Review of: "We Don’t Have a Health Problem, We Have a Village Problem"

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Potential competing interests: No potential competing interests to declare.

The cultural diversity and social structure of society in the world greatly affect the level of community attachment, especially in the fulfillment of health expenditure stocks from a macroeconomic perspective. Rural and urban communities, people with low and high education levels, and people with good and low health literacy will have varying degrees of compliance with a government policy. It would be interesting if this idea were followed up with several comparative studies in various regions globally.

Comparative studies can be conducted using examples of public health problems in developing countries. I have developed an approach based on local wisdom in efforts to combat stunting in Indonesia. Efforts to implement nutrition fulfillment for pregnant women and two-year-old babies are carried out in dasawisma groups (groups with 10 houses in a village area); they gather assets and resources in a collaborative manner to jointly solve the problem of malnutrition in their families. They donate eggs from cereal foods as vegetable proteins, they together build healthy houses with good ventilation, and they also work together to ensure the availability of clean water sources and environmental cleanliness.

Different levels of health literacy require different approaches to community empowerment. Several health ethnographic studies have found potential clashes of people's cultural beliefs about health information. In groups with low health literacy and education levels, they will comply with policies that prioritize reward and punishment mechanisms. In ethnic areas in the interior, there are customary fines for those who do not comply with the orders or rules set.