of training	2016	2012	2012
Room for rendering acupressure at PHC	Unavailable	Available	Unavailable
Equipment and facilities for acupressure care	Phantom	Phantom	Phantom
Standard Operating Procedure for acupressure	Not developed	Developed	Not developed
Tariff on acupressure at PHC	Not yet determined	Not yet determined	Not yet determined
Acupressure care for mild symptoms performed at PHC	Not exist	Not exist	Not exist
Number of patients obtaining acupressure care at PHC	None	None	None

For the output component, the study analyzed the following components, and determined each of their numbers: PHC staff trained in THC, patients treated with acupressure at the PHC,

PHC staff trained in data collection, mapping of traditional healers, traditional healers registered, traditional healers in PHC area of work, and home visits by staff for individual guidance on traditional medicine and herbal use.

From all the PHCs in the Bogor District, only staff from the PHC in Ciomas, Ciawi, and Caringin obtained training in traditional health care, and this became the inclusion criteria for selecting those three PHCs.

This study used a qualitative design, and to obtain valid and objective data, the data collection methods were document analysis, observation, and in-depth interviews. The documents analyzed focused on regulation, standard operating procedure (SOP), monitoring and evaluation activities, and traditional patient visits for health care issues. The observation was on facilities and equipment, and the practice of traditional care given at the PHC. A total of 20 subjects were selected through a purposive sampling method, with work related to traditional health care issues (Table 2). Using a list of main questions, which can be added later from the interview, the subjects were approached individually. Informed consent was obtained from each subject, and permission was granted to take photos and audio during the interview.

The study gathered 20 subjects for in-depth interviews, originating from three PHCs, who were staff in charge of carrying out traditional health care at each PHC, a total of three and all are midwives, coded as P1, P2, P3; two PHC staff trained for acupressure, one midwife and one nurse, coded as T1, T2; heads of each PHC, a total of three, all physicians, coded as K1, K2, K3; one staff in charge of traditional health care from the Bogor District Health Office (BDHO), a physician, coded as D1; two masseurs from the community with the education of elementary and primary school, coded as HCA1, HCA2; and four bone dislocation healers, with education ranging from elementary to high school, coded as HCA3, HCA4, and HCA5.

After transforming the data from an in-depth interview into a transcript, data were processed using content analysis. The transcript was further broken down into meaning units that related to the aim of the study. Each identified meaning unit was labeled with a code. Next, the meaning units were broken into categories; in this case, the categories were the variables of the inputs, process, and output.[21] Different colors were used to mark different categories. The analysis was conducted by two study team members. If doubtful information was found, the subject was revisited for clarification. Triangulation was done by cross-checking the information with the observation results and the documents reviewed.

The PHCs at Ciomas, Ciawi, and Caringin lie in the eastern part of the Bogor District, a district located 60 kilometers away from Jakarta the metropolitan city of Indonesia. Ciomas is the smallest geographical area with a population of 176,000 people. It has 11 dense villages, located close to the main road that connects Bogor and Jakarta and as a strategic economic location, therefore many industries are built here.[22] Similarly, Ciawi has 13 villages and a population of 115,000 people. Both Ciomas and Ciawi are urban-type subdistricts and have the least numbers of traditional practitioners. Caringin has the largest geographical area with a hilly contour comprised of 12 rural, farm-like villages, with a population of 63 thousand people. Caringin has practitioners that are more traditional; one is the Cimande, well known as a traditional healer for curing and treating fractured bones and dislocations.[17]

The PHC in Ciomas has 27 midwives and 13 nurses. The PHC in Ciawi is staffed by one physician, one dentist, 25 midwives, 11 nurses. The PHC in Caringin is staffed by one physician, one dentist, 25 midwives, and 13 nurses. These PHCs are under the jurisdiction of BDHO, which means that all health activities at the PHCs have to be reported to the BDHO.[22,1]

Results

The in-depth interviews revealed that there were no policy guidelines from the BDHO for rendering traditional health at the PHC. However, the BDHO said

Table 2. Summary of Reasons Why Acupressure is Not Delivered at Three Primary Health Care

No policy guidelines from BDHO on the conduct of traditional health care at PHCs in the work area
No Standard Operating Procedure at PHCs for acupressure
No tariff determined by the PHC for acupressure
Traditional health care is not a priority
No time for acupressure care due to heavy work load of responsible staff
No room designated for delivering acupressure care at two PHCs; if available, no sign indicates the room
Body rubbing oil for acupressure has to be self-procured
Inability to remember what was taught during training
Masseurs said that the community prefers to go to them for massage

Note: *PHC = Primary Health Care*

it was in the process of formulating them.

"Considering that Bogor District has many traditional healers, it is about time to start developing local policy on traditional health care." (D1, physician)

This year the BDHO encouraged all PHCs to collect data on traditional healers using the format of the MOH and report it by the end of the year (Table 3).

Only the PHC in Ciawi developed an SOP for acupressure care; however, the patient's fee for acupressure was lacking at all the CHCs. No SOP was found to guide individuals on the use of traditional medicine and herbs at all the PHCs.

The Law No 36/2014 Article 11 Paragraph 1 on Health Manpower states a person who provides traditional health care is carrying out health care using herbs, potions, and traditional skills such as massage and acupuncture. Health care staff eligible for conducting traditional health care must have a bachelor's degree in health and obtained training in basic traditional health care (at this time, it was only in acupressure) by the Ministry of Health (MOH). The three PHCs selected fulfilled the above criteria. The training was for seven days. One nurse at the PHC in Ciawi obtained it in 2016, one midwife at the PHC in Caringin, and one midwife at the PHC in Ciomas obtained it in 2012.[22] Finishing the training, they received a certificate of attendance and phantom. The Ministry of Health required one health staff member at each PHC to be responsible for traditional health care if that existed. However, when relating assignments to performance, it did not happen at all three PHCs because the assigned staff members felt that they were already overburdened with their main jobs.

"I am a midwife, and my main job is on maternal health. With so many patients at the health care, I cannot accept additional responsibility to take care of traditional health." (P1, midwife)

"We were trained only in acupressure, but not how to manage traditional health care." (T3, nurse)

To carry on health activities not budgeted at the health care, the Ministry of Health provided Health Operational Assistance funds, which were sent directly to the PHC. The PHC in Caringin made use of the funds to conduct a yearly meeting with the traditional healers and invited staff from the BDHO to give technical guidance. Ciawi used the funds for visiting traditional healers.

"I approve the [use of] Health Operational Assistance money for some priority activities under the traditional health care." (K1, physician; K2, dentist)

"Though only once a year, the Bogor District Health Office *staff is very supportive in helping us with providing technical guidance to the traditional healers."* (P2, midwife)

"Almost all traditional healers here are registered." (K2, dentist)

There was no funding support for home visits at all the PHCs to give individual guidance on the use of traditional medicine and herbs.

Only at the PHC in Ciawi was there a room for acupressure care shared with geriatric care. At all PHCs, a bed and manequin (a doll which is exactly like human used for practicum), water, ventilation, and waste bin exist. The PHCs in Caringin and Ciomas did not have a special room for providing acupressure care. The body rubbing oil, the main amenity for acupressure care, was not provided by all the PHCs. Acupressure was done manually using only the hands.

Ciawi has 85 traditional healers who are mostly practiced in treating and healing bone problems such as dislocation. Caringin has 121 traditional healers, mostly masseurs. The PHC in Ciomas lacked data on this, but from the community, it was found that the traditional healers in Ciomas are known for cupping therapy. The license of registration was issued by the BDHO. In Ciomas and Ciawi, which were more urban types, there

Table 3. Data Collection, Registration, and Technical Guidance of Traditional Healers at Community Health Centers in Ciomas, Ciawi, and Caringin, 2018

Component	Ciomas	Ciawi	Caringin
Form for conducting data collection	Obtained from BDHO	Obtained from BDHO	Obtained from BDHO
Data submitted to BDHO yearly	No	Yes	Yes
PHC staff in charge of traditional health care	Yes on paper to a midwife	Yes on paper to a midwife	Yes on paper to a midwife
Funding	No funding	Local PHC (HOA) fund for visits	Local PHC (HOA) for technical guidance and meeting with traditional healers
Training in traditional health care data collection, registration, technical guidance of traditional healers	No training provided by BDHO on this aspect	No training provided by BDHO on this aspect	No training provided by BDHO on this aspect
Number of traditional healers in the working area	No data available at PHC	85	121
Profile of traditional healers	Unavailable at PHC	Number and type of care available at PHC, mostly masseurs	Number and type of care available at CHC, mostly bone dislocation healers
Number of traditional healers licensed	Unavailable at PHC	Unavailable at PHC	54
Reasons for traditional healers not registering	No use	No use and afraid of being taxed	Understand the obligation to register

Note: BDHO= Bogor District Health Office; PHC= Primary Health Care; HOA = Health Operational Assistance

Table 4. Summary of Reasons for Inappropriately Conducting Data Collection, Data Registration, and Technical Guidance to Traditional Healers at Three Primary Health Care

No funding for this activity (PHC in Caringin)
No data available on traditional healers in the area (PHC in Ciomas)
Copy of license of traditional healer cannot be found (PHC in Ciomas and Ciawi)
Traditional healers are reluctant to register (PHC in Ciawi)
Masseurs said that the community prefers to go to them for massage

Table 5. Summary of Reasons Why Individual Guidance on the Use of Traditional Medicine and Herbs Did Not Occur

No funds available for home visits
PHC staff never obtained training in the said matter
No SOP or directions from the BDHO admitted by all PHCs
No visitors coming to the PHC seeking technical guidance on the use of traditional health care and herbs
Masseurs said that the community prefers to go to them for massage

Table 6. Individual Guidance for the Use of Traditional Medicine and Herbs at Community Health Centers in Ciomas, Ciawi, and Caringin 2018

Component	Ciomas	Ciawi	Caringin
Funding	No funds for home visit	No funds for home visit	No funds for home visit
Training on how to guide individual use	No training on how to guide individual use on traditional health care and herbs	No training on how to guide individual use on traditional health care and herbs	No training on how to guide individual use on traditional health care and herbs
SOP for conducting individual guidance on use of traditional medicine and herbs	Unavailable	Unavailable	Unavailable
Number of individuals visited PHC asking for individual guidance	None	None	None

were less traditional healers as compared with Caringin, which was rural. However, it was surprising that the traditional healers from the Subdistrict of Caringin understood the obligation to register. The PHC in Ciomas faced difficulties in collecting data on its traditional healers because of not having a budget for transportation to collect data, and the traditional healers were reluctant to answer because of a lack of understanding regarding the importance of registration and fear of being taxed later.

"The traditional healers here are afraid to be registered because they think that we will put [a] tax on them." (K3, physician)

"We do not feel the need for registration; also, we are concerned that it will relate to taxation." (HC11, HC12, elementary school)

"We are proud of having the license." (HCA3, HCA4, HCA5, senior high)

Discussion

The Ministry of Health defined traditional health care as care or treatment using methods and herbs other than western medicines that are inherited through generations based on traditions and habits, which are practiced in Indonesian families according to the norms of those living in the community.[14,15] Based on the Presidential Regulation No. 47 of 2016 Chapter 2 Article 4 Paragraph 1, health care facilities are private practices owned by a health professional, health center, clinic, hospital, pharmacy, blood transfusion unit, and health laboratory that offer optical care and services, medical care for legal purposes, and traditional health care.[23]

Since its establishment by the government in 1974, PHC is known as a facility to serve around 30,000 people through the provision of 13 basic health care activities by a team of health care professionals (physicians, dentists, midwives, nurses, pharmacists, immunizers, environmental health staff) in the areas of promotive, preventive, and curative medicine.[24] Only after the creation of the Directorate of THC Ministry of Health, traditional health care is to be integrated into the health center.

The above notion of the Ministry Of Health Indonesia is noble, and is in line with the 1997 WHO draft on the Declaration on Health Development in the Southeast Asia Region in the 21st Century (the Declaration). In the Declaration, member states laid out one important topic which was traditional medicine, and by that, the Indonesian Government has taken measures to increase the role of traditional medicine. Similarly, the Burmese Ministry of Industry and the Myanmar Food and Drug Administration actively promoted policies that are advantageous to private pharmaceutical companies in the manufacture of high-quality traditional medicine.[25]

Traditional medicine is famous in the neighboring countries of China, Thailand, India, and Myanmar, and has played an essential part in the history of medicine. Traditional medicine has been used for generations and is more affordable and easily obtainable even in rural areas. Therefore, as said by Salguero *et al*., traditional medicine continues to be widely used and plays a significant role in health care in China, Myanmar, and Thailand.[25,26]

The THC MOH first built the capacity of the health care staff to be able to perform traditional health care through training. Though the training was named training in traditional health care, it focused more on providing knowledge and skills to conduct acupressure

care. The training covered mainly simple human anatomy and physiology, basic acupressure, and acupressure methods using the concept of body meridians and nerve knots.[27]

All three PHC heads had assigned one staff member to be responsible for traditional health care when, in fact, the responsibility was given to health staff members who already have their main duties. An example was the midwife or nutrition nurse who already has her main responsibilities and then was given an additional responsibility to take care of traditional health care. Thus, traditional health care at the PHC did not have exclusive health staff. This approach did not work smoothly, considering the existing workload of the staff. Moreover, there was no training from the BDHO on how to manage traditional health care, so activities, if any, were conducted on a trial and error basis. No report on traditional health care activities was found from the BDHC because it was not programmed.

Beside Qigong and Tui na, acupressure is another form of Asian bodywork therapy rooted in traditional Chinese medicine. *Shiatsu* is a Japanese form of acupressure. Acupressure, like acupuncture, focuses on targeting the meridian points of the body, and is believed to improve wellness and treat illness; the latter is through the flow of vital energy, or life force called *qi (ch'i)*, through invisible channels. The 12 major meridians in the body connect to specific organs or networks of organs, organizing a system of communication throughout the body.[28]

The BDHO trains PHC staff members in traditional health care, which focuses on acupressure knowledge and skill through a 7-day training session. Upon completion of the training, the staff returns to their respective PHCs with a certificate, and manequin for carrying out acupressure.[27] The in-depth interview confirmed that the staff members, who were two midwives and one nurse, obtained training in acupressure as they showed the certificates also. However, so far, acupressure was not performed at all in three PHCs because the trained staff did not have time to provide acupressure care. Body rubbing oil, the main lubricant needed to do acupressure, has to be self-procured. A trained midwife admitted she forgot what has been trained. Another hindering factor was that no rate for acupressure care had been determined. Although a room was devoted to conducting acupressure in the PHC in Ciawi, there was no sign in front of the room mentioning the provision of care. Hence, the PHC visitors were unaware that acupressure is available. The PHC at both Caringin and Ciomas did not have a special room. From the interviews with the masseurs at Ciawi, they admitted that people preferred to go to them for massage because they were trusted more for their massage skills if compared with the PHC staff.

Chen and Wang[29], in their systematic review, concluded that acupressure was effective for relieving various types of pain in different populations. Their review provided credible evidence for the use of acupressure in pain relief; hence, acupressure can be put into the practice as an alternative therapy to relieve patients who suffer from pain.

Data collection, registration, and technical guidance for traditional healers in the work area of PHCs.

This activity was not performed at the PHC in Ciomas. In PHC in Ciawi and Caringin, this was the only activity on traditional health care, which seemed to work and showed results. The PHC in Caringin used the Health Operational Assistance funds to conduct a once a year meeting with the traditional healers and invited staff from the BDHO for giving technical guidance.

Traditional healers have to register their practice with the BDHO, and one copy of the license is to be kept at the respective PHC. From the in-depth interviews, no traditional healers from Ciomas so far were registered with the reason of no use to register. Though Caringin was a rural-type area, almost all traditional healers have been registered. The PHC in Caringin also kept a copy of the license. Findings similar to those at the PHC in Caringin were found at the PHC in Ciawi.

The Ministry of Health encouraged Indonesians to grow herbal plants. Many people practice traditional medicine such as consuming *jamu* (herbal drinks), or massage, or in more severe cases of treating bone problems by a traditional healer. The aim of this third activity was that the PHC staff could provide individual counseling and guidance to select and use traditional medicine and herbs as an alternative treatment, appropriately. This did not happen because no backup training, no SOP, no budget for home visits, and no such service was provided at the PHC itself. The latter was understood because the community hardly know that the PHC was providing activities in traditional health care.

Data collection, registration, individual technical guidance, including training for PHC staff on traditional medicine is part of the management of traditional health care at the PHCs in Indonesia. Chi has studied traditional medicine in Taiwan and China.[30] He looked from the perspectives of government policies and regulations on Chinese medicine, government statistics on the demand and supply of Chinese medicine to provide some insights for developing recommendations for appropriate integration policy.[31] He found that to integrate traditional medicine into a modern health care system effectively (Indonesia is already integrating traditional health care into the western health care at the PHC), Chi suggests that such integration should begin at the grassroots level. For instance, in the cases of Taiwan and

China, it starts with the training of physicians and practitioners. Chi's recommendation is suitable in the Indonesia context, where the government of Indonesia has started strengthening traditional health care through strengthening PHC, through training, providing tools, and improving data on available traditional health care accessible in the community.

However, integrating traditional health care into the mainstream of the existing health care system is not that simple; it requires study then clinical study to understand the efficacy, safety, and mechanism of action of traditional medicine.[31-32] It also would require more study on the management of how to integrate this traditional health care since it presents as a vertical program.

Conclusion

The Directorate of THC MOH worked to integrate traditional health care into all PHCs, acknowledging the philosophy that traditional health care is complementary to the western treatment provided at the PHC. It is clear that at the three PHCs studied, traditional health care is at its early stages.

Out of the three activities where the Ministry of Health has developed indicators, only one is running, which is the data collection, registration, and technical guidance for the traditional healers in these PHCs. Acupressure, though trained, has yet to be rendered. Guidance for individual use of traditional medicine and herbs is not performed. From the traditional healers' perspectives, traditional health is inherited in the families, it is already embedded in their minds, they know how to use and consume herbs, and hence they feel no need for technical guidance from the PHC staff.

The data collection, registration, and guidance provision for traditional healers can be chosen as the starting point for the development of traditional health care at the PHC. The BDHO can start to develop local regulations for SOP in traditional health care, to socialize it, and enable it to be adapted and adopted further by the PHCs. The seven days of training in acupressure is appreciated. However, acupressure skill must be maintained and updated; therefore, such training needs to be regularly conducted.

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