Master of Nursing Project

WOMEN'S ROLES AND SPECIFIC WOMEN PROBLEMS IN DEVELOPING COUNTRIES: INDONESIA

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Abstract

Changing of women's role in worldwide has lead to shifting women's participation in social life. Not only as housewife, women also play role as caregivers, career, and as money earner for family. Due to the complex responsibilities, home-work place conflicts seem impact seriously toward women's health. In addition several factors may affect to more defenseless situations for women. In developing countries women may experience more disadvantages situation than women in developed countries. This paper examines several literatures that focus on the women's health from the economic perspective and social demographic status begun in some countries and then in developing countries. Based on the review, the general issues of women's health in several countries can be identified that women mostly in the vulnerable position. The defenseless positions then affect to the lack of opportunity in maintaining women's health. In developing countries, lack of women awareness to their own health seems requires to be improved. Community empowerment and health education may relevant to improve women knowledge. In regard to women's awareness, the prevention program evaluation of early detection to cancer become an essential. It is important because the numbers of women with cancer in under developed countries tend to rise. The effectiveness of this cancer prevention programs in some developing countries less successful than in developed countries. At the final section, it offers recommendations to deal with such situation. Community participation from education sectors, community groups, district health services, and local governments become important resources. The model of recommendation may relevant with community empowerment and the recent program being implemented at community nursing settings. Empowerment program that deal with women health for Indonesian women trough community organization known as Pos Pelayanan Terpadu or POSYANDU *(integrated services in community*) and the recent community programs named RW Siaga (*Community group awareness*). To conclude, women and multiple roles bring benefits and disadvantages. Lack of supports and poverty may impact seriously to the poor health care access. Health care access included to achieve proper understandings to health care needs that can be indicated by women awareness to their own health

I. Introduction

Women's issues have been discussed intensely worldwide with many purposes, focusing on women's health problems due to a shifting change in women's roles in societies. It is asserted that women have responsibilities for their family as wife and caregiver. However, in recent times women have been requested to play more in providing financial support. Doyal (1990) recognized that women usually perform at least three types of activity; housewife, mother and employee.

The number of female workers or women employees has also increased due to global requirements and equal opportunity in job markets. For example, the number of male workers in Australia has tended to decline from 80 % in the 1970 to 71.6 % in 2005, while women's participation rate has increased to around 56.5 % in January 2005, it means 13 % point higher since 1978 (Pocock, 2005). In addition, Dowling and Worswick (1999) assert that the increase in women's participation in the labor market in urban areas in Thailand, The Philippines and Indonesia is due to economic and social status reasons. They mention that women from rural areas migrate to urban areas in order to raise their income by involving themselves as workers.

Although women's contribution as employees may bring positive impacts to the family and women themselves, there are some negative effects on women that may harm their health. The harmful effects may be caused by the multiple roles in their family and society, their socio-economic structure, lack of knowledge and poor community and political support. It seems that women need to deal with various conditions, to maintain

the balance between their domestic job responsibilities and paid job tasks, as the consequences may be detrimental to their physical and emotional.

In underdeveloped countries this situation appears not to be discussed due to varying factors, such as women's low bargaining position in the legislature due to gender and discrimination. For instance, the percentage of women participating as Indonesian legislative members was only 9.8 % in 1999, and the partnership with decision makers, communities and organizations that are concerned about gender equity in Indonesian seems frail (Parawansa, 2003). Another aspect is the lack of community responsiveness for women's welfare due to poor economic conditions and lack of knowledge. An illustration of this is the awareness of breast cancer screening among Asian women is lower than among western women due to misperceptions, lack of information and the inability to achieve such screening because of financial problems (Chin, et.al, 2005). In addition, it is asserted that Asian women's position in the social structure seems lower than the male position, and as a result it can lead to scarce support from family and community in accessing health care services. Markindes and Puentes (1992) asserts women's status, their position in the labor force and gender issues in societies have lead women to occupy the largest proportion of the population the below poverty line, be forced to accept low paying jobs and be unable to cover their health needs. These situations are more likely to be common in developing countries.

Culture and values within Asian societies may also affect women's attitudes toward their own health requirements and behaviors. For instance, Asian women tend to be hesitant to visit health care facilities for breast cancer screening due cultural barriers (taboo) and

economic problems (Tan et.al, 2006). Moreover, women may have limited access to health care services due to a lack of support from husbands or families, as well as time constraints due to domestic responsibilities (Lauver, et.al, 1995). Furthermore, women's lack of awareness of their own health needs may also become barriers for women to maintain their health (Sadler, et.al, 2000).

In order to identify relevant issues for women's health and the implications of women's roles in societies for their health, this paper is divided into several parts. The first section presents women's health issues in general views, then several women's roles in societies that can influence women's health status. Women's role in the work market will focus on the implications of being an employee and how women face juggling conditions. After that, the paper discusses working women in developing countries and their particular health issues. In the final part, this paper offers some recommendation for several agencies responsible for women's health concerns in a particular area in Jakarta, Indonesia.

II. Literature review: general perspective of women's health

A. Women's health issues in general perspective

Women health issues can be discussed in very broad view. Varying perspectives include women's natural physiological needs, and demographic, socioeconomic and environmental factors. Moss (2002) mentions that women in society and demographic factors such as age, occupation, marital status, income, and gender issues have become influencing factors for women's health. Other factors such as gender, income, family structure, education, age and occupation can influence the differences in health outcomes

between men and women. In regard to complex women's health issues, this review discusses several points of view on women's health issues.

1. Woman's specific conditions and health concerns

In the usual perspective on women's health, health care requirements concern to the reproductive system and particular female conditions. Women's natural conditions include pregnancy, childbirth, breastfeeding, and menopause, and in this way women experience different health problems from men (Doyal, 2000). Another ordinary circumstance that can influence women's health complaints is female anatomy and physiology. Specific female function has lead to a more definite discussion of women's physiological problems. Meleis and Im (2002) argue that the distortion and misinterpretation of research findings and women's health-illness experiences tends to be reduced to a physiological or pathological event. This means that the discussion of women's health issues should be viewed comprehensively, not only from a reproductive and maternal model, but also grandmother, biomedical and morality analysis. An illustration of this situation, in term of reproductive and maternal models, is that providing proper maternity health care facilities and access for pregnant women are important to prevent morbidity and mortality due to women's specific conditions. However in the reality, women's requirements in health care may be more complicated due to women's roles as workers, caregivers, spouses, and community members (Meleis & Im, 2002). In the community therefore other factors such as socio-economic and cultural should be in account to describe women's health issues.

2. Social economic status and women's health

In the context of socio economic and demographic factors, women's health can be affected by women's position in the community. Lahelma, Arber, Kivela and Roos, (2002) assert that social conditions such as poverty, marital status and culture background can put women into vulnerable positions in achieving health care. Women in society seem to have less power, status and financial supports than men, as well as less independence (Doyal, 1995 cited in Arber & Khlat, 2002). It means that such conditions can significantly affect women in receiving health care. Furthermore, in relation to marital status, married working women may take pleasure in their work if families and husbands provide social support, such as taking care of children, and sharing domestic jobs (Rao, Apet & Subbakhrisna, 2003), while single women with children experience more distress due to more complex tasks in maintaining the life and providing basic needs. Women as single parents experience stress, anxiety and depression more than women with partners due to social distress (Walters, 1993).

Low socio-economic status usually coincides with low education level and it may put women in vulnerable situation to meeting their health care needs. Women with a high education level may have better opportunities in accessing health care facilities because of cover by health care insurance as well as having a better social life. Artazcoz et.al (2004) present that women with a college education experienced fewer unmet needs than those are who had lower education levels such as Senior High School level. Moreover women's education level may also affect their low job position in work market, low payment and insecure workplace, with the result that women are trapped in poor health

conditions such as the unavailability of health insurance coverage and out of pocket costs. It is appropriate that women can access to the health care facilities by insurance coverage and adequate financial support. Commonly women state several reasons that cause them to delay care: to lack of financial support, lack of insurance and competing family and work responsibilities (Kaiser Family Foundation, 2004). This means that women with low social economic status and lack of health care coverage lead to lack of accessing health care services. As mentioned by Kjerulff et.al (2006), women without health care insurance may have limited access to specialist physicians, and the only option is the emergency service.

Another example is the numbers of women who have caesarian sections in poor countries is less than in developed countries due to lack facilities; lack of health insurance and out of pocket expenses (Kaiser Family Foundation, 2004). In addition, the majority of working women in developing countries have less access to the clinic or family doctors due to lack of support from their employers in accessing health care services (Duval, 2001).

On the other hand, women with better social support may express difficulty in attending health care services due to time barriers. It is asserted that women may have essential roles in family as mother and wife as well as money earner. The multiple roles in family and paid job task may lead to the lack of time to attend to their own health care. Mathews and Power (2002) mention work-home roles; social class, psychosocial, work characteristics and job insecurity are associated with women's health. As women may

have higher responsibilities than men in providing care for their family and relatives, women may chose part time job positions and as a result they may have less opportunity to access health care due to limited health insurance coverage for part time employees (Markindes & Puentes, 1992). In addition, Pocock (2005) mentions, part time work becomes the main option performed by Australian women to get work-life balance and deal with other responsibilities.

3. Environmental and cultural backgrounds affect women's health

Culture and national background may affect women's accessibility to and opportunity for achieving proper healthy status. For instance, women in developed countries may have better access to maintain their health compared with underdeveloped countries that have lower standard health care services for women. Moreover, women's health issues in developed countries may differ from health issues for women in underdeveloped countries due to diverse values in responding to women's health needs. For example, the health program goals for women's health in India focuses on providing sufficient nutrition for children and women due to the high percentage of pregnant women age 15-49 aged with anemia. On the other hand, in the United States the policy for women may focus on economic security and integrated women's health services throughout the life course.

The environment, cultural and historical issues in some countries may influence community attitudes to girls and women. Wyn and Solis (2001) assert that a woman's health across the natural life course may raise diverse issues due to varying factors such

as socio-economic, ethnic, geographic and cultural background, as well as her health behaviors. For example, women in the countryside mostly perform household jobs or provide care for family and relatives. Luk and Shaffer (2005) emphasize the different values between Chinese and western women regarding their responsibility for paid work and household jobs that may result in work/ family conflicts. In addition, Artazcoz et.al (2004) clarify that in from a traditional perspective, Spanish women have to stay at home and provide care for families because community attitudes consider that working has no beneficial impact for married women's health.

Women have to leave the labor market when they have children in order to meet their responsibilities as wives and mothers (Simon, 1995 cited in Artazcoz, et.al, 2004). In urban areas, working women usually combine domestic responsibilities with paid work, and as a consequence, they might ignore personal health problems due to time constraints and their social roles (Young, 1999).

4. Gender issues, race and ethnic disparities through women's health

Gender issues have strong implication for women's opportunity in accessing health care facilities and must be discussed due to the disparity that affects to women's health. Doyal (2000) sates that gender inequality in income and wealth makes women particularly at risk for poverty. Although men and women may have different health care needs and problems, providing balanced health care services for both genders is important. Implementing gender equity in health may produce better health outcomes for women and men (NSW Health, 2000). Poverty can affect both males and females, however girls

and women seem suffer more due to discrimination (Dwyer & Bruce, 1998; Jackson, 1998; Kabeer, 1994 cited in Doyal, 2000).

Discrimination against girls and women may cause a sense of low worth in families and societies, and as result they will grow up to become individuals with low self-esteem (Papanek, 1990 cited in Doyal, 2000). Not only causing low self esteem, but discrimination also influences stake holders in making decision for women's health. For example, equal rights for women and men are generally granted for health policies and legislation in Latin America and Caribbean countries, however in the real practice these constitutional requirements are not effected (Puentes & Markindes, 1992). It seems that lack of support from decision makers may contribute to lack of political support in achieving proper health care services. Lack of health care facilities and diminished social and political support may lead to poor health conditions. The World Bank has correlated gender equity with lower fertility and better health for women and children as well as with economic development (Barrett, 1995; Razavi, 1997; World Bank, 1998 cited in Moss 2002).

Another factor that can affect women's health status are ethnic and race disparities, which are related to different health complaints as well as divergences in health care achievements. For instance, the Kaiser Family Foundation (2004) identified differences in health status, health insurance coverage and access to health care between women of color and white women in the United States. It identified that women of color

experienced poorer conditions of health and had less insurance coverage than white women.

In regard to women's roles in society, in the next section this paper focuses on how such roles can affect women's health and how government support is needed to maintain and promote women's health. It is asserted that balanced attention from stakeholders seems important to accommodate women's needs for health care facilities. Meleis and Im (2002) suggest that the importance of balanced health care access and facilities, and the discussion of women's health should concern to the integration, transitions and the equation of women's health needs.

B. Women's roles in social and economic life.

Women's responsibilities in the family and community are varying due to multidimensional responsibilities such as caregiver, housewife, and as well as money earner. Combination roles in the community have lead to a juggling situation where women need balance and support from all society members. Although women have a basic role in their families, increasing family demands have lead to changes in women's roles as money earners. For example, Pocock (2002) mentions that women may participate as casual, part-time or full-time employees due to the increasing family demands on economical needs.

It is asserted that predominantly women have responsibility in the household for domestic jobs such as cleaning, cooking, shopping and gardening without payment. Arber and Khlat (2002) mention, that women are more likely to be unpaid carers for family members, performing both household jobs and health care for partners, children and

parents when needed. In addition, Doyal (2000), states that females have primary responsibilities for household and domestic labor. Caregiving is one of unpaid jobs that usually performed by women to maintain families' needs for health. The majority of caregiver are women who provide unpaid work for the family: husband, children, relatives and old or sick parents (Donelan et.al, 2001).When women perform care giving for their families in the long term care they may experience physical and emotional burden. As an illustration of this, women caregivers are more likely than non caregivers to express poor health, having serious medical conditions, and experience depression symptoms (Donelan, et.al, 2001). In addition, Artazcos et.al (2004) found that women with low education levels who have full time household responsibilities had a higher risk of poor self-perceived health status.

In relation to women's role as money earner, some factors such as marital status, financial condition, number of children and education level may become motivating factors for woman to be an employee or participate in labor markets. Some experts believe that working women may have a better life and better health status than other unemployed women (Artazcoz, et.al, 2004). Working can increase women's financial income and bring positive impacts, however women's participation in the labor market and its various tasks or activities than can affect to women's health status. Arber and Khlat (2002) assert combining household roles and paid work have contributed to work-family conflicts and has affected women's health as a result of overload, job conflicts, and contradictions. Young (1999) asserts that women with combined caring

responsibilities and paid employment often disregard their personal health problems due to family and social demands.

In developing countries, women's participation in the workforce may be caused by women's eagerness to help their spouses and fulfill family needs. As an illustration of this, the monetary crisis in most Asian countries, including Indonesia, has caused a surge of unemployment among men workers, and as a result, has increased women's contribution to solving economic problems by working longer than before (BPS, BAPENAS and UNDP, 2001). As the percentage of women in the workforce tends to go up, discussion about women health in relating to their roles in the work markets becomes important. In the next part this paper discusses the implications of paid jobs for women.

C. Women in work markets and the implications

Women's participation in the labor market brings advantages and disadvantages to their health circumstances. A benefit of being an employee is that working may enhance women's wealth, however it may harm women's health. The health complaints may include physical as well as psychosocial problems that may affect to the work-life balance at the individual, family and organizational levels. An illustration of this is where employees who are working in a more supportive workplace or who have more supportive families tend to experience less work-conflict (Byron, 2003). Walters (1993), asserts that women experience different mental health problems depending on family structure, socio economic status and position in workplace.

Positively, working may increase women's activities and their job experiences, resulting in more confidence and enjoyment in their social life, job satisfaction and having social support from environments (Doyal, 1998). It seems working women have better social, physical and mental health. On the contrary, women in the workforce may also suffer physical illness such as hypertension, stiffness, tiredness, lack of sleep and gastritis (Doyal, 1998). In addition, workloads and life demands can contribute to stressfulness which result in imbalanced individuals, families and organizational work-life control (Bryson et. al, 2007). Household and paid job responsibilities may affect home-work conflicts for married working women because of the gaps between family situations and company requirements in workplaces. For instance, women employees with dependent children experience more job stress and face greater work-family conflicts than those who are single and without children (Byron, 2003). In addition, support from family is also important to promote women's careers in the workplace. Women as mothers and money earners may need supportive environments and families to deal with household jobs as well as paid job tasks.

Rao et,al, (2003) mention married working women can deal with role strain by asking for support from spouses, family in-laws, parents, as well as agencies for childcare. Culture and traditional values in some Asian countries have put women under the arm of men. For example, after marrying a woman's decision to participate in the workplace may be related to the husbands' request such as in India, Bangladesh, Thailand and Indonesia (Dowling & Worswick, 1999; Rao et.al, 2003). In regards to family constraints, after having children working women in urban areas may chose part time jobs or resign from

work to meet family demands due to high cost of child care or nanny (Pocock, 2006). This means that a lack of family support for working women can become a barrier for women's career development, and may result in a worsening situation due to unemployment.

Career development for married working women may fail due to lack of qualifications, discrimination and poor community attitudes. Predominantly, women in underdeveloped countries work in lower paid jobs and their positions are likely to be lower than men. For example, the majority of women in underdeveloped countries work in textile factories and electronic industries (Doyal, 1990). Women in underdeveloped countries may have difficulties in accessing higher education; as a result women have lower qualifications and receive fewer wages than male workers. An illustration of this is that mainly males are positioned as managers in the work place, while women may play the role as ordinary employees due to less power, status, autonomy and independence (Moss, 2002). In addition women tend to refuse managerial promotion to avoid more difficult responsibilities that can contribute to the inadequate time in serving families (Rao, Apet & Subbakhrisna, 2003).

Although women's emancipation has influenced women's qualification and competences in workplace, society's attitude and community values toward women seem inadequate. For instance, Asian women are more likely to be portrayed in a conventional way that women should act as a servant for men, and their achievement is measured in how much time she has provided for her children and husband (Ingham, 2005). As a consequence,

women have to prioritize household responsibilities over workplace tasks and this may affect her restricted career development. Cultural backgrounds have also contributed to a defenseless position of women. For example, due to traditional values, women should not have paid work when they have children under three years old in Spain (Artazcoz. et.al, 2004). Furthermore, due to low job positions working women may achieve job dissatisfaction and receive inappropriate wages; low income then may contribute to their inability to realize appropriate health care needs.

Not only causing job dissatisfaction and powerlessness in accessing health care, women's participation in workplaces may also lead to mental health disturbances. Working may increase women's confidence, however negative emotional implications may appear. Walters (1995) mentions that women from well educated as well as uneducated backgrounds experience stress, anxiety, and depression due to their workload at home and in the workplace. Working women reported negative feelings such as fears of unemployment, violence against women, lack of time for themselves, lack of confidence and tiredness (Maclean, Glynn & Ansara, 2004; Walters, 1995). In Asia, women migrants from rural to urban areas experience psychological stress due to strange situations in cities as well as pressure caused by workplace requirements (Doyal, 1990).

Furthermore, women experience mental health problems differently, depending on their socio economic status, ethnicity, family structure, and quality of family relationship as well as the nature of their participation in the labor market (Walters, 1993).

In conclusion, women's wide ranging health issues have been affected by several factors. In the socio- economic perspectives, women may contribute positively to fulfill family demands as caregivers and money earners. At the same time women may suffer and have a defenseless position due to domestic responsibilities and fragile bargaining positions.

III. Literature Review: Specific women's health issues in developing countries.

This part describes the illustration of women in developing countries, particularly in Indonesia and its specific health problems that related to women's multiple role.

A. Economic crisis and women's health issues.

Women in developing countries may have poorer conditions than women in developed countries. Modern facilities, adequate financial support, integrated health care system and political support are common in western countries, while in developing countries, poverty, poor environment, lack of knowledge and limited health access may become familiar factors that can affect women's health status. The Asian Development Bank (2006) lists six poor conditions faced by Indonesian women due to poverty; they are lack of access to health and sanitation services, low education, limited clean and safe water, poor housing and absences of economic opportunities

In regard to working women's health, these factors seem to have a simultaneous impact on women's welfare. As mentioned by Puentes and Markindes (1992), most of women in developing countries have limited access to better health due to economic problems in such countries. Poverty, which is a common situation in developing countries, has led to a vulnerable position for women. This defenseless position can bring women to worse conditions due to high incidence of illiteracy.

The financial crisis in most developing countries in the middle of 1997, has led to an increase in unemployment, poverty, poor sanitation and limited health care access in Asia. Approximately 49.5 billion Indonesian people or around 24.2 % of total population were identified as living in poverty at the end of 1998 (BPS, 1999 cited in Gardner & Amaliah, 1999). Although poverty had decreased to 16.7 % in 2005, it then increased to 17.8 % at the beginning of 2006 due to subsidized fuel reduction (ADB, 2006). This instability of the economy also contributes to the worsening of nutritional status within women and children. As an illustration of this, the Indonesian mortality rate is 31 per 1000 life births, with 6 % of total population in poor nutrition status, and around 22 % of Indonesians have no clean water access (Coalition for Indonesian Health, 2005). Unhealthy environments and unsafe water supplies may lead to reproductive complication and anemia due to poor nutrition.

As poverty is a common situation in developing countries, in order to survive and to fulfill economic demands in families, women's participation as employees in developing countries may increase. However women's participation in the job market imbalances with the opportunity to get health care access. Suryawati (2005) clarifies several factors that can cause the scarcity: lack of natural resources, lack of education, lack of knowledge and skills, less infrastructure and public facilities, poor financial and lack of political support. In the dimension of socio economic factors and health, Indonesian women may deny medical and health care needs due to expensive medical treatment. As a result the numbers of chronic illness, communicable diseases and mothers' morbidity and mortality rates have increased (Suryawati, 2005).

Lack of nutrition is also a common problem within Indonesian women as poor food intake and inadequate nutrition supply may affect the powerless condition within Indonesian employees. For example, the majority of women workers in one factory in Indonesia experienced anemia, intestinal parasites, respiratory infection, reproductive health problems, lack of access to contraception, unwanted pregnancies, reproductive tract infection, abnormal menstruation, lack of pre and post natal care, and high infant mortality rates (Duval, 2001).

In the context of women as employees, working women in developing countries seems to experience unfavorable situations that caused by several factors. Donelan et.al (2001) state that women as care providers for family members may experience difficulties in getting appropriate and regular care for themselves due to time constraints, costs, and hard to get access. In the work market, Indonesian women have a significant function in supporting financial demands for families, not only in formal sectors but also in casual job markets. Meng (1998) states that most Asian women are more likely to work in the informal sectors due to the ease in performing both household and paid jobs. Other arguments also presented are that women may not engage in formal jobs due to due to discrimination and low levels of education (McKee, 1989, Lycetter and White, 1989 cited in Meng (1998). In addition, women may be involved in more complicated tasks due to employers' requirements and in order to answer global demands on workforces. Ingham (2007) mentions that globalization and modernization have changed the Indonesian traditional mode of living and it has encouraged women to be adjust to recent needs and pressures. Women may migrate from rural to urban areas to achieve a better life for families. As mentioned by Dowling and Worswick (1999), women in Southeast Asia are

a significant component in rising women's employee supply in work markets. In urban areas they may be involved in formal or in informal sectors of job markets. In formal sectors, high education and good performance become important requirements to find such jobs. Predominantly, women in Asia share in the formal job market such as in teaching and nursing (Anker & Heins, 1985, cited in Meng, 1996). This phenomenon is also common in Indonesia where women usually have a career as a nurse or teacher as their formal job (Ingham, 2005).

On the other hand, due to a low level of education, the majority of Asian women may be employed in informal job positions with low wages. The informal sectors may offer easier opportunities to get jobs and as a result, women may participate in low waged jobs and insecure job positions to meet individual and family needs. For instance, women in garment factories may receive lower salaries than men and they may be uninsured (Dowling & Worswick, 1999). In another informal sectors, women may go abroad to become housemaids in order achieve better salaries and improve their families' finances. Poverty, unemployment and lack of formal education drive the increasing numbers of women to migrate overseas (ADB, 2006). They may leave their husbands, children and families to achieve greater financial status. By way of illustration, it is asserted that young Indonesian girls are sent to Middle East countries and Singapore as housemaids or prostitutes (Coalition against Trafficking of Women, 2007). Although the remittances may bring advantages for families and the sending countries, it seems that women may suffer more than men due their vulnerable position. For example, in 1996 seventeen Indonesian women working as housemaids in Saudi Arabia were killed or died

mysteriously and 46 others were tortured or sexually abused (Coalition against Trafficking in Women, 2007). In addition, it seems that women workers abroad have unsafe and insecure positions while working overseas due to their illegal status. For instance, it is estimated 60 % of Indonesian workers in Malaysia are thought to be unofficial (ADB, 2006). These situations seem unsafe for the Indonesian workforce overseas, particularly for women, who may trapped in worse situation such as prostitution and women trafficking.

In industrial sectors, Indonesian women's contribution in factories also has significant economic value. An illustration of this is that predominantly the workers in the textile garment and footwear factories are women (Duval, 2001). Although women workers may have better income than other unemployed citizens, they seem to be in an unfavorable position. For example, comparing labor wages in the clothing industry in 1998, the hourly rate in Mexico was US$ 1.51, in Guatemala US$1.28, in China 0,43 cents and Indonesia the lowest, with a rate of 16 cents (Duval, 2001). In addition, Indonesian women expressed some unpleasant conditions in their workplace, such as sexual and physical abuse, poor machinery in such factories, lack of support from employers, and poor health care access and facilities. As an example, female workers may be refused to have two days monthly menstrual leave which is allowed under Indonesian law (Duval, 2001). In another unpleasant situation, 30 % of employees in one factory reported witnessing or experiencing abuse (Duval, 2001). Moreover, limited education levels of Indonesian women in urban areas may result in to less opportunity to get appropriate job position, and as result they may achieve low income paid jobs. Such low paid work

includes housekeepers, shopkeeper, sale promotion girls or street vendors. These job positions for Indonesian women are common and may put women in the unsafe work environments.

B. Illiteracy and women's awareness to health

The second factor that bring some disadvantage for women in most developing countries is illiteracy . Predominantly women live in impoverishment conditions in most under developed countries. Low education, lack of time and lower participation in social activities may result in defenseless conditions and can affect women's attitude to their own health. For example, Chinese women's awareness of early detection of breast cancer seems lower than that of western women (Sadler, et.al, 2000). As clarified by Doyal (1995), the majority of women's education level is lower than males in developing countries. Limited women's education level may have an impact on their ability to access information clearly. As a result, illiteracy and lack of knowledge may significantly affect women's understanding and awareness of their own health needs. Approximately 12.1 % population aged more than 15 years in Indonesia is illiterate (Koalisi Untuk Indonesia Sehat, 2007). Illiteracy in health care may affect clients' understanding of their illness or condition and influence clients' perception in taking appropriate prevention, therapy and rehabilitation.

In regard to health prevention programs, lack of community knowledge about health care issues may result in low self responsiveness to be an active participant in prevention of

illness and health promotion. The data shows Indonesian women may only see doctors after the illness or health condition is severe. As an illustration of this, 70 % of women who experienced breast cancer in Indonesia came to hospital in the late stages, compared with developed countries such as Japan where only 13 % came in the late stage (Sutjipto, 2007). There are several reasons that prevent Indonesian women from performing early detection of breast cancer: insufficient knowledge of cancer, lack of awareness of their own breasts, fear of the operation procedures, more confidence in traditional healers, socio-economic problems, taboo and unwillingness to show their breast to others (Sutjipto, 2007). In addition, the incidence of new cases is predicted to increase from 10 million in 2000 to 15 million in 2020, of which 9 million would be in under developed countries (Brown, at al, 2006). The authors list the top five cancers affecting women in developing countries: the largest is breast cancer, and then cervical, stomach and lung cancers, and the lowest is colorectal cancer. Breast cancer prevention is a relevant program in the recent situation because the incidence of cases is increasing The cancer global survey in 2002 identified 28 lung cancer cases per 100,000 population and 26 cases of breast cancer per 100,000 population in Indonesia (Pusat Promosi Kesehatan Depkes, 2007). This trend is an important area of concern due to the high severity and underprivileged states caused by cancer. In Indonesia, health promotion programs to prevent cancer for women's sub-population are available, however the implementation needs to be improved.

C. Poverty and lack of health care access.

Poverty is the essential barrier relating to the ability to access health care services. Poor socio-economic status may lead to less capacity to fulfill life demands including nutrition requirements, housing, education, and health care needs. Inability to meet such requirements may cause to poor health status, high morbidity and mortality rates, and low participation in education settings.

Women and men have specific health needs, however regarding health care access and opportunity it is important to facilitate both equally. Stakeholders may make a significant contribution to providing equality in facilitating health care needs for both men and women. There are several influencing factors in developing countries whereby women seem to face disproportionate barriers in the implementation of health care access and policy. Women may fail to get health care services because they are weak financially and are unable to communicate their needs. While, on the other hand policies that can be essential for women's welfare commonly fail in their implementation. Social, economic and cultural backgrounds are blamed as the influencing factors. However, in the real life women's unequal social position is the main reason in developing countries. Political support may be required in order to facilitate better access and better services in the community. Social support may be related to the attention and support from a group or community for women's wellbeing. Poor social economic life, illiteracy, gender issues and less political support may result in poor women's attention to and perception of health and health needs.

D. Women's health promotion in the context of primary health care.

Health promotion action includes five broad areas: build public policies that support health, create supportive environments, strengthen community action, develop personal skills and reorient health services (The Ottawa Charter for Health Promotion WHO, 1989a). In the practice, health promotion programs deal with primary care and prevention actions. The definition of primary can be described as "essential" or "fundamental" and "preventive" means providing effective disease prevention (Leppert, 1997). In the term of women's health, these concepts are essential to ensure that women's basic health requirements are met by several health professions. As a professional nurse providing services for women's health, it is necessary to develop adequate strategies in promoting the program. One strategy to prevent harm caused by illness and cancer is the screening method. Screening is defined as "disease detection at a symptoms or pre clinic stage". Smith et.al (2006) assert that women should be supported in seeking care and should have access to appropriate, affordable diagnostic and treatment of breast cancer. Sankaranarayanan et. al (2001) state that the effort of cancer screening programs in developing countries must be concerned with increasing women's awareness and preventive health seeking behaviors, screening all women aged 35 to 50 at least once a year, expanding services and providing repeating screening.

In Indonesia early detection for cancer has been introduced, and women encouraged to join this free service in 2006; however women's attention and visitation seems low. However, the data indicates this program's achievements in Indonesia are still under funded. An illustration of this is the national target for early detection of breast cancer, cervical cancer and cardiovascular disease in Indonesia is 50 % in 2010 (Gubernur

Provinsi DKI, 2007). The achievement of the target was only 4.5 % at the end of 2007 particularly at east Jakarta. This means that the effort of the early detection program needs to be improved intensely. In order to reach better target achievements it is essential to promote women's awareness to participate in such programs. As with other developing countries, women may have access to health care facilities supported by health insurance (ASKES in Indonesia) or social support for workforces (JAMSOSTEK in Indonesia), however women seem hesitant to visit health care facilities due to time constraints, husband's power, and family barriers.

Multi- professionals can be involved in prevention programs and nurses' contribution to health education and health promotion programs is important. In this circumstance, Binawan Institute Health Sciences (BIHS)-Faculty of Nursing may engage in health promotion programs due to the relevancy with the BIHS education subjects. The BIHS nursing subjects that are performed at community nursing setting may be useful because the objectives of the subjects adopt a comprehensive nursing process in the context of family and community health. Due to such relevance there is the potential to develop integrated regular students' activities at the community level to engage with government programs in promoting women's and community awareness of their own health by health education approaches.

E. Nurses' roles in community nursing approaches

Nurses' roles in the community nursing setting are essential in promoting women's health. Basic roles for nurses include educator, advocate, manager, provider and

researcher to allow nurses to perform essential tasks in enhancing women's skills and abilities in health care needs. Imbalanced proportion between population and health care providers at primary health center (PUSKESMAS) as well as lack of understanding within PUSKESMAS employees has lead to improper health services for families. In fact, poverty, illiteracy and lack of economic support may become barriers for Indonesian women to access health care information. As mentioned by WHO (2000), women's access to health information can be affected by their ability to understand and to access the information. In accordance the health care services for women in community, lack of facilities and media as well as community education programs have contributed to the helpless situation of ordinary people include women. These situations are common in several developing countries include Indonesia. For example, women in urban areas such as Jakarta may access health care services free of charge because of support from local government; however this facility seems limited in endemic cases such as dengue fever (DHF). For other cases it seems impossible to achieve better health due to the unavailability of health care facilities, health insurance and inadequate promotion programs. The eagerness to participate in early detection or health prevention programs seems reduced due to lack of awareness and inability to access the health care facilities. Communities should be encouraged to be aware that preventive action may prevent severity and save costs. Brown et al (2006) mention that cancer prevention and treatment come from studies developed in western countries, whereas in developing countries it still new and it is difficult to estimate the cost and cost effectiveness. Therefore strategies should align with the nation's abilities.

F. Recommendation: Health education to promote women's knowledge and community empowering.

This section illustrates how community nursing is performed in Indonesia. Commonly, community nursing in Indonesia refers to health care services at the community level with specific programs from government (Hatmoko, n.d). The community health program includes family planning, infant and children health, pregnancy and maternity health, immunization and aged care. All of these programs are usually conducted in POSYANDU (Health posts). Recently, the government introduced Community Alert in small group of families (RW Siaga) by community empowerment in health and social wellbeing. In regards to the recommendation of this project, it seems relevant to perform a program that can encourage and empower women in community.

The recommendation will be delivered in a specific area in coordination with the Primary Health Center (PUSKESMAS), local government and Binawan nursing faculty staff. These three parties are used to work together in performing family and community health under supervised PUSKESMAS staff. In the community, PUSKESMAS or primary health center has to perform health programs in national and local government contexts for family and community health. Each primary health center has responsibility to cover the health care needs in a specific area (suburb) with a population of approximately 300-1500 people, with varying sup populations. In order to achieve the primary health programs, PUSKESMAS will be supported by POSYANDU (health post) in the smaller area with approximately 100-200 families. POSYANDU has five tables of basic health services, including simple health assessment, immunization, family planning, health education and consultation, charting and reporting.

The POSYANDU activities are focused on the development of babies or children less than five years old as well as family planning programs. PUSKESMAS and POSYANDU may identify high risk families such as those with elderly people, chronic diseases, communicable diseases, having an infant and baby, and family planning program. Every month this activity is performed regularly in each small area and facilitated by health care providers. It seems that in these posts, the women empowerment programs can also be implemented effectively. Moreover, on the National Health System (SKN), the strategy to achieve Indonesian health development, it deals with primary health care services. It is characterized by easy access and encourages active community participation. The belief of this primary health care is that it is from community, by community and for community. In the implementation this strategy is adopted by government and health care providers to provide services for community with inter-sector and inter–program co-operation. The targets for this strategy are individuals, families and communities in eight aspects; including knowledge development, community nutrition improvement, family planning, mothers' and children's health, clean water and sanitation, immunization, preventive intervention and control of local endemic diseases. In regard to develop women's awareness of their health, health education and community empowerment are suitable recommendations in the community nursing setting. Several relevant issues and reasons that may support the recommendation include:

1. Community empowerment is important to enhance women's knowledge of their own health.

2. Health education and health promotion program may be created in order to promote women's awareness of their health care needs.
3. The program can be integrated with POSYANDU programs (usually POSYANDU's program focused on maternity health, infant band pre schools children health, as well as for elderly people /POSYANDU LANSIA). Sometimes, community nurses perform health education for families with communicable diseases.
4. Under graduate nursing students regularly perform clinical practice in community care settings. Therefore, these students may participate in and perform collaborative practices with community nurse staffs.

The recommendation will be performed to enhance women's knowledge in order to increase women's awareness of their own health. In this recommendation, the health education programs and screening programs should be implemented in the integrated programs with POSYANDU. Previously, the education and screening programs were implemented at special times and in particular places, so that the accessibility for women is weak. In the literature it is clear that there are several barriers to achieving program targets for the early detection of cancer and screening programs for Asian people in developing countries. The majority of Asian women's beliefs and awareness of their own health is low. Low participation may relate to illiteracy and poor knowledge of a healthy life. Therefore this recommendation may be performed to increase women's knowledge first and then provide health education to encourage active participation from individual, family, groups and community. It is also important to include non government organizations in program implementation because the private sector and non government

organizations may provide financial support for the advanced treatment and medications for complicated problems caused by cancer.

IV. Conclusion

Women's health can be seen from various perspectives: as a human being women have natural physiological functions such as for reproduction. In social life, economic, social and education levels may also affect to women's access to health care facilities. Women's health may also be discussed in the context of culture and environment. Diverse cultures in society may influence community attitudes toward women. Gender, race, and ethnic disparities are common issues in most developing countries that may contribute to a lack of support for women's health.

In regard to women's roles, woman may perform as housewife, caregiver, and money earner. These multi roles can cause physical and emotional disturbances, as well as prevent health care access due to time constraints and limited facilities. In several developing countries, women may participate as workers in order to support family finances. Women's participation in the workforce sometimes puts women in vulnerable positions due to discrimination and lack of education. This disadvantaged situation also contributes to the poor health care insurance caused by lack of economic ability. As a consequence women may suffer and have poor access to health care facilities.

Not only lack of facilities and the ability to access health care services, but also illiteracy among women in developing countries contributes to a lack of awareness of their own

health For example, Asian women are usually hesitant to come to early detection programs due to misperceptions and misunderstandings..

To conclude, women's health can be described from varying perspectives, however the shifting of women's roles in socio-economic terms becomes a challenging situation. As women have multiple roles in families and the community, their roles can affect to their welfare and health. Working women who contribute to increasing the family's earnings juggle with home and workplace responsibilities, and, as consequence, this may affect women's physical and emotional condition. In developing countries, the situations deteriorate due to lack of women's knowledge, traditional values of societies to women and inappropriate political supports. Community empowerment may become an alternative to enhancing women's power, however improving women's knowledge and awareness in regard to preventing more detrimental situation seems a potential to be developed. Several recommendations are addressed to the particular division between Primary Health Centre (PUSKESMAS) and community groups (POSYANDU, POKDARMAS, RW Siaga). Regular clinical placement for BIHS nursing students may become an opportunity to improve the government target achievements in health. Shared responsibility and contribution between nurses and communities can be meaningful resources.

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