Leadership, Social Capital, Access to Information and Community Empowerment To Address Health Issues


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Abstract

The community empowerment problem in health issue is the poor ability of identifying health problem and of solving health problem. The objective of research study was to analyze the most influential determinants relating to the community empowerment in health issue. The research method was the combination of quantitative and qualitative method. The quantitative research was a survey one with path analysis, while the qualitative one employed case study. The target of research was the midwives in Village Health Post and Village Health Forum in 30 villages in Karanganyar Regency of Central Java Province Indonesia.

The results of this study include that the determinant relating to community empowerment in health issue was divided into input, process, and output. The input determinant consisted of internal and external community ones. Internal community determinant included: physical, economic (natural) and social-cultural (leadership, mutual cooperation, initiation, innovation) resources. Meanwhile, the external community determinant involved access to information (TV, internet, newspaper), and health personnel’s and facilitator’s role. The internal community determinant most dominantly relating to community empowerment in health issue was leadership and social capital. Meanwhile the external one most dominantly relating to community empowerment in health issue was access to information.

The community empowerment process in health issue encompassed the process of using and utilizing efficiently the resource within the community as well as facilitation process and resource support from outside community. The output of community empowerment constituted the community’s forcefulness including the ability of identifying and of solving local health problems.

Keywords: Leadership, social capital, access to information, community forcefulness.

INTRODUCTION

Community empowerment appeared since the declaration of Ottawa Charter (WHO, 1986) stating the need for: (a) creating supportive environment, (b) enabling community participation, (c) developing personal skills for health, (d) reorienting health services toward prevention and health promotion, (e) building wide-ranging public policy that protects the environments and promotes health, and (f) strengthening community action. Ottawa Charter (1986) asserted that community empowerment is the core of health promotion and community participation is the dominant determinant factor in empowerment. Furthermore, the 7th Health Promotion International Conference in Nairobi, Kenya (WHO, 2009)
reconfirmed the importance of community empowerment, by stating the need for: (a) building health promotion capacity, (b) strengthening health system, (c) establishing cross-sector partnership and cooperation, (d) empowering the community, as well as (e) being aware of being healthy and behaving healthily.

We agree with the WHO’s definition of empowerment (cit. Natbeam et al., 1991) as a process of enabling someone to improve control over decision or action affecting the community health, aiming to mobilize the vulnerable individual or group by strengthening their life basic skill and to improve their effect on any things underlying social and economic condition. Meanwhile, the community empowerment in health sector, according to Republic of Indonesia’s government and UNICEF (1999) is any non-instructive facilitating attempt to improve the community knowledge and ability in order to be able to identify, to plan and to solve the problems by utilizing local potential and existing facility, either from cross-sector institution or Non Government Organization and community leader.

Sanders (1958 cit. Wass, 1997) argued that community empowerment could be seen as the process, method, program, and movement. Community empowerment as a process is a series of measures beyond the habit taken in building community empowerment. The community empowerment measures consist of: setting up the need felt, using local leadership, growing the self-help ability, and following up an institution/organization to forward the achievement of community empowerment objective. The community empowerment as a method is the means used to improve the community autonomy and ability, through their participation in decision making and problem solving processes. Community empowerment as a program constitutes the programs using community empowerment method and process in its implementation. Meanwhile, community empowerment as a movement is the foundation of mutuality and empowerment in community development through certain philosophical approach in line with the primary health care.

In line with this, WHO (2008) carried out primary health care reform, encompassing: (a) universal coverage reforms ensuring: the health system contributes to health justice, social justice and eventually to expense, (b) service delivery reforms: reorganizing the health care as to the people need and expectation, thereby making them more decent socially and more responsive to the world change, while providing better outcome, (c) public policy reforms: ensuring the community health, through public health action integrated with primary health service, applying cross-sector health policy and strengthening the national and transnational health intervention, as well as (d) leadership reforms: putting the imbalance of trust in command and control back into one hand, and “laisser-faire” handing it over the State or others, through open, participatory leadership, negotiation based on leadership indicating the complexity of contemporary health system. Meanwhile, the National Health System (2009) is organized by taking into account the revitalization of primary health care, encompassing: (a) just and evenly distributed health care coverage, (b)
providing the health service partial to the people, (c) national development policy, and (d) health leadership (Republic of Indonesia’s Health Department, 2009).

The Determinants of Community Empowerment in Health Issues

Several determinants of community empowerment in health issues are formulated by some scholars as follows: The first, Rothman et al., (1995 cit. Fleming et al., 2007) formulates the locality development model, viewing that the social change can be carried out through local community participation with the local potential and resources development. Minkler (1990 cit. Fleming et al., 2007) concludes that the locality development model is in harmony with the community empowerment because: (a) community empowerment is carried out through the local community’s active participation by developing local potential and resources; (b) the attempt of growing motivation, “bottom-up” planning, and appropriate action in achieving the achievement of empowerment objective; (c) as problem solving model to avoid the interest distortion so that the community can help themselves and each other, and (d) building local identity and pride as the member of community.

The second, Naidoo et al., (2000) formulates Beattie’s health promotion model in which health promotion program activity needs to take into account the change of approach from “top down” into “bottom up”, through four approaches: health persuasion, personal counseling in health, legislative action, and community empowerment. The third, Ewles et al., (2003 cit. Lewis et al., 2008) develops health promotion approach model in multidisciplinary perspective in which the health promotion needs to take into account the following aspects from multidisciplinary perspective: medical, behavior, education, empowerment, and social change.

The fourth, Ife et al., (2008) formulates the community service-based primary health care model, viewing that the community should be responsible for identifying the needs, setting up the priority, planning and providing health care, as well as monitoring and evaluating the health care. The fifth, Goodman et al., (1998 cit. Rehn et al., 2006) develops community empowerment model, including participation, leadership, skill, resource, values, history, community network and knowledge. The sixth, Anderson, et.al., (1988) develops community organization model, including empowerment, partnership, participation, cultural responsiveness, and community competency. The seventh, Blau et al., (1967 cit. House et.al., 2002) formulates a social-economic status determinant on health model. This model explains that someone’s health is individually affected firstly by education level and type. Then, education becomes the entrance to get job, and to earn living, and finally to collect capital/wealth indirectly affecting the health.

The eighth, Hancock (1993 cit. Collins, 2003) formulates the model of health and community ecosystem as the interaction between community, environment and economy, and the health. Community
aspect includes convivial, equitable, liveable. Environment aspect includes liveable, viable, and sustainable, while economic aspect includes adequately prosperous, equitable, and sustainable.

The ninth, Arnoux et al., (1991 cit. Collins, 2003) develops the model of individual health environment and community determinant. This model involves psycho-social environment (e.g. community support), micro-physical environment (e.g. water quality at home, in housing), race/class/gender environment (e.g. community construction of individual race, class, gender, education level, social-economic level, cultural effect), behavior environment (including: workplace physically, biologically and chemically). Meanwhile, the determinant of community health environment involving political/economic environment in local community (e.g. the effect of global political on local legislation, local unemployment level, and power sharing), macro-physical environment (e.g. weather quality at home, transportation option, high-quality housing subsidy availability, global climate change, food pollution, local environment sustainability), social justice level and justice within the society (e.g. fair income distribution, healthy social security network, community health maintenance security), and control expansion and community tightness (e.g. community group existence, local community development, helping each other rather than competition).

The tenth, Mardikanto (2010) formulates the model of family-based disease management carried out in self-help manner and independently by the family through growing awareness, improving knowledge and skill of maintaining health. The eleventh, Republic of Indonesia’s Health Department (1978 – 2010) formulates Village Community Health Development to facilitate the health problem solving cycles the villagers deal with, including (1) raising commitment and support from the policy makers and decision makers, (2) empowering the health personnel and cross-program cooperation, and (3) community empowerment through a series of activities consisting of: (a) coordination meeting at village level, (b) Community Self Survey (CSS) to identify the health problem, (b) Village Community Discussion to set up the health problem solving plan, (c) follow-up of platform resulting from Village Community Discussion, (d) monitoring and evaluation, and (d) health activity development and preservation by the community.

Research Framework

The ability of identifying the local health problems in health issues relates to education level, access to information, leadership, and Community Self Survey (CSS). Meanwhile that of solving the local health problems in health issues relates to education level, income level, social capital, leadership, community participation, local resource, and Village Community Discussion (VCD). Furthermore, the abilities of identifying and of solving the local health problems in health issues are the main component of community forcefulness in health sector, in health issues.
Research Method

The research design used was a cross-sectional one that was explanatory in nature, namely attempting to explain the relationship between variables based on empirical fact (reality) and provided with qualitative analysis explanation (Fraenkel et al., 1993). Thus, this research method employed mixed methods that combined quantitative and qualitative methods. The quantitative approach as the primary one, while the qualitative approach was the secondary one (dominant quantitative less qualitative) (Brannen, 2005; Padgett 2012; Punch, 1999). The quantitative research was conducted through survey research, while, the qualitative one with case study. The case study in this research was an embedded research, the one that has determined its research focus constituting the main variable to be studied based on the research objective and interest (Yin, 2003).

The population of quantitative research included 156 health aware villages. From this population, we sampled a disproportionate stratified random sampling taking 30 villages in this study. The population of qualitative research constituted social situation (Spradley, 1980 cit. Sutopo, 2002) interacting between place, actor, and activity in health issues with 107 informants participated from two villages. The sampling techniques used in the case study were purposive and snowball sampling ones (Patton, 1987 cit. Alsa, 2007).

The analysis on quantitative data consisted of univariate, bivariate, and multivariate analyses (Bohrnstedt, 1988). The analysis on case study research was carried out using holistic analysis and special analysis from the case (embedded). As a multiple case research, the data analysis referred to Yin’s (2003) argument: (1) within-case analysis, the analysis on any case to describe the issues and the themes in detail, (2) cross-case analysis, the theme studied was analyzed cross-sectionally per case, interpreted, and integrated the meaning contained in the cases, (3) formulating and interpreting information, and (4) interpretative analysis, reporting the meaning that can be learnt, both the learning on the issue behind the case that was carried out using instrumental case research, and the learning from unique or rare condition carried out using intrinsic case study research). Guba et al., (cit. Soy, 1997) stated that this stage was the one to explore the best learning that could be taken from the case studied.

Study Results

Considering the result of research, it could be concluded that the determinant relating to community empowerment in health issues can be divided into input, process, and output. The input determinant consisted of internal and external community determinant. Internal community determinant included: physical and economic (natural), and social-cultural (leadership, mutual cooperation, initiation, innovation) resources. The external community determinant included access to information (TV, internet, newspaper) as well as the personnel’s and the facilitator’s role. The internal community determinants most dominantly
relating to community empowerment in health issues were leadership and social capital. The external community determinant most dominantly relating to community empowerment in health issues was access to information.

Meanwhile, the community empowerment process included the process of using and utilizing efficiently the resource within the community, and facilitation process and resource support from external community. The output of community empowerment was the community forcefulness in health issues, the abilities of identifying and of solving the local health problems in health issues.

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INPUT

Physical and economic resource (natural resource)

Social-cultural resource (leadership, mutual cooperation, initiative,

Access to information (TV, internet, mass media)

Health personnel’s and facilitator’s role

PROCESS

Leadership

Social capital

Access to information

OUTPUT

Using and utilizing efficiently the resources within the community (internal)

Facilitation and resource support from outside community (external)

Community forcefulness in health issue

The ability of identifying the local health problems

The ability of solving the local health problems

Figure 1: The Model of Community Empowerment in Health Issues
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Discussion

From this research, it could be revealed that the internal community determinants dominantly relating to community empowerment in health issues were leadership and social capital. Meanwhile, the external community dominantly relating to community empowerment in health issues was access to information.

1. Leadership

Foster (cit. Schoorl, 1980) argues that the most appropriate way to diffuse new innovation in social system is to employ the prominent figure within the community. Rogers (1999) states that in any social system there is “opinion leader” as the community leader consulted when an individual wants to accept or to refuse the new innovation. Meanwhile, Cavaye (cit. Adiyoso, 2009) mentions the determinant of successful community empowerment is leadership, in addition to cooperation, willing, work hard, and established organization. Taruna (2010) includes leadership and facilitation factors as the determinants of successful community empowerment, in addition the presence of knowledge and information transfer factor, jointly decision making mechanism, increasingly stronger institution, and funding mechanism. Goodman et al., (1998 cit. Rehn et al., 2006) mentions the presence of leadership factor in community empowerment model, in addition to participation, skill, resource, values, history, community network and knowledge.

The definition of leadership, according to the scholars, has similarity, namely the ability of persuading an individual or a group of people in the attempt of achieving the objective of organization specified in certain situation (Samson et al., 2003; Gibson et al., 1997). Kouzes et al., (2007) concludes five aspects of leadership: (a) model the way: giving an example of the activity implementation, (b) inspire a shared vision: giving inspiration on the mutual vision, (c) challenge the process: conducting reformation in the process of achieving the objective, (d) enabling others to act: improving the staff’s ability of taking action through team cooperation, providing trust and developing staff’s ability, and (e) encouraging the heart: providing incentive and reward.

To be a strong and effective leader, according Katz (cit. Stoner et.al., 1992), the following skills are needed: (a) conceptual skills, the mental ability of coordinating and integrating all organizational activities, that of seeing organization as a whole and of understanding the interdependent relationship, as well as that of obtaining, analyzing, and interpreting the information received from various sources; (b) human skills, the ability of understanding and motivating others, either individually or in group, in order to attain participation and to direct toward the achievement of objective; (c) administrative skills, the ones relating to the implementation of management functions; and (d) technical skills, the ability of employing instrument, procedure, and technique of a certain area.
WHO (2008) conducted a reformation in primary health care including leadership reform, putting the imbalance of trust in command and control back into one hand, and “laisser-faire” handing it over to the State or others, through open, participatory leadership, negotiation based on leadership indicating the complexity of contemporary health system. Furthermore, WHO (2008) recommended the need for new forms of leadership for health. The public health sector needs the strong leadership role in controlling the public health care reform. Such the function can be conducted through policy collaboration with various stakeholders, to improve the effectiveness of reform efforts and political process management. WHO (2008) asserted that the government functions as the intermediary of primary health care reform, mediating the social contract for health. Meanwhile, one of principles in health management and information sub system in National Health System (2009) is visionary leadership, the one having vision, precedent, and strong will in developing health.

Krianto (2005) argues that the implementation of community empowerment program strategy and management is conducted through developing local leadership, in addition to improve the participation of stakeholders, growing the ability of identifying the problem, building the organizational structure’s forcefulness, improving mobilization, and using and utilizing efficiently the resource, strengthening the stakeholders’ ability, improving stakeholder’s control over the program management, and creating a relationship corresponding to outsider.

Sanders (1958 cit, Wass, 1997) explains the importance of employing local leadership in community empowerment process, in addition to determining the need felt, growing the ability of helping the self, and following up by an institution to forward the achievement of community empowerment objective. The local leadership, according to Sanders (1958 cit, Wass, 1997), is the community figure as well as formal and non-formal leader having strong influence on the decision making and encouraging the members of community to participate in utilizing the primary health care.

Considering the result of path analysis in this research, the size of leadership contribution is directly correlated with the villager empowerment in health issues of 41.86%, and indirectly through access to health information of 7.56%, and indirectly through Community Self Survey of 17.39%, and the total relationship contribution of 66.81%. Considering the result of case study, the roles of leadership in community empowerment in health issues are as follows: (a) to realize the improvement of public welfare through health, (b) to issue the appropriate health policy and health program funding policy, (c) to raise the community participation in health issue, (d) awakening the awareness and spirit as well as leading the health problem management, (e) diffusing health information by entering the field directly, (f) dealing with the obstacles and looking for the way out of any health problem, (h) serving as the motivator and catalyst of community empowerment in health issues, as well as pioneer and giving
model-precedent, (i) facilitating and providing fund stimulant, as well as giving the way out in health funding, (j) serving as the mediator in establishing cooperation and partnership.

Meanwhile, Sarwono (2007) generally is a leader serving to arrange the work procedure to achieve the objective, to determine the assignment for each position, to explain to the member of community about their own duty and function, as well as to guide and to monitor the member of community activity in order to correspond to the achievement of objective. In line with this, Brecker (1997) concludes that the community empowerment leadership in the twenty-first century requires the importance of focusing on the anticipation of change and managing it effectively, as well as applying the entrepreneurship.

Gamson’s (cit. Nix, 1976) study on eighteen communities concludes that the component supporting the successful social change was 30% of leader reputation. Next, Lassey et al., (1976) asserts that, to improve the competency of community leadership, the following should become the focus: (a) participatory decision making, (b) planning social change, including to expand the public participation, (c) the planned change process should be understandable and applicable widely by the community, as well as (d) potential leadership ability should be extended to the population through disseminating competency, knowledge, skill training, and leadership experience.

Mar’at (1982) views that leadership is one key to successful community empowerment. When the village leadership is care, honest, accountable, trusteeship, and responsible, the community empowerment program will be successful. Considering the result of research, Sumardjo (2001-2003) found the fact that a local leadership effectively developing a community group at least has four preconditions: trusted, competent, communicative, and having high cooperation in developing group. Next, Sumardjo (2001-2003) states that the effective strong leader figure has the following preconditions: (a) having good understanding about the community potential, need, and interest, (b) having partiality to the community and oriented to justice, (c) having sufficient energy to realize the attempt of meeting the community need. The characteristics of effective leadership are as follows: (a) having honesty, achieve the community’s trust successfully, (b) having real precedent, (c) applying the leadership style according the community situation, (d) having vision about its social environment condition, highly believed and supported by the real behavior character useful to the compliance of community need, and (e) having an effectively communication ability with the community and its social environment.
2. Capital

Wrihatnolo et al., (2007) states that the community empowerment needs social capital reinforcement. The social capital term is firstly introduced by Hanifan (1916 cit. European Commission, 2005) defining it as social cohesion and personal investment within the community. Social capital, according to Durkheim (1964 cit. Rahardjo, 2010) is the social bond between human beings within the community to form the social cohesiveness in achieving the objective of living within the community and a strength (power) to achieve the shared life objective that cannot be achieved personally. Meanwhile, Bourdieau (1986) defines social capital as a collection of actual and potential resources related to the institutionalized eternal relationship network, knowing each other, and the presence of recognition. The social capital, according to Coleman (1990) is the community’s ability of cooperating to achieve the mutual objective in a group and organization. Putnam (1993) states that social capital is the characteristic of social organization, including networking, norm, and social trust facilitating the coordination and cooperation for mutual interest.

Hancock (1999) states that social capital is the adhesive binding the community. Lin (2003) says that social capital is the investment in social relationship by expecting the reward (return). Fukuyama (2006) argues that social capital consists of two: mutual trust between the members of community and community participation. Meanwhile, World Bank (2009) defines social capital as an agency, a relationship, and norms, either quality or quantity, of social interaction in a community. Then, Arefi (2003) states that building consensus is a positive indicator of social capital. Whereas, Halpers (2005 cit, Ozmite, 2001) argues that social capital refers to inter-individual relationship consisting of three components: networking, norms of reciprocity, and sanction. Building social capital, according to Kawachi et al (1997), is in the form of community relationship, participation, and trust through social network.

Baum et al., (2003) argues that social capital involves two dimensions: structural and cognitive. The structural dimension refers to the objective elements, such as the presence of social network and associations within the community. Cognitive dimension refers to the subjective elements such as trust and norms of reciprocity between the members of community. Meanwhile, Nahapiet et al., (1998) explains the role of social capital includes three forms: structural, relational, and cognitive. Structural dimension is the individual’s ability of making the weak bond into the stronger one in a system. Relational dimension is the connection between individuals characterized through trust and cooperation. Cognitive dimension is the presence of mutual understanding that a individual or a group feels has sense of belonging. Hazleton et al. (2000 cit. Friede, 2006) added the fourth aspect, communication.
Considering the result of path analysis in this research, the size of social capital contribution is directly correlated with the community empowerment in health issues of 58.98%, and indirectly through community participation of 28.09%, thereby the total relationship contribution of 87.07%. Based on the case study, it could be seen that social capital including cognitive, relational, and structural dimensions. Cognitive dimension includes trust, norms of reciprocity, and sense of belonging. The presence of mutual trust between the members of family, neighbor, coworkers, and members of community, as well as the member of community’s trust in the health personnel and health infrastructure existing in the village such as Village Health Post affect the utilization of primary health care.

Relational dimension of social capital is the presence of social norm or value, activity as personal investment, visiting each other, sympathetic to and communicating with each other, cooperation and unity. The main foundations of social norm or value are religion and culture. The presence of kinship, proximity, and knowing each other between the members of community are correlated with the community empowerment in health issues. Close friend and neighbor frequently informs the health problems or diseases suffered from by the close friend or neighbor. The relational dimension of social capital lies in community’s daily life, such as: visiting each other, alliance, sympathy, and interrelationship between individual, family, neighbor, and group, thereby accumulated into a social capital that can meet the social need and potentially improve the villager empowerment in health issues. The helping each other-culture seems to be very strong like seen from the attempt of alleviating the burden of the poor neighbor and other members of community when they are sick.

The cooperation between the members of community could cope with the health problem. Sarwono (2007) states that to be successful, the cooperation needs the following preconditions: (a) the compatibility between the understanding of objective and job division of each members of community, (b) the willingness to delegate authority and to trust in the members of community in performing the duty, (c) the willingness to give in and to receive feedback from the fellow members of community about the duty performance as well as the presence of transparency, (d) the ability of conveying view and critique well (objectively and not-emotionally) to be acceptable to others, (e) the willingness to change/to improve the self considering the critique or feedback, (f) the member of community’s solidarity, emphasizing on the member of society interest and the willingness to help the members of community to achieve the objective successfully, and (g) the member of community’s accountability, willing to work as optimally as possible, willing to take risk, and not blaming each other for failure.

Structural dimension can be seen in the case study as involving: firstly, the presence of organizational leadership operating in health issues. Secondly, the presence of Family Empowerment and Welfare (FEW) as the semi-formal organization aiming to activate the role of woman in development.
process; the existence of FEW as the community network has played a role in solving the health problems. FEW has a tiered structure from FEW at Neighborhood, Environment, and village levels. **Thirdly**, the presence of Neighborhood- Environment is established to develop communication between the members of community, to hold routinely meeting to settle the societal problems, including health ones. Every decision, including the health one, is made through discussion to achieve consensus. **Fourthly**, the presence of Non Government Organization, by raising the community resource. The fund collected is then used for the community’s health activity.

Kawachi *et al.*, (1997) states that social capital can affect the health like social and environment determinant. Have *et al.*, (2000) and Yuasa *et al.*, (2007) proves that the presence of social capital through social network and community affects the quality of health protection. Meanwhile, the social cohesion level and trust become the basis to forecast the mortality rate at the state level. Kawachi *et al.*, (1997 cit. Sampson *et al.*, 2000) reports that distrust level (the proportion of population in each state agreeing that majority people cannot be trusted) shows the close relationship to the mortality rate according to age (r = 0.79, p < 0.001). The low trust level is related to the highest rate of primary cause of death, including coronary heart disease and stroke. Meanwhile, Hawe *et al.*, (2003) states that social capital relates to the community empowerment in health issues constituting the information exchange, the neighbor gives recommendation, tips (advise) or other more valuable information each other to get health care.

2. **Access to Information**

Access to information is the activity of community members in obtaining information in various ways, such as through health program socialization, education and training, mass media, electronic media, etc. Keleher *et al.*, (2009) states that health information literacy is recognized as the key determinant of health. Health information literacy is an individual’s ability of finding out and taking an action in obtaining the health care as due. Furthermore, Fineberg (2004 cit. Keleher *et al.*, 2009) explains that the health information literacy is the extent to which an individual has an ability of obtaining, processing, and understanding the health information and care needed to make decision appropriately. In line with this, Rootman *et al.*, (2002 cit. Keleher *et al.*, 2009) states that the access to health information includes knowledge of health and health care, the ability of finding, understanding, interpreting, and communicating health information, the ability of asking for appropriate health care and of making health decision critically including the ability of understanding and taking some action in social and economic determinant of health.
Meanwhile, Mardikanto (2009) argues that the community empowerment attempt needs to consider the access to information, because information is the new power in relation to the opportunity, service, law enforcement, negotiation effectiveness, and accountability. Furthermore, World Bank (cit, Adiyoso, 2009) establishes the access to information as one of main principles in community empowerment. Similarly, the Health Office of Central Java Province (2011) establishes the access to information as one of community empowerment elements.

Considering the result of path analysis in this research, the size of access to information contribution is directly correlated with the villager empowerment in health issues of 29.48%, and indirectly through leadership of 10.75%, as well as indirectly through Community Self Survey of 10.24%, thereby the total relationship contribution of 50.47%. Based on the case study, it could be seen that access to information is correlated with the socialization through electronic mass media (television), local newspaper, local radio, and pamphlet, subdistrict coordination meeting, and community-based surveillance.

Conclusion

Considering the result of research, it could be concluded that the determinants relating to community empowerment in health issues consisted of input, process, and output. The input determinant consisted of internal and external community determinant. Internal community determinant included physical and economic (natural), and social-cultural (leadership, mutual cooperation, initiation, innovation) resources. Meanwhile, the external community determinant included access to information (TV, internet, newspaper) as well as the personnel’s and the facilitator’s role. The internal community determinants most dominantly relating to community empowerment in health issues were leadership and social capital. Meanwhile the external community determinant most dominantly relating to community empowerment in health issues was access to information.

The community empowerment process included the process of using and utilizing efficiently the resource within the community, and facilitation process and resource support from outside community. The output of community empowerment was the community forcefulness in health issues, the abilities of identifying and of solving the local health problems in health issues.
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