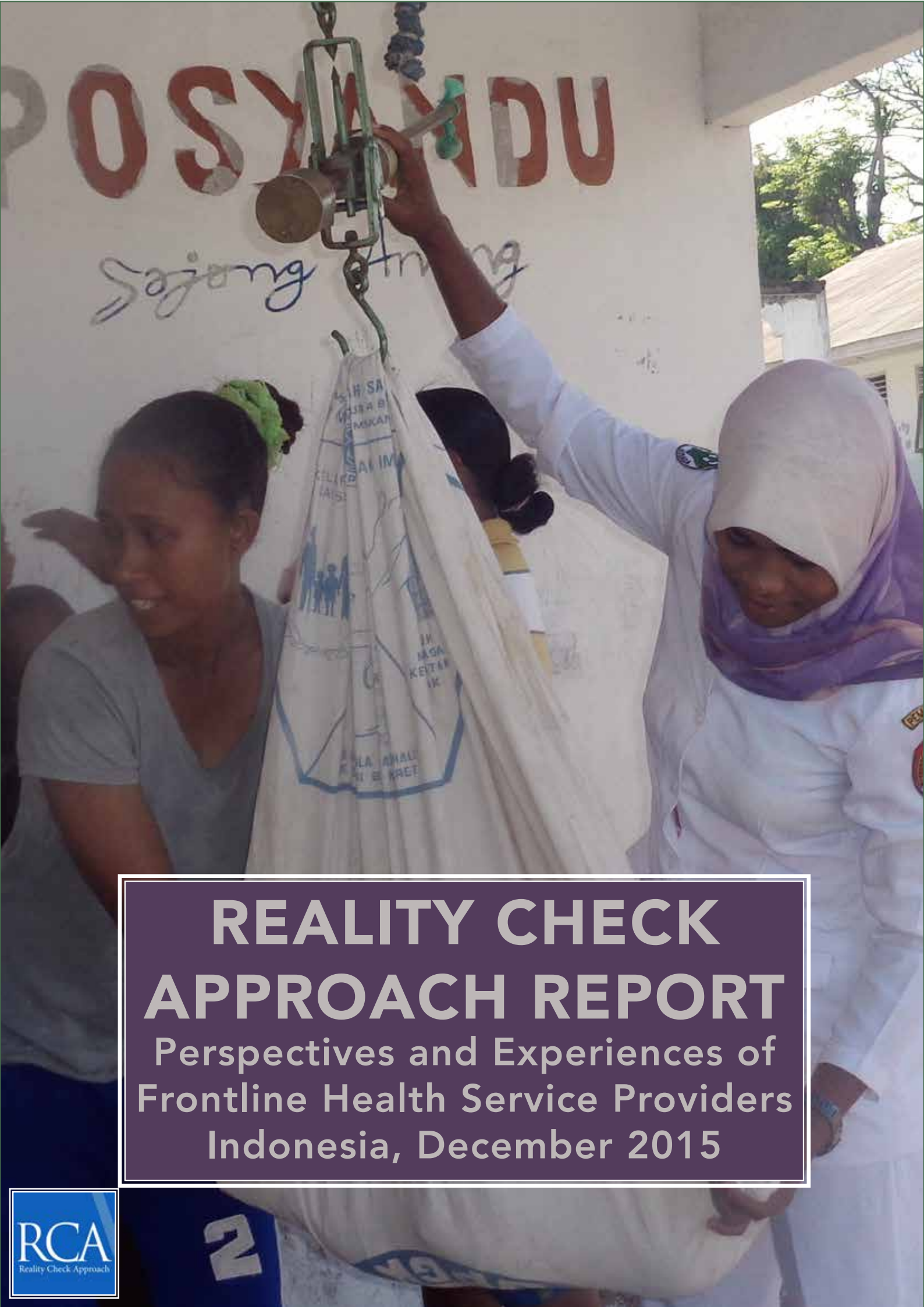

REALITY CHECK APPROACH REPORT

Perspectives and Experiences of Frontline Health Service Providers Indonesia, December 2015

RCA
Reality Check Approach

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All photos taken with the consent of those depicted.
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Glossary and acronyms

Arisan	rotating savings and credit system, operating on a 'lottery' type system
Bidan	midwife
BPJS	*Badan Penyelenggara Jaminan Sosial* (Social Security Agency)
BOK	*Bantuan Operasional Kesehatan* (Health Operational Fund)
Cadre	Community health worker
DFAT	Department of Foreign Affairs and Trade, Government of Australia
Dinas	official agency
Doula	woman who assists in the physical and emotional care of mothers in childbirth
Dukun	Informal healer (dukan patah tulang literally bone setter)
ER	Emergency Room
FHH	Focal households (neighbours of the host households)
GSC	*Gerakan Sehat Cerdas* (literally 'healthy and smart movement'), a Government initiative under PNPM Generasi to provide assistance in community health and education in villages
GOI	Government of Indonesia
honor	Uncertified (volunteer) e.g. honor nurse
HHH	Host households; where members of the study team stayed with families
IDR	Indonesian rupiah
IV	intravenous
Jamkesmas	*Jaminan Kesehatan Masyarakat* (Public Health Insurance)
JKN	*Jaminan Kesehatan Nasional* (National Health Insurance)
Kecamatan	Sub-district
KOMPAK	*Kolaborasi Masyarakat dan Pelayanan untuk Kesejahteraan*; a governance project supporting GoI and supported by DFAT
Mantri	male nurse or healer
PAUD	*Pendidikan Anak Usia Dini* (Early Childhood Education)
PKK	*Pembinaan Kesejahteraan Keluarga* (Women's village welfare group)
PKMD	*Pembangunan Kesehatan Masyarakat Desa* or Village Community Health Development
PNPM Generasi	*Program Nasional Pemberdayaan Masyarakat Generasi* (National government's assistance programme designed to achieve 3 MDGs objectives; maternal and child health, and universal education)
PNS	*Pegawai Negeri Sipil* (Civil Servant)
Polindes	*Pos pelayanan terpadu* (integrated health post)
PTT	*Pegawai Tidak Tetap* (essentially a short term contract worker)
Puskesmas	*Pusat kesehatan masyarakat* (people's health centre)
Pustu	*Puskesmas pembantu,* sub-health centre under the *Puskesmas*, usually supporting 2-3 villages
RCA	Reality Check Approach
RCA+	RCA+ Project funded by DFAT
Shaman	Spiritual healer
TBA	Traditional birth attendant
TB	Tuberculosis
UKBM	*Upaya Kesehatan Bersumberdaya Masyarakat* (people's empowerment programme on health and disaster management)

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Contents

RINGKASAN EKSEKUTIF

Studi *Reality Check Approach* (RCA) ini merupakan hasil diskusi dengan sekelompok pemangku kepentingan, termasuk Bank Dunia dan KOMPAK, yang diimplementasikan oleh tim RCA+ dengan dukungan finansial dari Pemerintah Australia melalui program *Knowledge Sector Initiative*.

Studi ini berfokus pada berbagai pengalaman dan perspektif para tenaga kesehatan yang sehari-hari bekerja di lini terdepan penyediaan layanan publik. Tujuan utama studi adalah untuk mengeksplorasi berbagai motivasi dan insentif bagi mereka dalam menyediakan layanan kesehatan, kepercayaan diri dan kapasitas dalam bekerja, tempat kerja dan sumber-sumber daya mereka, pandangan mereka terhadap para pasien dan pengalaman interaksi antara kedua belah pihak, berbagai layanan yang mereka sediakan, dukungan dari fungsi tim penunjang (*ancillary support*), serta konteks kerja mereka.

RCA merupakan sebuah pendekatan riset kualitatif yang telah mendapat pengakuan internasional. Pendekatan ini menyaratkan tim studi untuk tinggal di rumah masyarakat selama beberapa hari. Selama periode ini, tim studi melakukan percakapan dan interaksi informal dengan seluruh anggota keluarga, para tetangga dan anggota komunitas lainnya. Penekanan pelaksanaan studi adalah memastikan dilakukannya interaksi dan percakapan informal di ranah pribadi bersama anggota masyarakat. Tim studi juga memastikan bahwa interaksi yang dilakukan sebisa mungkin tidak menggganggu jalannya aktivitas keseharian masyarakat. 'Berbincang sambil duduk-duduk' tanpa struktur formal dan tanpa membuat catatan memberikan peluang terbaik untuk membangun rasa percaya dan keterbukaan. Selain itu, cara ini juga memungkinkan anggota tim studi untuk melaksanakan triangulasi melalui percakapan yang dilakukan dengan berbagai sumber yang kemudian diperkaya dengan observasi dan pengalaman langsung di lokasi studi.

Studi dilakukan di tiga provinsi: Kalimantan Tengah, Maluku, dan Sulawesi Utara. Kabupaten tempat pelaksanaan studi merupakan juga lokasi studi RCA Higiene dan Nutrisi yang dilakukan secara paralel. Namun desa tempat tim studi tinggal tidaklah sama dengan desa yang dikunjungi oleh tim studi RCA Higiene dan Nutrisi. Pemilihan lokasi ini dilakukan untuk memungkinkan penelaahan dan triangulasi lebih lanjut mengenai dinamika antara masyarakat dengan para penyedia layanan kesehatan di lini terdepan. Kabupaten diseleksi secara *purposeful* (tidak acak) berdasarkan indikator-indikator kinerja kesehatan yang secara relatif lebih buruk dibandingkan dengan kabupaten lainnya dari data Riskesdas 2013. Kecamatan untuk studi ini dipilih agar sesuai dengan studi paralel mengenai higiene dan nutrisi, namun tersebar di arah yang berbeda. Lokasi-lokasi studi paralel diseleksi berdasarkan beberapa faktor tambahan, seperti kondisi sanitasi dan akses air bersih.

Seluruh keluarga yang terlibat dalam studi dipilih oleh masing-masing anggota tim studi melalui diskusi informal dengan masyarakat yang ditemui. Studi ini melibatkan 19 keluarga yang menjadi tuan rumah bagi masing-masing anggota tim. Studi ini juga mencakup perbincangan terperinci dengan sekitar lima puluh penyedia layanan kesehatan lainnya termasuk pula percakapan dengan anggota masyarakat lain di tempat mereka tinggal. Selama empat malam, tim studi melakukan imersi intensif dengan para perawat, dokter, dokter gigi, bidan, dukun beranak dan kader kesehatan dengan menemani para penyedia layanan ini dalam melakukan kegiatan kerja. Tim studi juga mengunjungi tempat kerja para penyedia layanan dan berinteraksi dengan kolega-kolega mereka. Para peneliti juga berinteraksi dengan masyarakat biasa serta para pasien dari komunitas setempat untuk memahami perspektif mereka mengenai penyediaan layanan kesehatan.

Motivasi kerja di bidang kesehatan memiliki tiga kategori utama: cita-cita bekerja sebagai pegawai negeri sipil (PNS) yang seringkali tidak mengindahkan disiplin ilmu yang dimiliki, dukungan atau harapan keluarga, serta 'panggilan jiwa' yang seringkali berpangkal pada ajaran agama maupun tanggung jawab sosial. Status PNS berarti 'pekerjaan untuk seumur hidup', status sosial dan berbagai jaminan/keuntungan. Para peneliti bertemu dengan beberapa pegawai honor (yang seringkali berarti mereka bekerja dengan sukarela) yang cita-cita menjadi PNS baik melalui ujian negara maupun melalui diakuinya lama masa kerja mereka sebagai honorer. Keterlibatan dalam bidang layanan kesehatan nampaknya seringkali merupakan 'kebiasaan' dalam keluarga, di mana beberapa anggota keluarga memilih berkarir di bidang ini. Penempatan yang paling dicari bagi para PNS adalah yang dekat dengan kota di mana berbagai fasilitas perkotaan dapat dinikmati. Namun puskesmas tempat mereka bekerja seringkali tidak terlalu sibuk karena pasien lebih memilih pergi ke kota di mana terdapat banyak penyedia layanan kesehatan lainnya. Bekerja di desa sendiri memberikan kerugian bagi seorang pelayan kesehatan, karena para saudara dan teman dalam komunitas sering mengharapkan berbagai bantuan. Selain itu peluang untuk praktik sendiri di desa tempat tinggal terbatas atau bahkan sama sekali tidak tersedia. Namun, pegawai honorer mendapat keuntungan bila tinggal di desa asal mereka karena mereka dapat menggunakan hubungan keluarga untuk mendapatkan pekerjaan. Mereka juga mendapatkan bantuan dalam mengurus keluarga ketika mereka sedang bekerja. Beberapa tenaga honorer menopang kerja sukarela mereka dengan membuka praktik sendiri yang tidak jarang dimaklumi oleh kolega kesehatan lainnya sebagai cara untuk mendapatkan tambahan penghasilan. Motivasi bagi para dokter PTT untuk bekerja di daerah terpencil di antaranya adalah untuk mendapatkan insentif finansial, mendapatkan pengalaman untuk memperbaiki resume kerja, serta mendapatkan tantangan bekerja di lingkungan yang berbeda-beda. Para dokter dan perawat umumnya merasa sulit untuk membuka praktik sendiri di daerah pedesaan karena '*orang-orang disini jarang yang sakit*' dan '*[mereka] tidak punya banyak uang [tunai]*'. Namun, para perawat dapat membuka praktik sendiri yang cukup menguntungkan ketika ditempatkan di lokasi dekat perkotaan (*peri-urban*) maupun di lokasi dekat pedesaan. Para kader sebagian besar termotivasi oleh rasa ingin melayani masyarakat, namun juga mengakui pentingnya insentif finansial yang diterima sebagai kader.

Para penyedia layanan kesehatan di lini terdepan menceritakan sulitnya mendapatkan penempatan sesuai keinginan mereka, mengingat rekruitmen dan penempatan merupakan hasil keputusan pemerintah setempat dan bukan kepala puskesmas. Kebutuhan-kebutuhan yang ditentukan di tingkat daerah tidak selalu dilihat sebagai

keputusan yang paling rasional, karena pada kenyataannya beberapa fasilitas kesehatan mengalami kelebihan tenaga kerja sedangkan beberapa fasilitas kesehatan lainnya amat kekurangan tenaga kerja. Pindah lokasi penempatan, menurut mereka, membutuhkan '*koneksi yang tepat*' atau keberuntungan.

Banyak staf kesehatan yang berinteraksi dengan para peneliti memiliki keseharian kerja yang cukup ringan, terlihat dari sedikitnya waktu kerja yang harus mereka lalui serta tidak adanya puskesmas yang amat sibuk yang para peneliti kunjungi sepanjang periode studi. Namun, ada beberapa yang mengakui beratnya upaya menjaga keseimbangan antara tanggung jawab dalam pekerjaan dengan domestik, dan hal ini biasanya dialami oleh mereka yang bertanggung jawab menangani kondisi gawat darurat, persalinan atau mengelola fasilitas kesehatan seorang diri. Mereka yang tinggal berjauhan dari keluarga menghadapi tantangan tersendiri dan mereka yang tidak mendapatkan bantuan domestik dari keluarga besar menceritakan tantangan mereka dalam hal mengasuh anak, yang tidak jarang berujung pada keharusan mereka membawa anak-anak mereka ke tempat kerja.

Penyedia layanan kesehatan, baik formal maupun informal, pada umumnya merasa mereka tidak mendapatkan pelatihan yang cukup selama masa kerja dan tidak terpapar kepada ide-ide maupun program-program baru dan terkini. Kurangnya peluang pelatihan ini nampaknya cukup akut di lokasi pedesaan. Beberapa melakukan pekerjaan di mana mereka tidak mendapat pelatihan sama sekali sebelumnya, terutama para staf yang belatarbelakang pendidikan kesehatan yang pada saat ini menduduki jabatan administratif. Selain itu, mereka yang menangani persediaan obat-obatan serta mereka yang bekerja di fasilitas yang sama sekali tidak memiliki dokter juga mengalami hal serupa. Peluang mengikuti pelatihan tidaklah terjadwal/kontinu serta dikeluhkan hanya didatangi oleh staf senior saja. Para dokter di beberapa lokasi merasa bahwa mutu pelatihan di akademi keperawatan tidak mencukupi dan para perawat membutuhkan lebih banyak arahan dari para dokter lebih banyak dari perkiraan para dokter sendiri. Beberapa staf tidak mengaplikasikan pelatihan yang telah mereka terima, sebagai contoh seorang dokter gigi yang mendapatkan penempatan di lokasi tanpa akses listrik menceritakan pada kami bahwa jumlah pasien yang harus ia tangani dapat dihitung dengan jari selama dua tahun masa kerjanya di sana. Dan ia khawatir akan lupa pada keahlian dan pelatihan kedokterangigiannya. Dua konsekuensi dari kesenjangan dalam pelatihan ini adalah penyediaan tindakan/informasi yang melampaui kompetensi para staf sendiri atau kecenderungan menghindari resiko (yang membawa tendensi untuk melakukan rujukan ke fasilitas kesehatan yang lebih tinggi).

Para penyedia layanan kesehatan di lini terdepan juga menceritakan sejumlah rasa frustrasi mereka terhadap kondisi fisik tempat kerja terutama mengenai lokasi dan kenyamanan akses, namun jarang mengakui bahwa banyak fasilitas kesehatan memiliki ruangan yang tidak terpakai. Akses air dan listrik cukup beragam kondisinya baik di tingkat puskesmas maupun pustu. Air dapat berasal dari sumur, ledeng ataupun langsung dari sungai. Tim peneliti mengunjungi puskesmas yang tidak memiliki jaringan listrik, namun di tempat yang lain ada pula puskemas yang memiliki generator sendiri. Banyak puskesmas tidak memiliki koneksi dengan jaringan listrik selama 24 jam sehari. Tiga puskesmas dan satu pustu tidak mendapatkan sinyal telepon genggam. Pengadaan peralatan untuk fasilitas kesehatan juga dilihat sebagai keputusan yang datang 'dari atas' dengan sedikit peluang untuk mempengaruhi keputusan tersebut. Hal ini seringkali berujung pada ketidaksesuaian antara peralatan dengan sumber daya lainnya, misalnya ada spesialis kesehatan yang tidak memiliki instrumen

yang khusus dibutuhkan untuk pekerjaannya dan terdapat pula beberapa peralatan baru dan canggih yang tidak pernah dipakai karena tidak ada seorang pun yang memiliki keahlian dalam menggunakannya. Beberapa kepala puskesmas berbagi rasa frustrasi mereka mengenai ketidakberdayaan mereka dalam mempengaruhi proses penyediaan peralatan di puskesmas masing-masing.

Seluruh puskesmas yang kami kunjungi mengalami kekurangan persediaan obat-obatan yang membuat para staf tidak memiliki banyak pilihan lain selain, misalnya, hanya memberikan vitamin atau menulis resep untuk pembelian obat di luar. Hal ini merupakan salah satu alasan utama yang diakui masyarakat mengenai mengapa mereka tidak datang untuk berobat ke puskesmas. Beberapa dokter, dokter gigi, perawat dan bidan menceritakan bagaimana mereka menyiasati kekurangan ini dengan membeli obat sendiri dan kemudian membebani biaya pembelian tersebut kepada para pasien. Para staf juga mengekspresikan rasa frustasi mereka terhadap kesulitan yang harus mereka hadapi dalam meminta/memesan obat-obatan serta bahan dan alat habis pakai (BAHP) lainnya berdasarkan kebutuhan yang ada ataupun secara cukup terjadwal. Belum lagi mengenai bagaimana terbatasnya jenis obat-obatan yang masuk di dalam daftar yang dapat dipesan. Bahkan ketika permintaan/pemesanan telah dilakukan, penyediaan seringkali datang terlambat.

Berdasarkan observasi kami, banyak puskesmas yang kelebihan tenaga kesehatan namun amat sedikit staf yang mengakui hal ini ketika bercerita pada kami. Hanya mereka-mereka yang dalam kesehariannya berjuang di fasilitas-fasilitas sub-puskesmas yang kekurangan tenaga kesehatan sajalah yang menyuarakan keadaan ini. Satu contoh ekstrem adalah sebuah puskesmas yang sedianya melayani penduduk sejumlah 500 orang namun memiliki jumlah keseluruhan staf sebanyak 30 orang. Sehingga sang Kapus (kepala puskemas) membuat permohonan ke kantor dinas kesehatan setempat untuk tidak lagi menempatkan staf baru ke puskemasnya. Kami juga melihat bagaimana beberapa puskesmas memiliki banyak staf dengan waktu luang yang panjang. Para staf ini menghabiskan waktu luang mereka dengan bercakap-cakap, bermain *games* dan menonton TV. Bahkan puskesmas tersibuk yang ditemukan dalam studi ini menangani kurang dari 20 orang pasien per harinya. Tingginya jumlah staf berkorelasi dengan tingginya tingkat ketidakhadiran, sedangkan kekurangan tenaga kesehatan secara umum berujung pada para staf merasa kewalahan dan kebanjiran tugas. Kerja di dalam puskesmas seringkali didistribusikan melalui jadwal piket namun staf yang usianya lebih tua atau yang posisinya lebih senior jarang memedulikan pengaturan semacam ini dan mengharapkan staf junior terutama yang honorer untuk mengerjakannya, terutama untuk pekerjaan yang dilakukan di siang/sore hari.

Para pasien yang datang ke puskesmas-puskemas yang kami kunjungi cenderung berasal dari kelompok sosio-ekonomi rendah yang mengatakan bahwa mereka menggunakan layanan kesehatan tersebut untuk penyakit-penyakit ringan maupun untuk pemeriksaan/monitoring, misalnya tekanan darah atau kadar gula darah untuk diabetes. Masyarakat menyatakan bahwa mereka memiliki preferensi untuk membeli obat langsung dari warung, apotik dan pasar. Tidak hanya karena hal ini lebih mudah (dalam hal lokasi, jam buka, kehadiran penjual/staf took dan ketersediaan stok obat) namun juga karena – menurut klaim mereka – obat-obatan yang tersedia di tempat-tempat tersebut lebih baik mutunya daripada yang tersedia di puskemas. Beberapa staf medis formal menerima kehadiran pengobatan tradisional karena menurut mereka pengobatan tersebut membuat para pasien merasa lebih nyaman. Namun ada pula staf-staf medis formal lainnya yang

menolak pengobatan semacam ini mentah-mentah. Seringkali masyarakat tidak mengetahui jenis-jenis pelayanan yang disediakan oleh puskesmas dan karenanya mereka tidak mengetahui bahwa mereka dapat datang ke puskesmas untuk memanfaatkan layanan-layanan ini saat dibutuhkan. Namun, para penyedia layanan kesehatan tidak jarang memberikan argumen bahwa rendahnya jumlah pasien yang datang ke puskemas disebabkan karena masyarakat sekitar '*malas*' dan '*mengharapkan semua layanan bersifat gratis*'. Selain itu, para penyedia layanan ini tidak jarang mengakui rasa frustrasi mereka akan saran-saran mereka yang tidak didengar masyarakat dan dengan jujur pula mengakui bahwa dalam beberapa kasus mereka sudah menyerah untuk memberikan saran. Di lain pihak, para pasien berbagai kepada para peneliti mengenai pengalaman mereka meminta saran dan penjelasan yang seringkali tidak mereka terima. Masyarakat sekitar mengatakan pada para peneliti bahwa mereka menginginkan staf kesehatan yang dapat mereka percayai, dapat didatangi di luar jam kerja, tinggal lama di tengah-tengah masyarakat, ramah dan '*murah senyum*'. Kekhawatiran terhadap kemungkinan tingginya biaya pengobatan ataupun stigma yang diberikan petugas kesehatan mengurungkan niat beberapa calon pasien yang ingin mencari diagnosis.

Jumlah pasien rawat jalan, tanpa pengecualian, rendah di seluruh pustu dan puskemas. Fasilitas-fasilitas rawat inap, jika tersedia, sebagian besar digunakan untuk memberikan infus atau untuk persalinan, walaupun preferensi melakukan persalinan di rumah tetap ada. Hanya satu puskesmas yang menyatakan telah memiliki pengaturan kolaboratif dengan dukun beranak yang berjalan aktif. Beberapa dukun beranak menceritakan bahwa di masa lalu mereka mendapatkan pelatihan resmi dan bahkan mendapat pengakuan dan pujian dari para bidan formal atas kerja dan perawatan mereka untuk para ibu bersalin. Namun sekarang merasa bahwa mereka dipinggirkan dan bahkan dalam beberapa kasus dianiaya.

Program-program ekstensi yang bersifat pencegahan cukup aktif diselenggarakan ketika ada pendanaan khusus untuk itu. Para tenaga kesehatan mengakui rasa senang mereka menjalankan program-program tersebut karena seringkali mendapatkan insentif finansial dalam melakukannya dan mereka dapat pula menyelesaikan satu hari kerja lebih awal, sesaat setelah program usai dilaksanakan. Pelaporan atas program-program ini memberikan rasa pencapaian bagi mereka, terutama ketika jumlah pasien yang datang ke puskesmas rendah. Nampaknya program-program semacam ini lebih banyak menjadi bagian dari aktivitas puskesmas di lokasi *peri-urban*.

Para tenaga kesehatan formal mengeluhkan bahwa mereka berhadapan dengan peraturan yang tidak jelas, terutama mengenai obat-obatan, penerapan biaya, tunjangan pegawai, berbagai hak terutama akses terhadap pelatihan lanjutan serta posisi resmi mengenai praktik pribadi. Mereka seringkali merasa bingung mengenai fungsi dari berbagai kartu sehat pasien yang berbeda jenis, serta tidak merasa yakin mengenai saran apa yang perlu mereka berikan kepada pasien, terutama mengenai apa yang termasuk maupun tidak termasuk dalam asuransi kesehatan para pasien. Banyaknya skema berbeda menimbulkan 'sakit kepala' administratif dan hambatan dalam administrasi mereka sering berujung pada '*para pasien sebenarnya tidak pernah mendapatkan pelayanan yang benar-benar gratis*'. Skema-skema tersebut menciptakan beban kerja yang besar secara administratif. Kapus juga mengelukan banyaknya rapat yang perlu dihadiri. Terjadi pula kekurangjelasan dan kekurangkonsistensian dalam mempekerjakan serta membayar para tenaga pendukung (*ancillary*) seperti supir dan petugas kebersihan.

Laporan ini diakhiri dengan memberikan sejumlah implikasi studi yang bersumber dari perspektif para penyedia layanan kesehatan sendiri maupun dari hasil observasi para peneliti yang terlibat dalam studi.

Para staf kesehatan di lini terdepan mencatat adanya:

- Kebutuhan untuk pengambilan keputusan di tingkat yang lebih rendah untuk pengadaan obat-obatan dan peralatan berdasarkan kebutuhan;
- 'Kejar target' dalam hal kunjungan pasien, kurangnya sumber daya dan pelatihan menyebabkan preferensi yang semakin meningkat untuk melakukan rujukan dari fasilitas di tingkat yang lebih rendah seperti puskesmas ke fasilitas di tingkat kapubaten;
- Kebutuhan untuk memperjelas peraturan-peraturan di tingkat operasional serta status hak-hak yang dimiliki;
- Kebutuhan akan integrasi fungsi tenaga pendukung (*ancillary*) yang lebih baik;
- Kebutuhan akan pembagian tugas yang lebih rasional.

Para peneliti mencatat bahwa:

- Adanya kesenjangan yang kritis dalam mutu dan jumlah sumber daya manusia yang ada dengan kebutuhan yang sebenarnya;
- Adanya insentif yang bekerja secara kontradiktif dengan menghargai program dan aktivitas penyuluhan secara lebih tinggi dari peningkatan kualitas kesehatan;
- Adanya kebutuhan penyediaan layanan yang lebih bersifat *client-centred* (melihat pasien sebagai fokus pelayanan);
- Utilisasi kader desa masih rendah, sedangkan mereka berpotensi besar membantu program-program intensif berbasis rumah serta program dukungan lainnya terutama yang bertujuan mengubah perilaku;
- Adanya kebutuhan untuk mengadopsi di tingkat lokal rekomendasi Menteri Kesehatan mengenai kerja sama antara bidan dan dukun beranak;
- Adanya kebutuhan untuk menangani ketidaksesuaian yang genting terjadi antara sumber daya fisik dengan kebutuhan di lokasi fasilitas kesehatan masing-masing.

EXECUTIVE SUMMARY

The Reality Check Approach (RCA) Study was commissioned by a group of stakeholders including the World Bank and KOMPAK and was implemented by the RCA+ project with financial support from the Government of Australia through the Knowledge Sector Initiative.

The study focussed on the experiences and perspectives of people who are working day to day at the frontline of health service provision. It specifically sought to gather insights on their motivations and incentives to provide health services, their confidence and capacity to work, their work places and resources, their views and experience of patients, the services provided, the ancillary support services and the context of their work.

The RCA is an internationally recognized qualitative research approach that requires the study team to live with people in their own homes for a period of time and to use this opportunity to have many informal conversations and interactions with all the members of the household, their neighbours and with the others in the community with whom they interact. The emphasis throughout is on informality in people's own space and with the least disruption to their everyday lives. This 'hanging out' without note-taking and formal structure provides the best possible conditions for trust building and openness. Furthermore, it enables the study team members to triangulate the conversations from multiple sources and enrich these with their own observations and experiences in situ.

The study was undertaken in the same 3 provinces (Central Kalimantan, Maluku, and North Sulawesi) and same districts, but different villages, as those chosen for the parallel Hygiene and Nutrition RCA study to enable further examination and triangulation of the dynamics between the community and frontline service providers. The districts were purposefully selected on the basis of relatively poor health performance indicators using data from Riskesdas, 2013, and the sub-districts for this study were selected in conjunction with the parallel RCA study on hygiene and nutrition but radiating form the sub-district in the opposite direction. The parallel RCA study locations were also selected using additional factors such as sanitation status and access to clean water.

All study households were selected by individual team members through informal discussions with people in the community. The study included living with a total of 19 host families, and having detailed conversations with a further of fifty frontline providers in the communities in which they live. It involved a four night four day intensive immersion with nurses, doctors, dentists, midwives, traditional birth attendants and cadre (community health workers), accompanying them in some of their work activities, spending time at their work places and interacting with their colleagues. The

researchers also interacted with over 530 ordinary members of the community and patients to understand their perspectives on health provision.

Motivations to work in health fall into three main categories; aspiration for civil servant employment (often irrespective of particular discipline), family encouragement or expectation and 'calling' often fuelled by religious beliefs or social responsibility. Civil service status means 'a job for life', status and benefits. Researchers met several honor (essentially 'voluntary') staff who aspire to civil servant status either through taking the exams or through recognition of long service. Involvement in healthcare often seems to run in families with several members choosing this career. The most sought after postings for civil servants are ones near towns where the facilities of town can be enjoyed but where *puskesmas* are often less busy, as patients often prefer to choose from the many providers in town. Working in one's own rural home village has downsides as relatives and friends in the community often expect favours and private practice opportunities are limited or non-existent. However, honor staff benefit from living in their home village utilising family ties in securing work as well as help with looking after their families while they are working. Some honor support their voluntary work with private practice, which is often condoned by other health service providers as a means to enhance their income. The motivations for short term contract doctors (PTT) include the cash incentives for remote postings, gathering experience to enhance resumés and challenges of working in different environments. Doctors and nurses in general felt that it was difficult for them to open their own private practices in rural areas 'because people are less often ill' and 'have less cash'. Midwives, on the other hand, can have profitable private practices whether posted in peri-urban or rural locations. Cadres are largely motivated by service to the community but also noted the monetary incentives provided are important.

Health service providers shared that it was usually quite difficult to get the posting they wanted. They share that recruitment and placement is decided by local government not by the head of the *puskesmas*. Needs that are regionally determined are not always seen as the most rational with some health facilities over-staffed and others chronically understaffed. Transfers, people shared that require the 'right networks' or serendipity. Political affiliations can work in people's favour or disfavour.

Many staff we interacted with have a relatively easy work life with few demands on their time and none of the *puskesmas* visited were particularly busy. But there are some health service providers who find maintaining a work/life balance very challenging and these are often those who deal with emergencies, attend births or manage facilities on their own. Those who live long distances from their families face particular challenges and those without family support shared their problems with childcare, sometimes resulting in them having to bring their children to the workplace.

Generally both formal and informal health service providers felt they did not have enough in-service training and were not kept up to date with new ideas and programmes. The lack of training opportunities seems particularly acute in rural locations. Some were doing jobs for which they have no training, especially those health trained staff who were now in administrative roles, but also those running dispensaries and those working in facilities without doctors. Not only is the training that is available intermittent but people complained it is often only senior people who attend. Doctors in some locations shared that they felt the quality of nurse academy training is inadequate and nurses need more guidance than they had expected to have to give. Some staff are not using the training they have received, for example a dentist has been posted where there is no electricity and told us she has seen only a handful of patients in her entire two year

posting and fears she will forget her training. Two consequences of this training gap are the provision of treatment/information beyond competences or risk aversion (and a tendency to refer to higher levels of health provision).

Health service providers shared a number of frustrations with the physical workplace especially around their location and convenience of access but rarely mentioned that many facilities have unused rooms. Water and electricity access in *puskesmas* or *pustu* varies. Water may be from wells, piped or direct from the river and one *puskesmas* had not electricity connection and another had its own generator but others did not necessarily have power for 24 hours. Three *puskesmas* and one *pustu* did not have a phone signal. Equipping of health facilities is also seen as decided from above with little opportunities to influence. This often results in a mis-match of equipment with other resources, for example health specialists without the needed specialist equipment and brand new unused equipment without the expertise to use. Several *puskesmas* heads shared their frustration at not being able to influence equipment procurement.

All *puskesmas* visited suffer from periodic shortages of medicines leading to health staff providing only vitamins or writing prescriptions for outside purchase and is one of the leading reasons people in the communities shared why they do not use the *puskesmas*. Some doctors, dentists, nurses and midwives shared that they make up the shortfall by purchasing medicines themselves and passing the cost on to the patient. Again the staff expressed frustration that it was not easy to request medicines and other consumables based on their needs or frequently enough and that it has to be from a limited range of listed medicines. Even when requests are addressed, supplies are often delayed.

Many *puskesmas* were observed to be over-staffed but hardly any staff shared this with us except those who were struggling in under-staffed sub-*puskesmas* facilities. One extreme example is where the *puskesmas* serves a population of 500 but has thirty staff and the head has begged the district office not to send any more staff. Our observations from several *puskesmas* found many staff idle, spending time chatting, playing games and watching TV. Even the busiest *puskesmas* in this study sees less than 20 patients per day. High staff levels also correlated with high absenteeism while, on the whole, understaffing results in the incumbents often feeling overwhelmed and overstretched. *Puskesmas* work is often distributed through rotas but older or more senior staff often renege on these arrangements and expect junior staff especially honor staff to take on the work especially work that entails working in the afternoons.

Patients of the *puskesmas* we visited tend to be from lower socio-economic groups who say they use the services for non-serious ailments and for monitoring, for example of blood pressure or for diabetes. People express a preference for buying medicines directly from kiosks, pharmacies and markets , not only because this is more convenient (location, opening hours, presence of staff, adequacy of medicines) but they claim the medicines are better quality than those available from the *puskesmas*. Some formal medical staff actively embrace traditional healing as they say it makes people more comfortable but others reject such healers. Often people are quite unaware of the range of services being offered by the *puskesmas*. But health providers often defend the low numbers of patients attending the *puskesmas* on the grounds that people are ‘lazy’ and ‘expect all the services are free’. Furthermore, they frequently often shared their frustration that their advice is not listened to and openly shared in some cases that they have simply given up trying to give advice. On the other hand, patients tell us that they ask for advice and explanations and often

do not get them. People in the community told us they preferred health staff whom they could trust, were available out of hours, lived for a long time in the community, were approachable and 'smiley'. Fear of potentially escalating costs or stigma deter some from seeking diagnoses.

Without exception, numbers of out-patients were low in all *pustu* and *puskesmas*. In-patient facilities, when available, were mostly used to administer IV re-hydration or for delivery of babies although the preference for home births persists. Some traditional birth attendants shared that they had received official training in the past, had even been praised by formal midwives for their work and care of mothers but were now finding that they were being marginalised and in some cases persecuted. Extension programmes (preventative) were active wherever there were special funds for these and health service providers shared that they liked these because they often got monetary incentives and could complete a day's work early. The reporting on these also provides them with a sense of achievement especially where patient numbers are low. There seems to be more of these kinds of programmes attached to peri urban *puskesmas*.

Formal health service providers complained that they do not have clear regulations especially in regards to medicines, charges, allowances, various entitlements including for further training and the official position on private practice. They are often quite confused about the functioning of different patient health cards and unsure of the advice they should give to patients about what is and what is not included in their health insurance. The many different schemes give rise to administrative headaches and the bottlenecks in their administration often leads to 'patients never actually getting anything for free'. The schemes generate a large amount of paperwork. *Puskesmas* heads also complained about too many meetings. There is also a lack of clarity and consistency in the employment and payment of ancillary staff.

The report concludes with a number of study implications from the perspectives of the frontline health staff themselves and from what researchers have observed;

Frontline health staff noted

- A need for more local decision making on medicinal and equipment needs;
- Patient targets, lack of resources and training result in a growing preference for referral from lower level facilities such as *puskesmas* to district level facilities;
- A need for more clarity on operating regulations and entitlements;
- Better integration of ancillary support;
- More rational sharing of tasks.

Researchers noted

- Critical mismatch of human resources to needs;
- Perverse incentives which value outreach programmes and activities over improved health outcomes;
- A need for more client-centred service delivery;
- Under-utilisation of the village cadres who potentially can add much value to intensive home based advice and support programmes, especially around behaviour change;
- The need for local adoption of the recommendations of the Ministry of Health regarding co-operation between midwives and traditional birth attendants;
- A need to address the critical mismatch between physical resources and needs.

1 INTRODUCTION

This Reality Check Approach (RCA) Study has been commissioned by a group of stakeholders including the World Bank and KOMPAK and implemented by the RCA+ project with financial support from the Government of Australia through the Knowledge Sector Initiative.

The Government of Indonesia Mid Term Plan (2015-19) prioritises improvement in the quality of primary public services and expansion of access to more people. This study seeks to focus on the health sector and to explore the experiences and perspectives of people who are working day-to-day at the frontline of health provision rather than the more conventional lens of operational compliance. There is a gap in knowledge of service provision from the perspectives of service providers themselves, a World Bank study (2014)[1] on production, distribution and performance of physicians, nurses and midwives in Indonesia highlighted the need to *'better understand factors affecting the willingness and ability [of the three professions] to move to underserved areas'*. Another study on Indonesian Village Health Institutions (McLaughlin, 2014)[2] explores the relationships between formal and informal health providers but the perspectives of the staff themselves was not the focus of this study.

The Government of Indonesia is purposely shifting its focus to preventive healthcare away from the current focus on curative health.[3] Their plans include restoring the mandate for the *Puskesmas* as the focus of public health efforts in addition to personal health.[4] In addition, a 2014 Ministerial Regulation on *Puskesmas* requires a minimum level of health staffing in at sub-district *Puskesmas*[5] comprising nine different positions. In addition, community based health programmes should be operating including Village Community Health Development which are supposed to be customised to the needs of the community[6] may include any of the following;

- family nutrition programme (UPGK, *Upaya Pelayanan Gizi Keluarga*);
- integrated health service programme/ post (*Prosyandu/Posyandu Program/ Pos Pelayanan Terpadu*);
- village medicine post (POD- *Pos Obat Desa*);

[1]World Bank Discussion Paper, The Production, Distribution and Performance of Physicians, Nurses and Midwives in Indonesia: an Update, World Bank Group, Health, Nutrition & Population, p.39, September 2014.
[2]McLaughlin, K., Indonesian Village Health Institutions: a Diagnostic, PNPM Generasi Publication, 2014 <http://pnpm-support.org/publication/indonesian-village-health-institutions-diagnostic> (accessed on 30 April 2015)
[3]Restoring the function of Puskesmas, Australia-Indonesia Partnership for Health Systems Strengthening <http://aiphss.org/restoring-the-function-of-puskesmas/>
[4]Health Minister Decree (KEPMENKES) #128/2004 states that a Puskesmas has three main functions: 1, implementing Public Health Efforts at primary level in its working area; 2, as a centre for providing health data and information and to prompt health-oriented development in its working area; 3, implementing Individual Health Efforts (UKP) at primary level of good quality and with user-oriented
[5]services Health Minister's Regulation #75/2014, article 16 clause 3.
[6]Manajemen Puskesmas dan Posyandu <https://somel us.wordpr ess.com/2010/02/14/manaj emen puskesmas dan posyandu/> (accessed on 16 June 2015)

- community-funded health efforts (DUKM – *Dana Upaya Kesehatan Masyarakat*);
- village-based midwives with village delivery polyclinic (*bidan desa dengan polindes/pondok bersalin desa*)
- development of traditional medicine (*pembinaan pengobatan tradisional* e.g. toga – *tanaman obat keluarga*).

This wide range of services and diversity of service points present challenges to the co-ordination and effective delivery of services. Furthermore, there are many other health service providers including private doctors, public service doctors/nurses who also provide private services, traditional birth attendants, health volunteers, spiritual healers and herbalists. Little is known about how these work together to provide health services at local level.

The study was therefore designed to gather insights into how frontline service providers operate in relation to each other. Specifically, it examined frontline service providers own perspectives on:

- Their motivations and incentives to work in health
- The administrative support for local service provision
- Distribution of responsibilities at different points of service (*puskesmas, pustu, polindes*), workload and distributions of work
- Their capacity and capability to provide services
- Problem solving
- Day to day practice and standards, services they provide
- Working environment
- Government health policy and the local context for their operation.

Structure of this report

This report begins with an overview of the Reality Check Approach (RCA) methodology, including adaptations made for this study as well as study limitations (section 2). The following section 3 presents the Findings and begins by providing an overview of both the study context and a description of the main study families. Specifically, sections 3.1-3.3 set the scene by describing the village context and introduce the frontline service providers who participated in the study. Section 3.4. discusses their motivations and incentives to work in health. Section 3.5. looks at their confidence and capacity to work. Their workplaces, resources including human resources and distribution of work is examined in section 3.6. The frontline staff view of patients is covered in section 3.7. with section 3.8. describing the services provided. 3.9. section looks at administrative and ancillary support and the final section examines their external environment. The report concludes with implications drawn from the perspectives and experience of informal and formal health service providers themselves as well as from researchers observations (section 4).

2 Methodology

The Reality Check Approach (RCA) is a qualitative approach in which trained researchers gather in-depth qualitative data through a multi-night immersion, open conversations and participant observation. This informal approach provides a context that enables the researcher to gain insights into the reality facing the people with whom they stay, their neighbours and the wider community. The main idea is to have sustained, detailed conversations and intense interactions with a small number of people in their own homes. Sharing in their lives provides opportunities to better understand and contextualise people's opinions, experiences and perspectives. The RCA is generally intended to track changes in how people live and experience their lives and involves repeating the RCA with the same people at approximately the same time each year over a period of several years.

The Reality Check Approach extends the tradition of listening studies (see Salmen 1998 and Anderson, Brown and Jean 2012)[7] and beneficiary assessments (see SDC 2013)[8] by combining elements of these approaches with researchers actually living with people whose views are being sought, usually those who are directly experiencing the issue under study.

RCA is sometimes likened to a 'light touch' participant observation. Participant observation involves entering the lives of the subjects of research and both participating in and observing their normal everyday activities and interactions. It usually entails extensive and detailed research into behaviour with a view to understanding peoples' perceptions and their actions over long periods of time. The Reality Check Approach is similar in that it requires participation in everyday life within people's own environments but differs by being comparatively quick and placing more emphasis on informal, relaxed and insightful conversations than on observing behaviour and the complexities of relationships.

Important characteristics of the Reality Check Approach are:

- Living with rather than visiting (thereby meeting the family/people in their own environment, understanding family/home dynamics and how days and nights are spent);
- Having conversations rather than conducting interviews (there is no note taking thereby putting people at ease and on an equal footing with the outsider);
- Learning rather than finding out (suspending judgement, letting people take the lead in defining the agenda and what is important);
- Centering on the household and interacting with families/people rather than users, communities or groups;
- Being experiential in that researchers themselves take part in daily activities (collecting water, cooking, work, hanging out) and accompany people (to school, to market, to health clinic);
- Including all members of households/ living in units;
- Using private space rather than public space for disclosure (an emphasis on normal, ordinary lives);
- Accepting multiple realities rather than public consensus (gathering diversity of opinion, including "smaller voices")
- Interacting in ordinary daily life (accompanying people in their work and social interactions in their usual routines)
- Taking a cross-sectoral view, although each study has a special focus, the enquiry is situated within the context of everyday life rather than simply (and arguably artificially) looking at one aspect of people's lives;
- Understanding longitudinal change and how change happens over time.

Study participants and locations

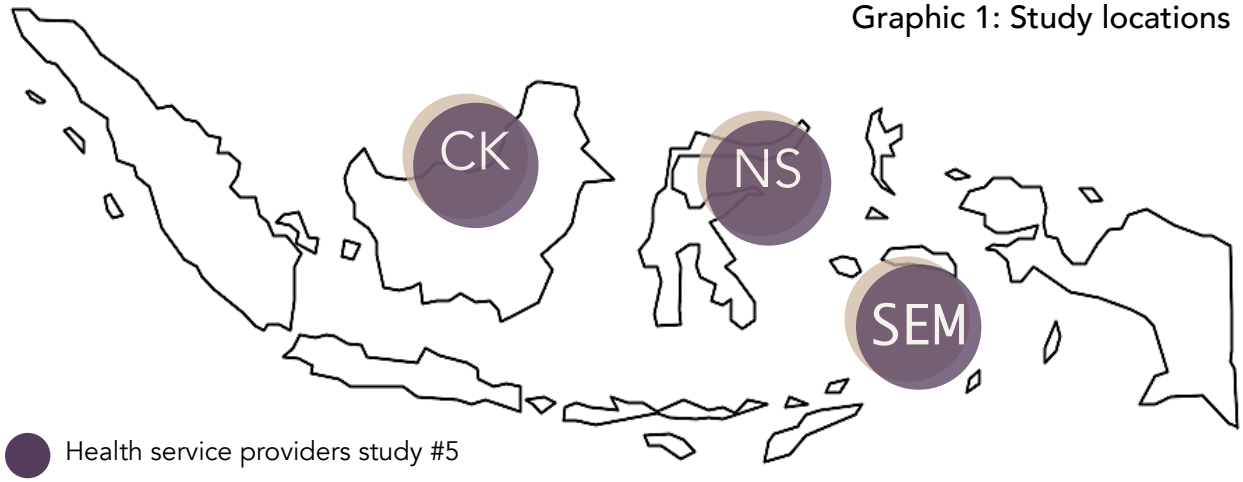
Locations

The study team selected three provinces for the study in collaboration with the reference group for the study. These were purposively selected as having relatively poor health performance indicators (Riskesdas (Riset Kesehatan Dasar/National Basic Health Research, 2013)[9] including the following;

- Use of health facilities for labour/delivery
- Low Birth Weight

[7]Salmen, Lawrence F. 1998. 'Toward a Listening Bank: Review of Best Practices and Efficacy of Beneficiary Assessments'. Social Development Papers 23. Washington: World Bank.
Anderson, Mary B., Dayna Brown, Isabella Jean. 2012. Time to Listen; Hearing People on the Receiving End of International Aid. Cambridge MA:CDA.
[8]Shutt, Cathy and Laurent Ruedin. 2013. SDC How-to-Note Beneficiary Assessment (BA). Berne: Swiss Agency for Development Cooperation.
[9]http://www.depkes.go.id/resources/download/general/Hasil%20Riskesdas%202013.pdf

Graphic 1: Study locations



Location	Sub location
Central Kalimantan	Peri urban & rural mountain
North Sulawesi	Peri urban & rural inland
South East Maluku	Peri urban & rural coastal

- Low weight (0-59 months) <2500 gr / height <48 cm
- Stunting
- Wasting
- Ratio of Weight/Height
- Low height 5-12 years of age
- Low weight 5-12 years of age
- Overweight & Obese 5-12 years of age
- Overweight & Obese 13-15 years of age
- Male adult obesity >18 years of age
- Female adult obesity >18 years of age

The selection also took into account districts having the least number of physicians at village level based on World Bank Discussion Paper (2014)[10], as shown in the figure below:

We also used remoteness and geography as further determinants in order to include a range of experience of health service provision. A further RCA study which focuses on people's perspectives of hygiene and nutrition followed this study and purposively included the same provinces and districts but different sub-districts in order to optimise the opportunity for complementarity.

The study team

The study team was composed of ten researchers, (see Annex 1). All had participated in a full Level 1 RCA training (see below). The three main sub teams were led by experienced Indonesian RCA practitioners. Technical advice was provided by an international long-time RCA researcher.

Study Participants

Host households

Table 1 was provided to researchers as base for selecting host households with frontline service providers (and to remind them who else they should interact with in the community). In each team it was agreed that two team members would live with formal service providers and one would live with an informal service provider.

None of the households were contacted in advance of the study in order to ensure that they did not make special arrangements for

[10]World Bank Discussion Paper, The Production, Distribution and Performance of Physicians, Nurses and Midwives in Indonesia: an Update, World Bank Group, Health, Nutrition & Population, p.17, September 2014.

Table 1. Types of frontline service providers to interact with

Formal Frontline Health Providers
Midwives, responsible for ante and post-natal checks, assist in labour and deliveries, may supervise a polindes in a community.
Nurses incl. mantri , responsible for personal health service provision in the puskesmas and in posyandu
Community/public health specialists, responsible for the public health service provision both in the puskesmas and (should be) in posyandu
Physicians incl. GP (in a few rare cases may involve specialists)
Health/UKBM cadres
(May also include) Dispensary available in the *puskesmas* or *pustu*

Informal Frontline Health Providers
Traditional birth attendants (TBAs), no longer officially allowed to assist labour and deliveries), but can function more or less like 'doulas' and cooperate with midwives in the referral system.
Traditional healers incl. shamans, dukun patah tulang (bone fracture healer)
Alternative medicine pvroviders – herbalists
Drug/medical stores, informal medicine sellerst

A total of 19 households were selected for the study as described in section 3.1.

the researchers. Researchers spent time in the communities getting to know the community (sometimes one night with another household) and being known before negotiating access to particular homes where they stayed for several days and nights.

Frontline service providers and their families were mostly very open to the approach and welcomed researchers into their homes and soon understood the purpose of the study and the need for the researchers not to be afforded guest status. Through easy conversations and fitting in with everyday life the researchers were able to engage all members of the family.

Each team member discreetly left a 'gift' for each family/living with unit on leaving, comprising food items to the value of around IDR 300,000 to compensate for any costs incurred in hosting the researcher. As researchers insist that no special arrangements are made for them, they help in domestic activities and do not disturb income-earning activities, the actual costs to 'hosts' are negligible. The timing of the gift was important so people did not feel they were expected to provide better food for the researchers or get the impression that they were being paid for their participation.

A further 50 frontline health provides were included, so the study covered 69 frontline health providers.

Table 2. The frontline health providers we interacted with

Very remote ↓ Not remote

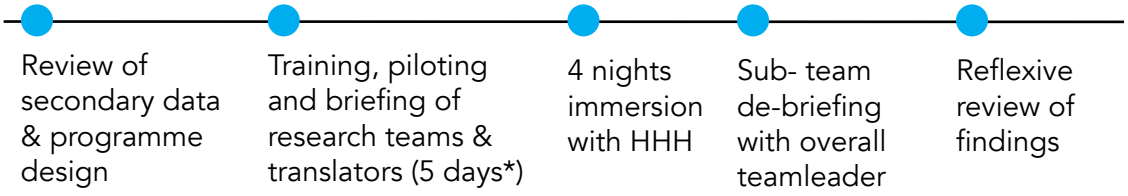
location		Nurse/ *Mantri*	Midwife	Cadre	Doctor	TBA	Dentist	Pharmacist, Environmentalist & Nutritionist	Shaman
Rural	SEM1	2	2	3	2	1	1	1	0
	CK1	2	0	0	1	2	0	0	0
	NS1	3	4	2	1	1	0	1	0
Peri urban	SEM2	5	1	0	1	1	1	1	0
	CK2	5	3	0	1	1	1	0	3
	NS2	0	3	2	3	0	0	0	0

Other health service providers

In addition to the host households, researchers had detailed conversations and interactions with other health service providers in each location as detailed on tabel 2 above.

Neighbours and other community members

In addition to the 19 host families and their work colleagues (50), researchers interacted with their neighbours and the wider community, including village leaders, religious leaders, teachers and medicine sellers using the same approach of informal conversations, (see annex 3 for the list of people met). Overall, this study was based on the views of at least 530 people with whom we interacted with during immersion.



**researchers had either already been fully trained previously and so took part only in the 1 day briefing or were new researchers who took part in the full five days*

Training, Immersion and Debriefing

All the researchers and translators have participated in a mandatory five day training on the core principles and techniques of RCA. This training concentrates on researcher behaviour and seeks to reduce researcher bias by getting researchers to recognise and work through their biases and build good practice of reflexivity vital to promote rigour in the execution of RCA studies. This training includes a two night immersion in villages where researchers and translators are able to try out their learning and new skills, followed by a day to reflect on this immersion experience and internalise lessons learned. All researchers and translators also undertake an additional one day briefing on the purpose of the RCA study and key technical background. During this period they collaboratively develop 'areas for conversations' (see annex 2) which are used as a prompt for purposeful conversations.

Insights from living with households and interacting within the community were gathered over a period of four days and four nights immersion.

Each team member kept their own field diaries but they never wrote these in front of the people they were conversing with. To illustrate context and findings, photos were taken, all with the consent of the people concerned. These narratives and visual records formed the basis of detailed one day debriefing sessions held with each of the six sub-teams as soon as possible after each round of the study was completed. These were led by the Study Team leader or Technical Advisor and provided an important opportunity to further triangulate findings. These de-briefings were captured in rich note form and comprise the core documentation for this study.

Following completion of all study rounds the sub team leaders met to review the findings. This provided a further opportunity to ensure that the information emerged naturally from the conversations which were had at location level and were not overlaid with researcher interpretation.

Study areas for conversation

RCA is not a theory based research method although it often generates people's theories of change and contributes well

to grounded theory approaches. It does not have a pre-determined set of research questions relying as it does on iterations from information gathered in situ and building on progressive series of conversations. However, as part of the briefing process for researchers areas for conversations were developed to act as a guide to ensuring that conversations are purposive. The outcome of the deliberations with the research team are provided in Annex 2 Areas for Conversations.

Ethical considerations

Like most ethnographic based research, there is no intervention involved in RCA studies. At best the study can been viewed as a way to empower the study participants in that they are able to express themselves freely in their own space. Researchers are not covert but become 'detached insiders'. As per American Anthropological Association Code of Ethics, RCA adopts an ethical obligation to people 'which (when necessary) supersedes the goal of seeking new knowledge'. Researchers 'do everything in their power to ensure that research does not harm the safety, dignity or privacy of the people with whom they conduct the research'. All researchers are briefed on ethical considerations and Child Protection Policies before every field visit (irrespective of whether they have previously gone through this). All researchers sign Code of Conduct and Child Protection Policy declarations as part of their contracts. All data (written and visual) is coded to protect the identity of individuals, their families and communities. As a result the exact locations and identities of households and others are not revealed in this report. Any names used in the report are fictional to protect the identity of individuals.

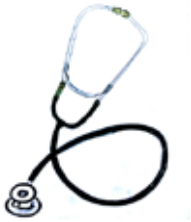
Study limitations

As with other research methods, this study has a number of limitations. This was the first RCA in Indonesia where researchers were required to stay in the homes of particular service providers rather than simply with ordinary people and this sometimes proved challenging. Not every researcher was able to negotiate this kind of access and had, instead to stay with families near to the frontline service provider. Particularly in peri-urban N Sulawesi most frontline health staff stayed in the district town and commuted to work and it was not possible to stay with them.

Researchers in C Kalimantan experienced some problems with the wide use of local languages which meant that while conversations held directly were in Bahasa Indonesia, side talk was often missed because local languages were used.

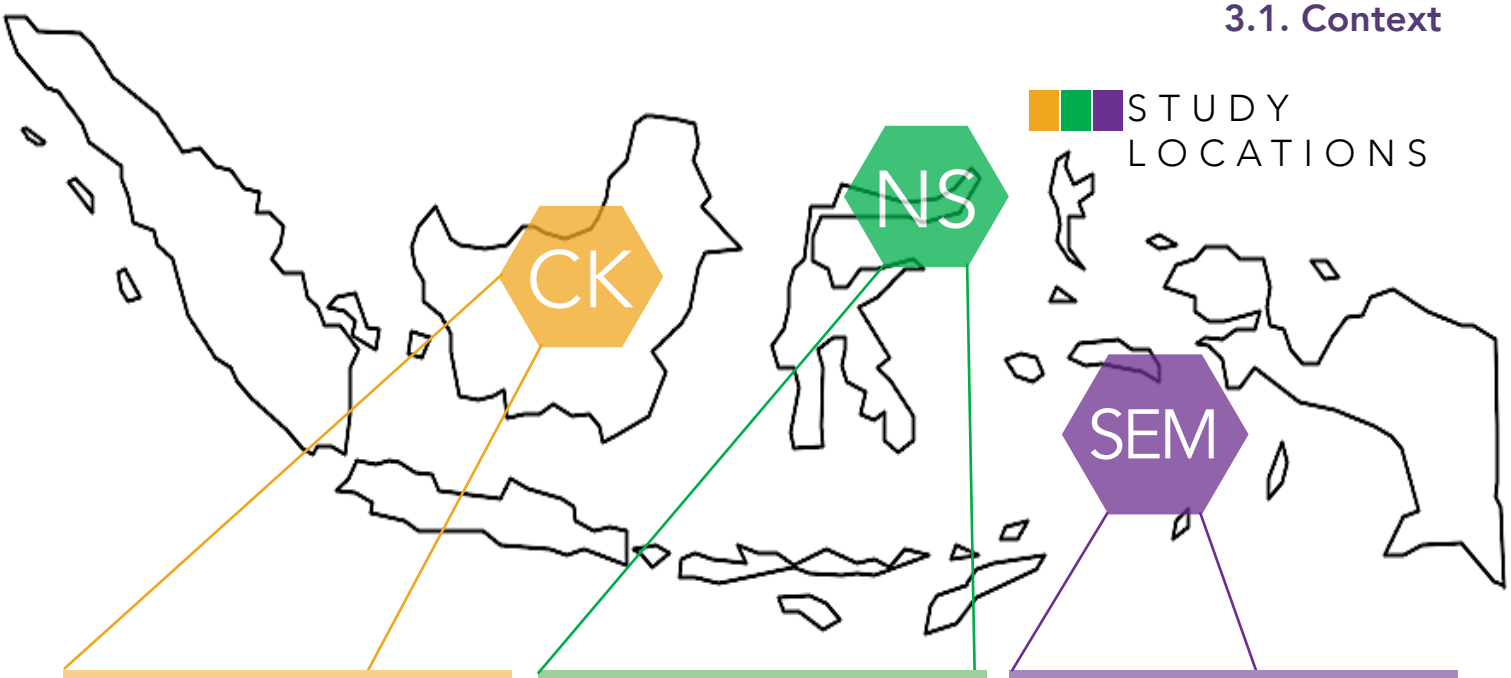
In rural C Kalimantan people left their homes early in the morning and returned later and then withdrew inside their homes at about 7pm leaving less time to interact. In peri urban C Kalimantan the village comprised over 6,000 people who have mostly adopted an urban lifestyle and do not know each other very well and are very busy.

In SE Maluku the studies took place at the end and beginning of months and so missed the monthly posyandu sessions which are ussually held in the middle of the month.



3 FINDINGS

3.1. Context



CK1: Rural villages in forest situated on lower reaches of river with river access only (floods). Population 2800+

- River, wells, rain water
- Diesel generator < 12 hours/day
- Good in sub-district, limited or not at all in surrounding villages
- Rubber sapping, rattan collecting, swallow nest production, timber mill, seasonal river fishing
- Mostly Muslim, some Catholic

CK2: Peri-urban town amidst hills & farmland situated on large river (floods annually). 1 hour from district capital (3 hours in rain). Population 2000+

- River, spring
- Grid electricity
- Good service (new tower)
- Mostly employed in timber and coal company
- Muslim

NS2: Peri-urban, inland. 1 hour from provincial capital. Population 1000+ households, but fluctuating population

- Wells
- Grid electricity
- Good reception
- Trade, transport, pond fish, farming (copra, nutmeg, cloves, paddy)
- Mostly Protestant, some Muslim

NS1: Rural coastal area, 5 hours from provincial capital on main highway

- Wells
- Grid electricity
- Good near main road, otherwise very limited
- Farming (copra, maize)
- Mostly Muslim

SEM1: Rural coastal village on island, 3 hours district capital accessed by main road. Population 1000+

- Wells
- only privately owned generator
- no phone signal
- Farming, fishing
- Majority Catholic

SEM2: Peri-urban coastal, 30 minutes from district capital

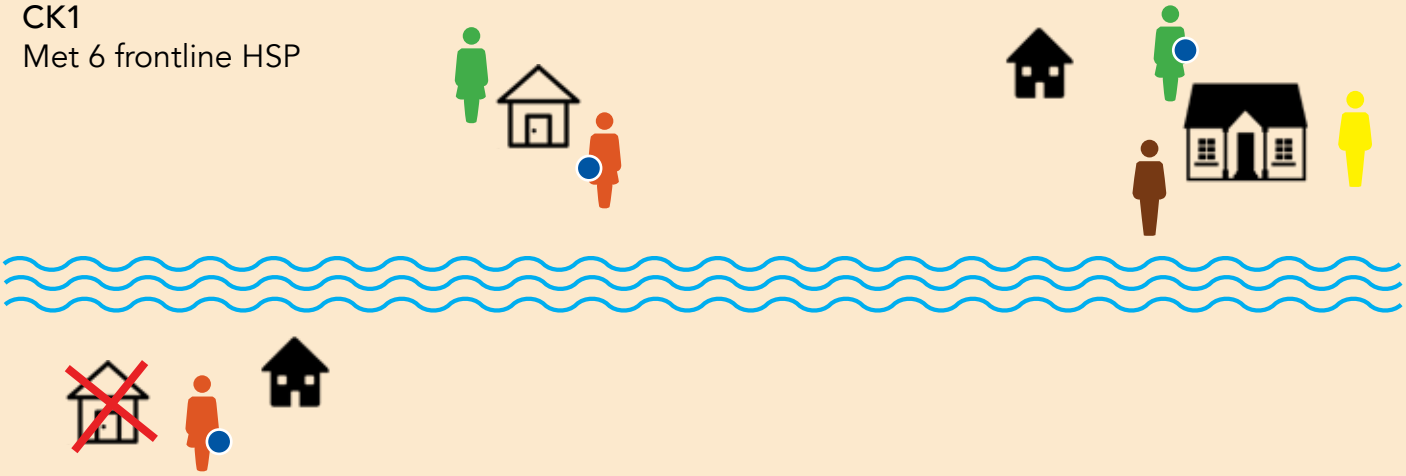
- Buy drinking water, wells
- 24-hours grid electricity
- medium and low phone signal
- Farming, fishing
- Christian and Muslim

We met 69 frontline health service providers:

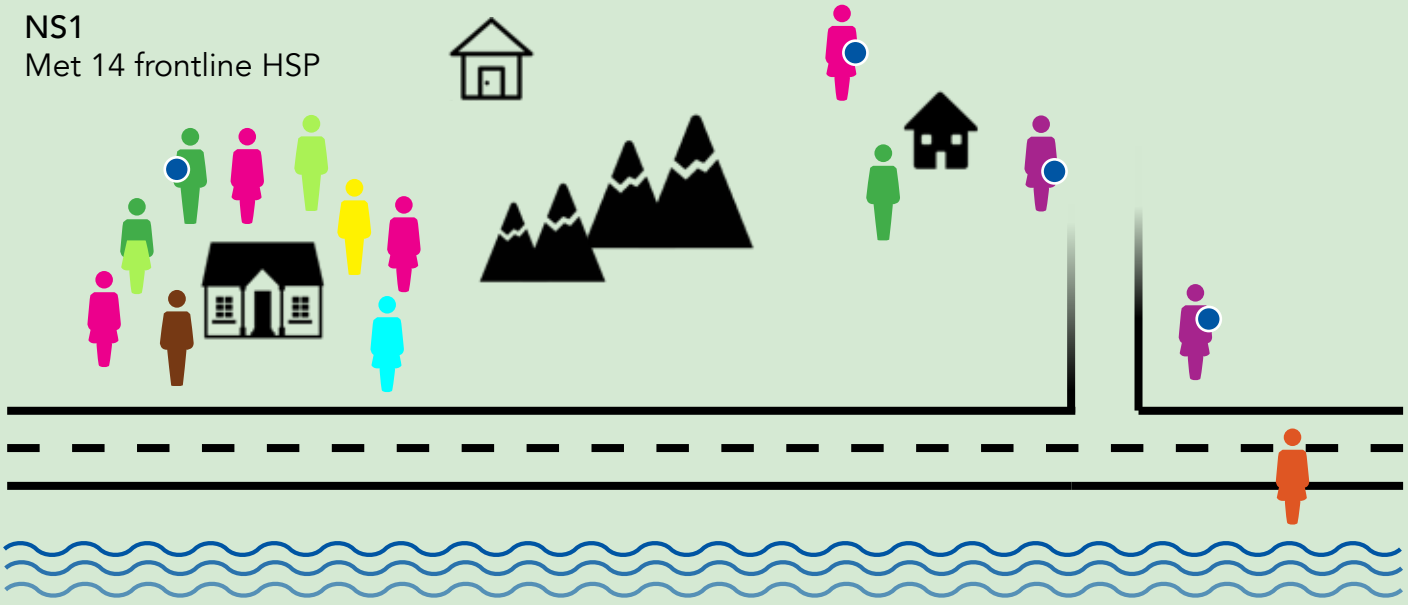
focusing 17 of them

Nurse
Doctor
Admin
Shaman
Dentist
Cadre
Midwife
TBA
Security guard & driver
Pharmacist, Environmentalist & Nutritionist
Focusing

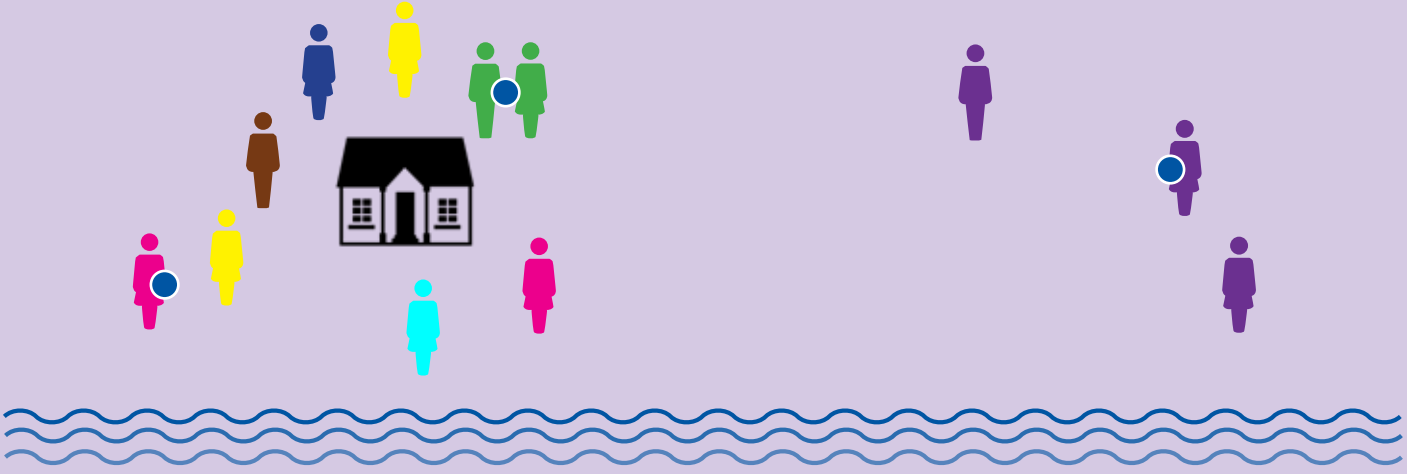
CK1
Met 6 frontline HSP



NS1
Met 14 frontline HSP

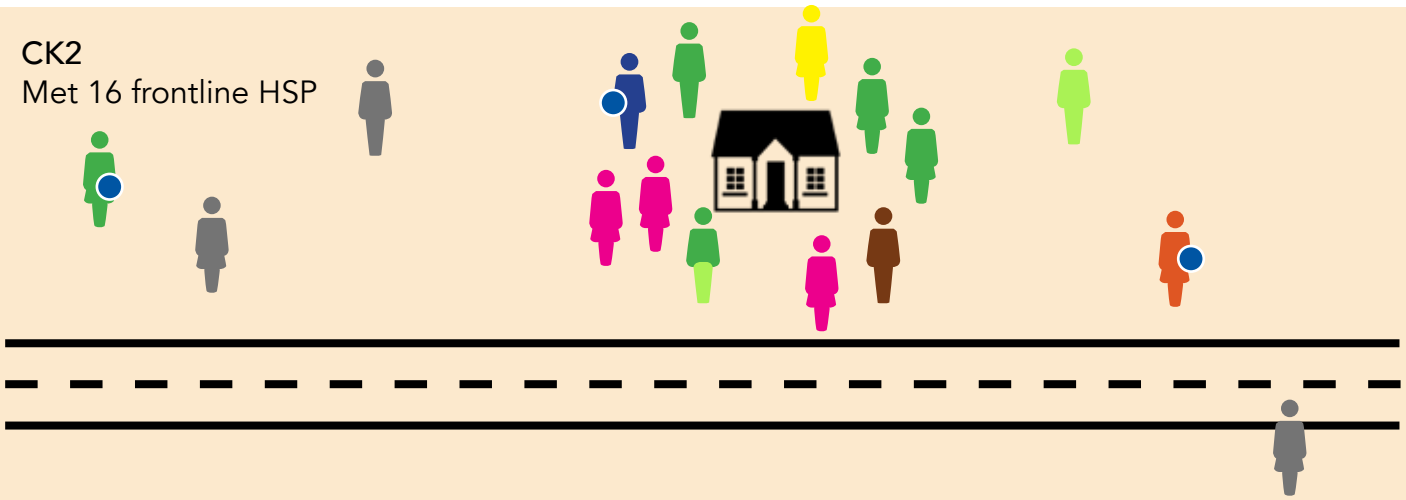


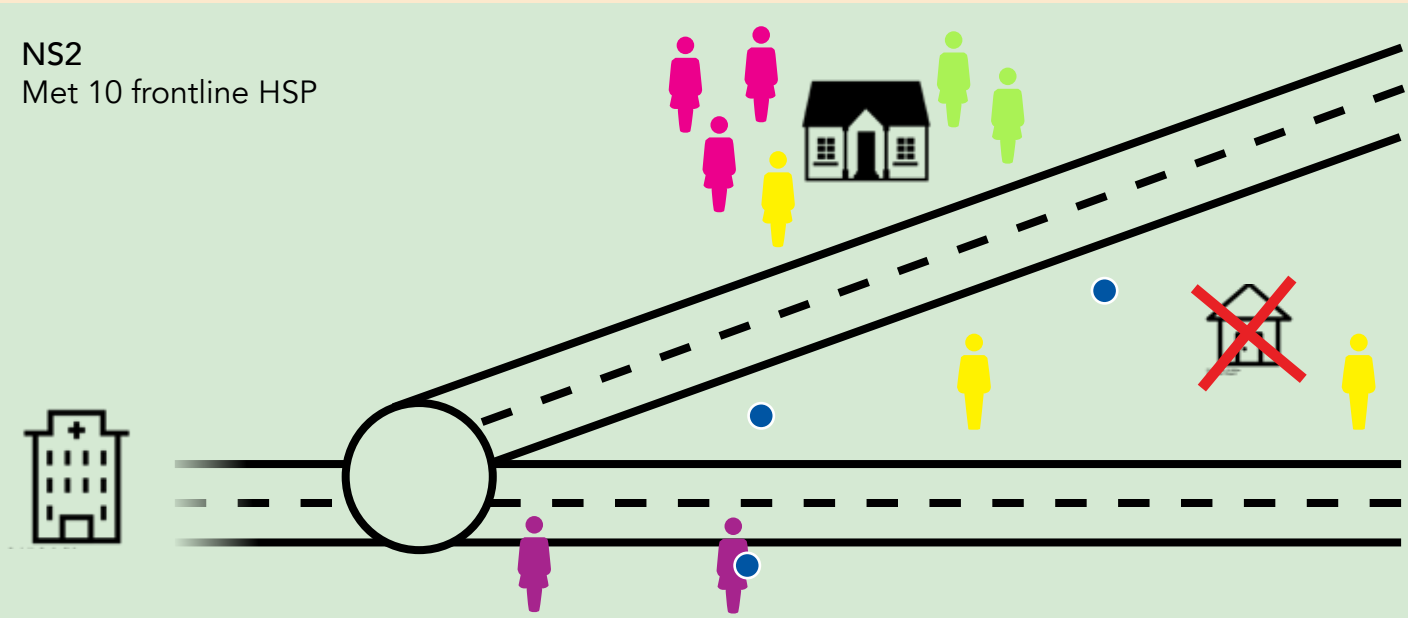
SEM1
Met 12 frontline HSP

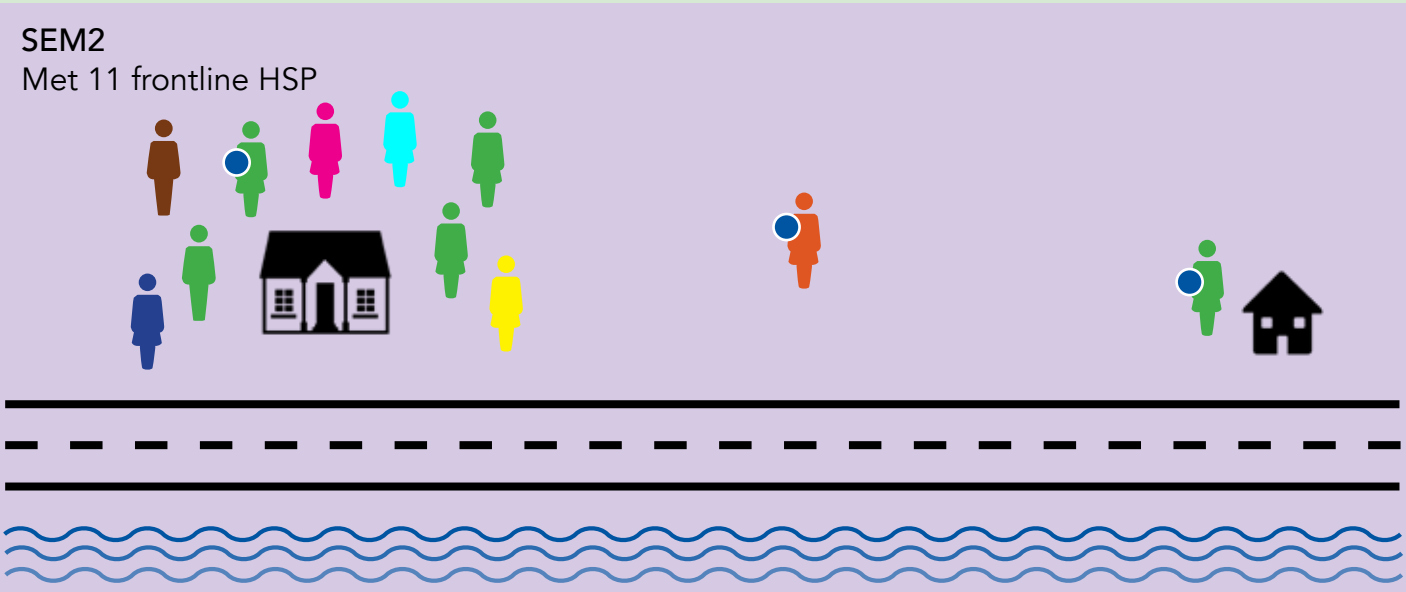


at their homes and workplaces: Puskesmas Polindes Pustu/ Poskesdes Private hospital in 6 study locations

River Coastline Main road







3.2. Introducing the frontline health providers

We primarily interacted with four different types of health provider all of whom are included in the official provision of local health services;

- permanent-base, i.e. civil servant (*Pegawai Negeri Sipil* (PNS)) status;
- temporary or contract-base, e.g. non-permanent employee (*Pegawai Tidak Tetap* (PTT)) status
- honor working on honorarium-base[11];
- voluntary-base, e.g. cadres (community health volunteers) who work on incentives and traditional birth attendants (TBAs)[12] who do not have a fixed charge for their services.

Whilst we had rich interactions and conversations through staying with nineteen frontline health providers, we also interacted with a further fourty health providers (as shown in the graphic).

Meet
just a few of them:

Everyday I commute from my home to the village *pustu* by motorbike which takes about 30 minutes. I am the only nurse assigned here and some days I feel stressed out doing everything myself. Sometimes I have ten patients a day and what with treating them and the required administrative work I find this really tiring. I have asked for help but even though there are thirty staff in the puskesmas just a short distance away, nothing is done about my request.
-- SE Maluku

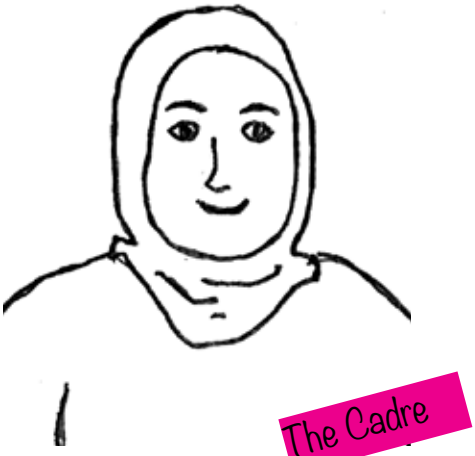
I am a young dental nurse currently employed as honor at the puskesmas. Unfortunately, I failed my PNS (civil servant) exam last year but hope to try for this again. I stay in the official house next to the puskesmas with the head of the puskesmas who is a relative of mine and, perhaps unusually for a young man, I cook for him. Only when he is visiting his family in the district town do I go home and live with my parents in the nearby village for a while. I have worked here for two years now and do all the dentistry work here as there is no dentist.
-- C Kalimantan

I felt being a traditional birth attendant was my calling and followed my mother in this. At first I didn't want to be one . I think I got the power from her and I should not ignore this if I can help people. She was very well respected here. I have been practising for about five years and am younger than most traditional birth attendants. As a Muslim I do this as a service to God. I know I am good at this because midwives have told me I do everything right and have said sometimes I do a better job than they do. I have delivered seventy babies and only referred one to the district hospital because there were problems. I often work together with the midwives. My husband is really supportive though he worries about me working too hard especially when I get called out at night. But he is proud of me. I would like to become a certified midwife one day.
-- C Kalimantan

[11] Funded from different sources including local, provincial or district government funds.
[12] According to national policy framework published by Ministry of Health in 2011, the *Pedoman Pelaksanaan Kemitraan Bidan dan Dukun*, TBAs are recognised as part of the Mother, Newborn and Child Health (MNCH) support system.

'I have been here as a contract doctor for just four months. There is a shortage of PNS doctors in the district so there are two contract doctors posted here. I applied on line and got my second choice of region. My colleague is a woman who has been here for three years although we are both on two year contracts. It is considered a remote posting so we get double what I was earning before. This is a busy puskesmas as we are three hours drive from the nearest district hospital . It actually has an emergency room because of the road accidents in the area. This is the biggest problem here as drivers are drunk. The *warung* owner across the road from the puskesmas does well as there are always people accompanying road accident patients wanting to eat there. Although we have a laboratory here it can only do routine blood and urine tests and we have no X-ray or scanning equipment so I always refer these cases to the district and the ambulance takes them there. All we can really do here is clean the wounds and apply stitches. I also prefer to refer women in labour as we don't really have good maternity services here. We are specially busy on Fridays because it is market day. We often run out of medicines here so I have an agreement with the head of the puskesmas to buy medicine myself and pass the cost on to the patients.'
-- C Kalimantan

There are supposed to be two staff posted at this *pustu* but I am the only one. I have been qualified as a midwife for just five years having graduated from Midwife Academy, although originally I wanted to be a teacher. Midwives are in short supply around her so I got PNS (civil servant) status straight away after graduation and I was able to be posted in my home village three years ago. I live in the house attached to the *pustu*. This means I am effectively 'on call' twenty four hours . Like you saw, last night I got a visit from a pregnant woman at eleven last night and then a man bitten by a scorpion soon after that. I don't charge for this like others because these are my friends and my father's friends so I don't have the heart to do that. I can never go away for holidays. The maximum I can be away is two days. Even when I had my own baby three years ago I only took a month off because there was nobody else to look after the *pustu*. Sometimes I get summoned to work at the puskesmas especially to cover others' leave periods over Christmas as I am Muslim.
-- N Sulawesi



I am a cadre and have served twice in this capacity . I used to be a voluntary teacher at the high school but after my husband became village head I became a cadre again and also leader of the PKK. I feel I have to be a cadre as the wife of the village head. I have many duties as wife of the village head , like right now ,as you see, I have to cook meals and provide drinking water for the construction workers building the Church. I also run this small kiosk and do most of the farming as my husband is busy and can only go to the farm at weekends. My husband gets a letter reminding us of the posyandu arrangements the day before, usually around the 15th of each month. The posyandu is held at our house. On the day, I get up early and prepare green bean porridge, if we have received the funds for this, for the babies. The money either comes from the puskesmas or the GSC, but we don't always get it. There are five cadres; three work with the pregnant mothers and babies and two work with the old people. The nurses from the puskesmas do the main tasks but I help with the weighing. We cadres previously got IDR 100,000 for each posyandu day, but it has been a year that it is cut to IDR 50,000 and even at times we get IDR 10,000, paid in a lump sum by the government. Personally, I go to the kiosk to buy medicines as the ones from the puskesmas are not that strong. I want my youngest to go to nursing school. I have started a vegetable garden for the community behind the high school and am hoping that, with the help of other mothers, we can provide most families in the village with fresh carrots, spinach, cabbage and beans.
- SE Maluku

Table 3: The current status of the staff we interacted with

	location		Nurse/ *Mantri*		Doctor		Others (Midwives, TBA and Cadre)		
			Civil servant	Honor or volunteer	Civil servant	PTT	Civil servant	PTT	Honor or volunteer
Very remote	Rural	SEM1	5	1	1	2	2		1
		CK1	1	2	1		2		1
		NS1	3			1	6		3
	Peri urban	SEM2	4	1		1			1
		CK2	2	2		1	2	2	
Not remote		NS2			1		5	1	2

3.3. Where they live and work

The idea of remoteness has various interpretations and effects on the willingness of health staff to stay in remote places. While not having facilities such as electricity and phone signal are inconveniences, health staff often told us that if you can access the main town easily then the place is no longer really remote as 'we leave at weekends'.

Doctors especially prefer to commute from their own homes if possible and few live in the accommodation provided. They commute from the nearest town, which can sometimes be up to three hours by motorbike in some areas, while some choose to rent a room or stay in the government assigned house during weekdays and go to town at the weekend.

Box 1

'People living here in this coastal village feel it is very remote because it has no electricity, no phone signal and the price of goods is very high. But there is a reasonable road to the district capital which takes about two to three hours by car. For us that means it is not so remote. I wanted to come here to escape urban life and get another experience, so straight after qualifying as a dentist in Jakarta I applied for a PTT position in this district. I stay in the house next to the puskesmas with other contract staff. But we all only stay Monday to Friday (occasionally Saturday morning) all of us go back to the town at weekends and stay together with about nineteen other PTT in a kind of dormitory. Here we can use social media and enjoy urban life together.'

PTT doctor, Rural SEM

Table 4: Living in the village or commuting

	location		#Government health staff	Living in village (permanent)		Temporary (rent/official accommodation)	Daily commute
				Local	Incomers		
Very remote	Rural	SEM1	20	4	1	3	12
		CK1	23	3	10	10	
		NS1	18	18	4	3	9
	Peri urban	SEM2	24	1			23
		CK2	14	6	4	4	
Not remote		NS2	49	2	1		46

3.4. Our motivation to work in health

We had extensive conversations with health providers around their motivations to work in health, what had led to their present occupation and place of work and what they aspire to.

Motivations fall into several types;

- A motivation for civil service employment, often irrespective of what discipline
- Family encouragement and expectation
- 'Calling', often fuelled by religious belief or social responsibility

Wanting to be a civil servant

Other RCA studies in Indonesia have revealed that people have very strong aspirations for all kinds of civil service work and, with increasing family investment in education, are not looking to futures in manual trade, farming and fishing. Civil servant status means a 'job for life' and benefits such as access to credit, as well as allowances and often housing. It is also seen as a job with status. Many older health staff told us that in the past there had been a 'good decade' when everyone expected 'to become a civil-servant as soon as we graduated from school,' (Nurses, rural SE Maluku).

The following illustrate how the drive to be a civil servant overrides the choice of sector;

> *I applied to teaching school first as I didn't want to be a nurse but I was not accepted on two occasions. My relatives suggested it would be easier to become a nurse so I could join the puskesmas in my village. My younger sister has done the same thing and we are both honor nurses, although she is still training."*
> (*Honor* nurse, C Kalimantan)

> *"I have been a nurse here for four years now. I did not plan to be a nurse. I was the youngest in the family and everyone is a farmer but my dad pushed me to be a nurse. I actually wanted to be a policeman. I was one of only five men in the nursing college (about 5%) and got my PNS status straight after graduating."*
> (Nurse, N Sulawesi).

> *"He didn't want to be a nurse but his father got him into military nursing school"*
> (Mother of this nurse)

> *"...although originally I wanted to be a teacher."*
> (Midwife, N Sulawesi)

Many who have not yet acquired civil servant status shared that they accept the uncertainty of being a honor or a volunteer with the hope to someday become a civil servant employee. Learning from past experience of others, there is an understanding that if one has been doing the job long enough, eventually they will be accepted as a civil servant, although this can sometimes be a long time coming. For example, a married couple in SE Maluku who have both been nursing for 25 years spent their first seventeen years with just honor status. '*We supported ourselves by making and selling cakes*' they explained (see Box 2). The wife of the security guard in the *puskesmas* in rural C Kalimantan is a volunteer cleaner and hopes that '*I will get a civil-servant status for this if I do this long enough*' while the cleaner in another *puskesmas* in peri-urban C Kalimantan has finally been appointed as civil-servant two years ago, having '*done the job for 22 years in the same puskesmas.*' Other honor status health workers shared that they are not happy about their status and lament that '*bribes worked in the past, but they are not possible now. It needs a good network and exam success to get the post.*'

Box 2

"My husband and I both have more than 25 years nursing experience and both work at this puskesmas. We were posted here 8 years ago when we both became full civil servants (PNS). Before that we were both honor nurses for a very long time and supported ourselves by making and selling cakes. We live in the three bed-roomed house which was built at the same time as the old puskesmas about eleven years ago. Oddly this did not have a kitchen so we had to install one at our cost. Since then a new puskesmas and new house for the doctor has been built about two years ago. My husband is now the head of the puskesmas. Our family has been drawn to medicine; our eldest son is now in his early twenties and is an honor nurse and works here too. He is married to a midwife he met at private Nursing Academy who was able to get a permanent posting here. They rent a room in the village five minutes from the puskesmas with their younger daughter who is three. And our youngest child, a daughter, is studying public health in Ambon Diploma School. Our middle boy used to drive the ambulance for the puskesmas and tried nursing school but dropped out after four semesters. He really wants to be in the army. We also look after our nephew and hope he will go to Police Academy. He often helps by fetching things we need for the puskesmas, as you saw, he just collected the solar panel for the fridge. The doctors here keep changing, none of the present ones have been here for more than a year. We felt closer to the male doctors than the new women doctors."

S E Maluku

Box 3

Tika graduated in dentistry from a private university in Jakarta about nine years ago. It's an expensive option and people said her parents sent her there 'as an investment'. Her mum denies this, '*Children aren't an investment. We're only supporting what they aspire to be.*' She has an older sister who is '*very different from me. She likes to change jobs and to travel. She even wants to visit me here in Maluku, but hasn't found the right time.*'

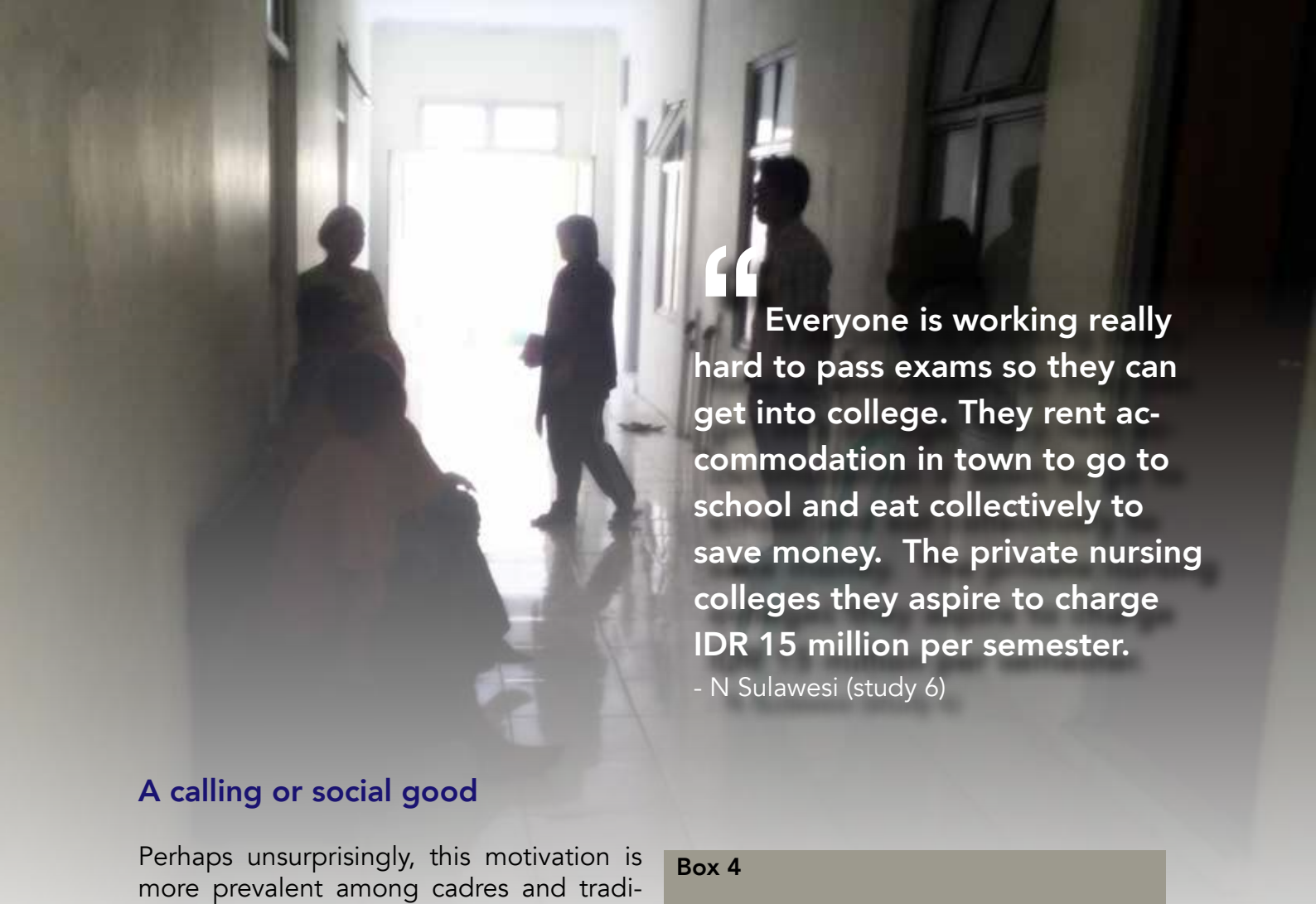
Field notes SE Maluku

Family encouragement and expectations

Families often comprise a number of health workers as the example in Box 2 illustrates and some *puskesmas* have obvious family lineages (e.g. rural SE Maluku, peri-urban C Kalimantan). So there are expectations based on these 'heritages' but there is also pressure to become a civil servant (PNS) with health work a possible choice that comes from parents and wider family. One midwife echoed what others said about the burden their education costs had put on their parents, '*there was no way back, because I was already in the midwifery school when I began to understand how tough midwifery actually was compared to nursing. Leaving school was not an option, my mum had sacrificed a lot for me to get in,*' (Midwife, SEM-1). Others talked about being the only one in the family with prospects to become civil servants, something we have come across in other RCAs in Indonesia, '*I am his last child from a line of farmers, so my father pushed for me to be a nurse*' (Nurse, NS-1). Family also influences the decisions based on perceived job security, for example '*a relative's advice dissuaded me from being a teacher,*' (Nurse, CK-2) because working in the village's health facility was felt to have higher job security than the village's school.

Family ties seem to have a particular influence in helping to secure honor vacancies when they arise. For example, there are eleven close family-related staff working in the *puskesmas* of rural C Kalimantan including two sisters who work as honor nurses.

> **"There are lots and lots of advertisements all round the village for nursing colleges and many want to be nurses as they see a shortage in their village.**
>
> - C Kalimantan (study 6)



“Everyone is working really hard to pass exams so they can get into college. They rent accommodation in town to go to school and eat collectively to save money. The private nursing colleges they aspire to charge IDR 15 million per semester.
- N Sulawesi (study 6)

A calling or social good

Perhaps unsurprisingly, this motivation is more prevalent among cadres and traditional birth attendants than others as they work voluntarily or with small recompense, but some formal health workers also shared that this influenced there decision to serve e.g. ‘*I am a devoted Adventist and serve people because God has given me that gift*’ (Midwife, peri urban N Sulawesi).

As noted above in the introduction of the TBA, ‘*I felt being a traditional birth attendant was my calling and followed my mother in this. At first I didn’t want to be one. I think I got the power from her and I should not ignore this if I can help people. She was very well respected here*’ (Rural C Kalimantan). Her words reflect others whom we have met during this study and other RCA studies in Indonesia.

Across all the locations for this study, people noted common motivations for being a cadre, with the most frequent being ‘status’ and ‘role model’. Their tasks are seen as fulfilling social responsibility, with ‘*no other advantages except being recognised as an active member of the community*,’ (Cadre, peri-urban N Sulawesi).

Box 4

“I am currently continuing my study so I can be certified as a private doctor. I moved here about two years ago as a PNS doctor and recently married a local woman who lives in the city. I live in the puskesmas house during the week and one of my wife’s aunts takes care of me here doing my washing and cooking for me. I love working here as people are so friendly and polite unlike my home province, Sumatra, or like it is in Java. Patients never complain here. But I know the other staff are mostly looking to be re-assigned so they can be with their families. I am at the puskesmas each morning but come back to the house if there are no patients. I go round the villages on my motorbike and if they need me they stop me. I do the same by boat so I can go village to village. I am happy when people come to the house and I always help them. I am the only doctor here so I make myself available.”

Rural C Kalimantan

Location: winners and losers and how this affects motivation

As civil-servant or contracted (PTT) health providers, people expect to live away from spouse or family, especially in their early professional life.

Several of the PTT doctors we met actively took the opportunity to be assigned to remote areas for two main reasons: financial- 'to '*break even*', '*having spent a lot for medical school*' and prospects- '*to improve my résumé*' and a few shared that they also want to 'challenge themselves'. Hardship allowances provided for those posted in remote areas can effectively provide double salaries and these are important ways to help pay off education related debt or finance further education.These are anyway short term contracts and the doctors see them as temporary.

The group of PTT doctors who are all single in S E Maluku consider they have pleasant postings in what they describe as '*peaceful coastal villages*' receiving allowances and enjoying urban life at weekends (see Box 1). Although not a PTT, the recently qualified young doctor whose situation he describes in the Box 4 sees his current position in a rural location as a relatively easy and pleasant posting where he can get experience but also continue his studies for private practice.

There is much store placed in getting a civil servant posting near town. The peri-urban N Sulawesi location is regarded as a 'hotspot for PNS' and nearly all fifty staff of the *puskesmas* have civil servant status. This 'ideal posting' is some thirty minutes drive from a major town where nearly all the staff reside. This is regarded as a the 'best of all worlds' as the *puskesmas* outside of town is not that busy, they are not in demand twenty four seven and they have access to amenities like schools for their children in town. In peri-urban S E Maluku, none of the *puskesmas* and *pustu* staff live in the village except a local nurse because, '*it is just 30 minutes away and it's so much*

> **"Why oh why? I don't understand why this village does not have a phone signal. There is nowhere in the village we can get a signal.**
>
> - PTT doctor, Rural S E Maluku

Box 5

'I have been posted here, my home area, as a PNS nurse for seven years now. I was not happy about this posting although others might think it is good to be serving my own community. But, it is really hard when everyone around is related to you. I would rather be assigned somewhere where I can be neutral. I am always getting demands to help members of the family out. I have to give them food. I can't refuse. Food is now my biggest expense. I am the only member among the thirty staff working here at the puskesmas who actually lives in the village'

SE Maluku

'I used to sell medicines from home but often people expected not to have to pay, especially as many of them are my relatives and so now I only help to buy medicines for people who pay me in advance'

N Sulawesi

Box 6

'I keep thinking about moving back to Ambon. I am a qualified midwife assigned to the puskesmas about five years ago. My husband and I live in rented accommodation with our younger daughter. The older one is staying with her grandma in Ambon so she can go to a better school. But my mother is getting old and I want my second daughter to go to a better school too. The PAUD *here is very limited and children get bored. They only teach them to count from 1-10 and sing a few songs. I want more for my daughters so we will probably move. But for now, as long as the village needs me and welcomes me here and still wants to listen to me, it is fine.'*

SE Maluku

easier to daily commute, then we can still do other things in town after puskesmas hour.'

Box 5 illustrates the difficulties of working and living in one's own home village where family and others expect special privileges. A midwife voices what others feel about the limitation of living in remote places, particularly as the family gets older (Box 6).

Money issues as motivators/demotivators

There are hardship allowances for some remote postings although people shared that the definition of what is remote is not always clear. For example, a doctor in C Kalimantan told us that according to the national government rules, the area he has been assigned to is a remote area, but after getting there found out that according to the local government it is not, '*I end up not getting as much incentive as I should in a remote posting*'. Another , who had managed to swap from a non- remote to a remote area doubled his income from IDR 4 million to IDR 8 million per month. There are usually costs with being posted in remote areas, including rent and transport and the possibility to be supporting two sets of accommodations; the work base and where the rest of the family resides. Some doctors wanted to debunk the conventional stereotype, '*Please do not think that by becoming a doctor, we automatically have a bright future. Not everyone has enough money to immediately continue to specialisation, or have parents already operating private practices that we can instantly join.*'

On the other hand, frontliners originating from the region or marrying a local person, tell us it is better for them to become a civil-servant than a contract doctor (PTT). '*At least we are not far from the family*,' and the civil servant status remains for their entire career while PTT is temporary.

The *honor* staff generally struggle financially and advantages of having family ties to the workplace are clear. The *honor* nurse in rural SE Maluku shared that the '*salary for honor depends on the local government's budget so the amount can change from month to month*', but is never more than IDR 1 million (less than half the lowest paid PNS nurse). And others explain that *honor* staff are recruited by the local government on a needs basis. The tactic of *honor* nurses is to accrue experience and at the same time minimise living costs. But some also start lucrative private practice as one young *honor* nurse shared, '*I am a role model to*

Box 7

The head of the puskesmas has offered a room in their house for the new doctors. There was an empty official house next door but it is not furnished and they did not want to stay there as they prefer company. The wife of the puskesmas head cooks for them and looks after them. 'All the doctors who stay with us are like my children', she says. The doctors pay nothing towards their food or upkeep.

Field Notes , Rural SE Maluku

Box 8

Some families have been living apart for 5 years or more because of their postings. One woman works as a midwife here and her husband is a teacher in another village eight hours away. The cost of transportation and the time for visiting has become a major problem for them.

Field Notes, Rural C Kalimantan

The family has bought this honor *nurse all the equipments she needs to run a practice from home (C. Kalimantan peri-urban)*

my younger sister. She now follows suit by entering nursing school. We are going to have our own practice together. We have bought our equipment with the support of family money'. (Rural C Kalimantan).

The need for earning outside the meagre *honor* allowances are acknowledged, even to the extent that some civil servant health workers consent to allow the *honor* staff to fill the private practice niche. For example, in peri urban C Kalimantan, there is an unwritten agreement in favour of the *honor* nurse endorsed by the contract doctor, '*The honor nurse only gets IDR1 million per-month, so she opens a private practice. This restrains the doctors from going around the village after puskesmas operating hours, so she can do her practice without competition*'. Fellow staff also refer patients to the *honor* nurse after *puskesmas* opening hours saying, '*the doctor is resting now, you can go to this nurse.*' The locals perceive it differently, though, '*the doctor always locks the door after puskesmas hours when people still look for her a lot. Probably she is just lazy.*'

There is ambivalence about whether there are better opportunities for private practice in remote areas or more built up areas. Contract doctors in rural SE Maluku felt that '*people here just don't get sick that much, so opening our own private practice would not be something in high demand or gainful.*'. Even with high patient to doctor ratios (1: > 1,000 population), in rural areas, doctors say it is a challenge for them to successfully open their own private practices mainly because people have little cash. People feel it is more possible for a midwife or a nurse who are trained in antenatal and postnatal care to have a profitable private practice than for doctors. This is also because patients can use traditional treatments and self medicate with drugs available from the kiosk and markets but give more priority to delivering the babies with professional help. For example, a midwife coordinator in peri urban SE Maluku shares how '*the locals prefer to give birth with the help of a midwife who has moved to another village and opened her private practice there*' and can't understand why they would want to go far and pay for a service that they can get for free in the *puskesmas*. But we heard that the relocated midwife is much loved '*very kind, loving and smiley. A beautiful woman, always attentive and knows us well*,' unlike the

> **"The *honor* nurses here, (both recent young graduates) only get paid if the BOK is available.**
> - N Sulawesi

Box 9

In the seven years she's been working in the *puskesmas*, Vera only receives a basic salary with no other allowance. It is different from the time when she served in another village, when she received an additional monthly regional allowance of IDR 500,000. '*I know that teachers get allowances, well, even I once enjoyed it in the previous posting. I don't know what happened with this current posting, but maybe it is my fate for now.*'

Peri urban SE Maluku

Box 10

By coincidence we met up with the young woman doctor we had met in C Kalimantan in Jogyakarta. She has decided not to renew her contract in the village. She had not run a private practice in the village as she felt that she might compete with others who needed it more. We speculated that the families which dominated health provision in the village. She is looking for a post in Jogya where there are more opportunities.

C. Kalimantan

Box 11

The young dental nurse helps his parents tap rubber every morning he stays with them before going to the puskesmas. He says his salary is enough for him because he is now single but as an honor nurse it is hard.

Peri urban C Kalimantan

un-smiling midwife co-ordinator. Nevertheless she also is in the process of getting a permit for her own private practice. '*I want to be bidan keluarga (family midwife) taking care of each pre-natal, delivery and post-natal needs in the family and keeping track of the children development and immunisation*', but she has strong competition!

Working in peri-urban areas provide more perks for a lot of the frontline providers, compared to rural areas, not only due to the better facilities. Vaccines supply are brought home by the *puskesmas* head to be '*kept in my fridge since it is on for 24 hours, unlike the puskesmas fridge.*' A nurse is able to supplement her income in peri-urban by helping her younger sisters selling '*mung bean popsicles in town on a motorbike*'.

A midwife in rural SE Maluku shared a common experience when she was still in PTT programme, '*I had to get my salary in the bank as it was being transferred monthly to my bank account. There was no way that I could go to the capital city each month for it, so I went every three months picking up IDR 9 million'*.

For many cadres we met the monetary incentive is important, as a rural N Sulawesi cadre shared, '*I receive IDR 100,000 for doing one day per month at the pustu. I write the names of patients coming in to pustu.*' This amount seems quite common for a day's work for the cadre but it depends on the funding source and it is not always very regularly paid. For example the cadres in rural SE Maluku used to receive IDR 100,000, but now '*it is reduced to IDR 50,000 with the official reason that there had been miscommunication under the leadership of previous GSC leader, so it was always supposed to be IDR 50,000. And worse, since April the incentive has never been distributed when it is supposed to be a yearly distribution.*' Another talked about receiving IDR 10,000 despite the official amount of being IDR 50,000. And another in N Sulawesi told us that the small amount she gets is insignificant since '*I spend about IDR 500,000 a month for arisan*[13] *with different women groups in the village – this is much more than the incentive I get monthly from helping at the posyandu*'.

Box 12

After finishing her work at the *puskesmas* around noon, this honor nurse goes back home and begins her private practice work. She helps me with my sprained ankle and gives me painkillers and her grandma massages my ankle with a herbal rub. Soon after another woman arrives for a blood pressure check and was given vitamins. That evening another calls her out to their house. The nurse returns and collects her IV equipment from her house and some IV bags from the *puskesmas* and administers this at the patient's house. Sometimes she gets called out at night. She keeps track of all her consultations in her own records book

Peri urban C Kalimantan

Table 5: Staff turnover in the study health centres

Very remote

Not remote

location		Numbers of staff	How many want to move?	Turnover (% of leaving after staying more than 5 years)
Rural	SEM1	20	2	5
	CK1	18	2	20
	NS1	25	2	< 10
Peri urban	SEM2	30	2	5
	CK2	14	3	20
	NS2	50	1	<5

[13] Rotating savings and credit group, often of women.

How easy is it to get the location we want?

Table 5 shows that, with the exception of C Kalimantan where one in four leaves after staying more than five years, the turnover of staff is rather low with less than 10% of staff leaving the particular facility after longer than five years' post and withonly more than 7% actively searching for transfers at the moment.

Recruitment for health civil-servant staff in what are considered to be remote areas is dependent on the local government perception on the region's needs. This is illustrated by the *puskesmas* head in rural SE Maluku sharing, '*the authority (for staffing) is held by the local government, not the head of puskesmas*', so he feels powerless to modify staffing according to needs. For example a civil-servant midwife in rural SE Maluku found it quite easy to get civil servant status because there is a perceived high need in the area. One of the two midwives posted here shared that '*I immediately became a civil-servant after I passed the selection process held by the district government three years ago. There was a need for six midwives and there were six of us applying, so all of us were instantly granted a civil-servant status*'. The new directive which requires all *pustu* to have a midwife has also created further gaps for this especially as some *puskesmas* still do not have midwives assigned.

Generally we found much frustration about transfers. People said that without the right connections then these arrangements are left to chance. For example a rural N Sulawesi PTT doctor felt he was lucky to find '*another doctor who wanted also to swap locations with me. My previous posting for 18 months I had constant problems with the boss over leave, so I asked for a transfer. Without the 'fluky' swap it wouldn't have been possible*'. The doctor he exchanged with halved his salary by doing this as the location was no longer regarded as remote but he said he would save a lot on transport costs and would not be out of pocket . A nurse here shared a similar experience of making a swap within the same district after two years. Another chance arrangement was shared by a civil-servant midwife who was informed by the head who knew she wanted to move that '*there was a vacant position in my home town and that is how I came back here.*'

Box 13

I want to move back to the village where I was first posted, even though it has water problems and no phone signal or electricity because of the family demands here. I have put in for transfer and have to wait.

SE Maluku

Box 14

The midwife's husband explained that several staff at the puskesmas are there because they are relatives.

Field notes peri urban C Kalimantan

> **"There aren't enough midwives for every village here, and they are only available in sub-district capitals. It is better not to have a nurse than not to have a midwife.**
>
> - Doctor SE Maluku

Political affiliation can affect transfer both positively and negatively. For example, the previous *puskesmas* head in NS Sulawesi was a civil-servant midwife and said to be very political, '*she supported the losing Bupati (regent) candidate, so she resigned out of the administrative structure due to her concern that she might be posted somewhere else difficult as a punishment. Her replacement is a low civil-servant rank because he is connected to the incumbent Bupati.*'

In peri-urban C Kalimantan where 11 out of 14 *puskesmas* staff are blood related. The locals see it as '*normal, they're all respected as an elite rich clan*', and the incumbent Head of *puskes-*

“ I occasionally ask my colleague who is still unmarried to substitute for me in the evening, because I have kids.
-Nurse, peri-urban N. Sulawesi

Box 15

‘I have been posted here for three years, and will continue if the locals think I am still useful for them and are still willing to listen to my suggestions.’ Performing her current role single-handedly requires this midwife to ‘communicate and collaborate closely with my (nurse) husband and ask him to back me up when I have to assist labour in the middle of the night.’ Her husband is fortunately an antenatal care nurse, however, ‘the new regulations no longer allow male nurses to assist in labour. But for me, having him around when I have to do my work in the homes of people makes a difference. I usually inform him in advance my 3-monthly schedule: She points to the chart on the wall and explains; there are these many pregnant mothers at present… and these are the weeks in which they are expected to give birth. This way I hope he will remember to adjust his schedule if he has to go outside the village.’

Rural SE Maluku

mas was appointed by the previous Head who is now the village leader, *‘as he used to be the right hand of the previous head*‘, explained a nurse there.

Work/Life balance

Many staff we met have quite an easy life with few demands on their time as none of the health facilities we visited were particularly busy. But there are some who have found maintaining a work/life balance as challenging. The ones mostly affected are those who have to respond to emergencies, birth deliveries, are managing facilities such as *pustu* by themselves and those who live away from their families, especially those living long distances away.

The teacher husband of a *pustu* based midwife in N Sulawesi told us he had not imagined that a midwife’s job would be so time consuming and intrusive on family life. ‘*I never thought it would like this when I first married her. The middle of the night people knocking on the door whom I can’t say ‘no’ to… At a time when she was pregnant herself and weak, she still had to look after others when I was trying to look after her. I hope she follows the proper procedures each time, I worry for her.*’

Box 16

Vera is a nurse. She has two sons, (5 and 7 years). Her husband is unemployed and she has two younger sisters who live with them. They live in the puskesmas house, ‘nobody minds because they are pleased a local girl has come back to serve the community. People refer to her as ‘putri daerah’ (princess of the area).
But it is hard to make ends meet. She and her sisters have started making mung bean iced slush to sell in town. On good days, they can sell 800 – 1,000 and earn IDR 500 – 700,000 per day.
She doesn’t mind her husband being unemployed, which he seems to have been for quite some time but she finds it hard to balance family and work. Mornings start early with preparing the mung beans for the ice slush and packaging the ones to be sold that day. As the only one at the puskesmas who lives on the spot she opens the place up in the mornings. Then she does her work –mostly administration which she does not like but she has been told she is good at it. She also leads on the malaria and TB programmes. She is the last to leave each day and locks up but she often has to do the cleaning as there is no cleaner and people don’t observe the cleaning rota. In the evening, she teaches her first-grade son to read. One morning, as she had not found time the night before, she became quite upset and eventually lost her patience with her son who was having trouble pronouncing letters of the alphabet. She shared that sometimes she really feels the stress of being a working mother but, ‘ if I feel tired, I just go to my room, lock the door from the inside and sleep’.

Peri urban , SE Maluku

When living away from origins the usual support networks are not available. The nurse mentioned above in SE Maluku depends on her two sisters to help with looking after her two sons. But where the family lives away from relatives, childcare can be problematic, for example in rural N Sulawesi three women nurses have to bring their toddlers to the *puskesmas* each day while they are working.

Some families of TBAs shared their concerns about their mothers' work, especially since there has been an increasing marginalisation and, sometimes, persecution of TBAs. One TBA's daughter urges '*my mother to stop practising. She doesn't have any education and is sometimes unsure what to do when there's some complication. She may get into trouble with the authorities one day.*' (Peri urban C Kalimantan). Another TBA daughter who is now a nurse, tells her mama '*about the danger of continuing to assist delivery of a mother who's got HIV/AIDS when nobody is aware of her condition.*' In this area of peri urban SE Maluku she says the prevalence is 'quite high'.

3.5. Our capacity and confidence to work

Generally, both formal and informal health service providers felt they did not have enough in-service training and were not kept up to date with new ideas and programmes. Some were being asked to do jobs for which they have no training, for example several of the *puskesmas* administrators were trained as nurses, dispensaries were often staffed by junior staff with no special pharmacy training and, a dental nurse is expected to function as a full dentist and a nurse is expected to diagnose and prescribe. Cadres often shared with us that they would like more training so they can do more in the *posyandu* and more for their communities health. TBAs felt they were being side-lined because of their lack of certification rather than their lack of knowledge and experience, which is often extensive.

Dental equipment has become rusty because it is not washed and dried properly (C. Kalimantan peri-urban)

Certification was often mentioned by all levels as key as a male nurse in rural N Sulawesi shared, '*with professional certificates, you are protected from being accused of malpractice, particularly by the authorities*'.

Long term staff shared their personal experience of training which was often very intermittent. They say they would welcome more refreshers training and other forms of continuing education. Nearly all said it was a long time since they got invited to or received trainings. For example, doctors and nurses in N Sulawesi told us, '*It has been 4 years since we were posted here and there has been no kind of training.*' Some note that when training is provided it is '*only senior people who get training in Jakarta or the provincial capital and they are supposed to bring this training to us, so as a midwife I have never been to training*',

> **"My training as a nurse should limit what I can do. I am supposed to only examine patients from the outside, check pulses and blood pressure. Diagnosis and medicine prescription should be done by doctors. But here, I have to do it all.**
> - Nurse peri-urban SE Maluku

(Midwife, N Sulawesi). An environmental specialist in SE Maluku shared, '*training is decided by the local government. A long time ago there was good workshop training in the provincial capital where we shared programmes that we had implemented. But that was it.*'

But some doctors, in particular, shared that they did not think the nurse academy training provided is adequate. For example, a PTT doctor in peri-urban C Kalimantan did not expect to have to provide so much guidance to the other staff in *puskesmas*, '*the midwife doesn't even know how to treat pre-eclampsia. Once there was a pregnant mother coming with pre-eclampsia and I asked the midwife to get the medicine to treat, but she came back with a medicine having the opposite effect.*' He was also worried about the ease with which '*staff give shots and/or medicines without considering the side effects.*'

'*Many of the nurses do not know how to maintain and clean up equipment. The blood pressure meters, for instance, can easily become rusty. Sometimes we remind them but they still don't do it.*' (doctors rural SE Maluku). And the *puskesmas* head in rural C. Kalimantan expressed his concern about the nurses there, '*They are poorly trained and don't know what they have to do. They are used to working by and waiting for instructions, different from the private hospital's nurses. There are fewer nurses in private hospitals but they all know what they have to do. I wish that longer periods of training were given to new nurses assigned to remote areas before they come as there is less chance they will be receive training once they get here.*' For others the training they have is not being used, for example a PTT dentist in SE Maluku who says she has only had a handful of patients in the two years she has been posted there, worries that '*if every day of my entire assignment here is spent like this, I will forget my dentistry training when I go back to Java.*' Her GP colleague points out another problem that doctors' assignment letters are renewed every five years and the renewal requires a minimum number of trainings to have been undertaken but '*If we're in the city there are many opportunities for training but here we not only have little practice because of the low numbers patients, training is rare.*'

> **"I am a nurse who has been appointed finance and accounting officer for the *puskesmas* but I have never had training for this... And I don't even know why I was appointed**
> - Nurse, C Kalimantan

There seem to be two main consequences of health providers who are insufficiently trained; provision of treatment/information beyond their competence and risk aversion. A *mantri* in N Sulawesi we met in the parallel RCA study on hygiene and nutrition routinely moves house to house and conducts blood pressure tests. He prescribes either red capsules, green or yellow pills (the latter turned out to be antacids and vitamins but people are not told this) depending on the blood pressure read-

Box 17

"While I was at the puskesmas, a patient came with a skin problem. The nurse was confused and whispered agitatedly to her colleagues. 'What would be the med… what would be the med?' Eventually she gave the patient some medicines. Later we chatted about what happened she said,' I was confused not because I don't know the appropriate medicine to give, but what should be given as substitute when there is no such medication in stock. So, I just gave her vitamins and told her that if it doesn't get better, she should come back here"

SE Maluku

"I went to consult the doctor at the puskesmas about my cramps in my hands. They just gave me vitamin B tablets as they were not confident of the diagnosis."

C Kalimantan

ing and charges between IDR 25-35,000. Box 17 provides other examples of working above competence levels. Another *mantri* in C Kalimantan had prescribed hydro-cortisone cream for sores on a baby's head which were not eczema and had given ibuprofen and chloramphenicol for a child who was vomiting and had diarrhoea but without a diagnosis of typhoid or cholera. He also charges a standard IDR 35,000 and usually asks people if they want an injection first without any explanation of what this is for. We observed a nurse while she distributed biscuits at a primary school in SE Maluku and she showed first graders how she could test for iodine presence in salt. Children were excited that the starch she added made the salt purple but the message they understood was to eat more salt because it has iodine in it. Similarly, mothers have misunderstood the nurse's emphasis on their babies putting on weight each month because there is little explanation of how the growth monitoring actually works and consequently mothers feel they should introduce solid foods early. Some nurses seem to encourage this.

Where health providers lack confidence and fear reprisals, this leads to an over emphasis on referral at times when in fact the facility/health provider could cope with the patient.

Some TBAs shared with us how they recall the '90s being the period where they had been given good training as '*Bidan Terlatih* (Trained Midwife)' and wholly included in the maternity care system and were lauded for doing a good job.

Old puskesmas *which no longer used (C. Kalimantan)*

3.6. Our workplaces

Table 6: Function rooms in health facilities observed

Very remote → Not remote

Location	type	Doctor consultation room	Dentist room	Emergency room	dispensary	Diagnostic laboratory	Maternity unit	In patients	Staff accommodation
SEM1	PK	✔			✔	✔	✔		✔ x2
CK1	PK	✔	✔	✔	✔		✔	✔	✔
NS1	PK	✔		✔	✔		✔	✔	✔ x5
	PU	✔							✔
SEM2	PK	✔			✔	✔	✔		✔ x3
	PU	✔			✔		✔		
CK2	PK	✔	✔	✔	✔	✔	✔	✔	✔
NS2	PK	✔	✔		✔	✔	✔		

Workplaces are explored from the health providers' perspective in terms of the condition and adequacy of physical buildings, utility provision, equipment, consumables and staffing needed for day-to-day operation. While health staff often talked about under-resourcing, much of our observations suggest there is substantial over –resourcing in many places.

The location of the facilities

In some study locations, people shared that their health facility is too close to other health facility, like in peri-urban C Kalimantan and N Sulawesi. In some other study locations they are too far even to go for a referral, particularly in the dusuns of rural C Kalimantan, or in area where people don't prefer to go to, like the plan of rural SE Maluku to build an in-patient facility up the hill instead of near the current location which near the coast.

Minimal equipment in the in-patients facility, rural N Sulawesi

Table 7: Underutilised buildings/rooms

Very remote → Not remote

Location	Unutilised rooms in puskesmas	Unutilised staff accommodation	Unutilised health posts
SEM1		1	*Pustu, Polindes*
CK1	2		*Posyandu*
NS1	2 in-patients 5 empty		
SEM2	2		
CK2	1	2	*Posyandu*
NS2			

The buildings

People shared a number of frustrations with the physical facilities especially concerning their location and convenience but rarely mentioned that they have many unused rooms. Our observations and conversations however revealed several unused spaces and facilities (see Table 7). Some indicated that decisions are made from above and there is little consultation about what is actually a priority and needed. Construction seems to be piecemeal rather than coherent or demand -driven as the example from SE Maluku demonstrates where the old *puskesmas* building was considered '*no longer fit*' and a new building has been built two years ago but they retain some services in both.

The rural SE Maluku *puskesmas* is planning to build new in-patient facilities which the Head welcomes as '*at present we refer to the district hospital quite often*'. But other in-patient facilities already established in rural areas are hardly used, questioning the need.

In rural N Sulawesi, for instance, a two-storeyed *puskesmas* has '*three rooms upstairs that are supposed to be administration rooms but only one is used for accounts work.*' The *puskesmas* in peri-urban C Kalimantan has eleven rooms including a laboratory which is never used.

Some staff felt that convenience and practicality had been less considered in the siting of health facilities; for example in peri-urban N Sulawe-

Box 18

There is a *pustu* but it was never open while we were there. We were told that *'it is not functional yet'* but it seems unlikely that it will ever be more than a posyandu venue.

Parallel RCA Study N Sulawesi

Another *pustu* has been renovated recently in another nearby village. It has accommodation for the PTT nurses but they refused to stay, saying they wanted to live in the city and would '*struggle in the village*'.

Parallel RCA Study N Sulawesi

A new *pustu* has been built up the hill but this is far from the centre. The rationale was that the centre of the village was 'smelly' but this new *pustu* is not used because of the hike up the hill

Parallel RCA Study SE Maluku

There is one *pustu* but always empty – nurse does not want to work there because there is a 'ghost in the *pustu*'

Parallel RCA Study C Kalimantan

The polindes was built just 2 years ago but is not used because it is next to the cemetery. In the neighbouring village the new poskesdes is just 10 minutes walk from the puskesmas and so is not used.

Rural C Kalimantan

The Puskesdes has no staff and no electricity . It used to be maintained by two midwives but since one left the other has decided not to stay. She is not popular anyway also not liked so only goes there to run a monthly posyandu

Rural N Sulawesi

si, the midwives work which involves check-ups is housed in a separate building away from the main building where registration and records are kept and in S E Maluku the maternity unit is also in a separate building with the midwives office in another building. Other examples are presented in Box 17.

The Utilities

The *puskesmas* in rural SE Maluku relies on its own generator as there is no electricity in the village. They complain that when they try to use the computer the lights dim and the dentist here has to do all the work manually. In rural C Kalimantan, the village is powered by a government provided diesel generator but only for some hours of the day (mostly evenings) and two years ago they had an emergency and the generator was not working. The *puskesmas* Head worries about having a repeat of this. Peri –urban C Kalimantan suffered long power cuts while we were staying and has no back up generator. In peri-urban SE Maluku the *puskesmas* Head prefers to store the medicines and vaccines at his house because his power supply in town is more reliable than at the *puskesmas*.

The water supply in C Kalimantan is poor with both locations relying mainly on river water which is semi treated and pumped to the centres. Water shortages are a problem here and in peri-urban S E Maluku.

Three of the six locations have very limited or no phone signal, which is especially of concern in emergencies or when patients need to be referred.

“We do need new equipment but we just wait for whatever has been planned from above –there is no way to ask.

-doctor N Sulawesi

The Equipment

There is often a mis-match of equipment with other resources which frustrate many of the health staff we interacted with. For example, there are specialists without the needed specialist equipment and brand new unused equipment without the expertise to use (see box 19). We came across a sense of powerlessness over this problem as a puskesmas head in peri-urban SE Maluku shared, ‘*In nearly ten years I have been Head, there has been no replacement of equipment even though I keep asking for it. For instance, we had three blood pressure meters before, but one had a broken part and then another had another broken part.*

“Actually we could handle accidents here without referral as we have the staff, but we don’t have the proper equipment.

-Peri urban S E Maluku

Filthy sink with mosquito larvae, peri-urban C. Kalimantan

Table 8: basic utilities at the health facilities

Very remote ↓ Not remote

Location	type	Water	Electricity	Phone signal
SEM1	PK	Well	Own generator	None
CK1	PK	River water	Govt generator	Limited
NS1	PK	Pump	Grid	Good
	PU	Pump	Grid	Limited
SEM2	PK	Well	Grid	None
	PU	Well	Grid	Good
CK2	PK	River water	Grid	Good
NS2	PK	Pump	Grid	Good

> **We just bring and use our own equipment to avoid risk of working with broken ones.**
>
> - Doctors rural S E Maluku.

> **I ask the doctors to bring their own stethoscopes and other equipment.**
>
> - Head, rural S E Maluku.

Box 19

The dentist unit has no special chair, no dentistry equipment and no electricity. '*I knew it would be a difficult posting and I had to bring my own tools*' shared the young dentist who has been there nearly two years. '*I have to do a de-scaling by hand , something which might take thirty minutes using an electric drill takes 2-3 hours…. I really think the patient should at least be comfortable during this time*'.

SE Maluku

Box 20

The ambulance was procured from the local government, but '*the charges for use are IDR 300,000 for the first 50km with additional km costing IDR 10,000.*' With district capital about 76 kms away from the village, the villagers need to pay a total of IDR 800,000 each time they are being referred to the district hospital. '*It was too much for the people, so in a community meeting it was agreed that ambulance user would only need to pay for the gasoline IDR 200,000 regardless of their Jamkesmas/ BPJS membership*' Ambulance services is supposed to be covered by BOK, but '*BOK disbursement has been stalled for the last 7 months, so some operational costs I take care of with my personal money first.*'

Puskesmas head, Rural SE Maluku

I became a handyman myself and just 'cannibalised' between the three so at least we have one that functions.'

Several facilities have a problem disposing of old broken furniture and equipment. For example in the *puskesmas* in rural N Sulawesi, the area is littered with old bed frames and mattresses. Old furniture is piled up in a corner downstairs, while the delivery room is equipped with an USG machine and other new equipmen is covered up and has never been used.

In the parallel RCA study a new *puskesdes* has a new maternity bed and chair, also still wrapped in plastic as it has been for two years as they have never been used. The midwife posted here only comes three days per week and leaves a note on the door on the other days. There has never ever been a birth here as people prefer to go to the district hospital.

Table 9 indicates that all the *puskesmas* facilities had working ambulances. Even so, they experience problems with maintenance and operating costs. For example a brand new ambulance has been provided in C Kalimantan but the allowance for fuel and maintenance is IDR 1 million/month which is not enough (see Box 20). To mitigate this problem in one location in N Sulawesi they have established a hospital transport scheme manned by volunteer drivers using their own cars.

Old furniture disposed in the backyard (Rural N Sulawesi)

Table 9: Working equipment at the health facilities

Very remote ↓ Not remote

Location	type	Beds/ mattresses	oxygen	USG	IV Drip apparatus	stethoscopes	ambulance
SEM1	PK	✔				✔ X5	✔
CK1	PK	✔	✔			✔	✔
NS1	PK	✔ X3	✔ X3	✔ unused	✔ X3	✔ X5	✔
	PU	✔ X2	✔		✔ X2	✔ X2	
SEM2	PK	✔				✔ X3	✔
	PU	✔			✔	✔	
CK2	PK	✔	✔			✔	✔
NS2	PK	✔ X2	✔		✔	✔ X5	✔

“If a patient comes and we don’t have medicines we give them vitamins. I tell them they can come back if they do not get better.

-SE Maluku

Box 21

The *pustu* has been given three beds and stirrups, all sent by ‘central government’ and the midwife says she does not need these. She has about <1 births per month The stirrups are just used as a toy by her boy.

Field Notes N Sulawesi

Box 22

There is a really old rusting ambulance and the roads are very bad. They prefer to use a boat to transport patients but some of the villages are not accessible by boat. The head of the puskesmas told me that he had made two requests for a new ambulance but they were always rejected. Finally he persuaded the legislative member who happens to live in the village to go with him to complain to the regional legislature. This time they were successful and have a brand new Ford Ranger. The puskesmas head has become the ambulance driver as he is the only one who can drive in the village.

Field Notes peri urban C Kalimantan

The consumables

Puskesmas suffer periodically from shortages of medicines. The Head in peri urban C Kalimantan shared his concern with his staff about the shortage of diarrhoea medication during the current ‘*diarrhoea season*’, nurses in several locations talked about running out and having to provide ‘*only vitamins*’. This is also echoed by patients who often told us when talking about their preferences for health services that they did not want to use the puskesmas because ‘*they don’t have the medicines*’. For example, the *puskesmas* in rural N Sulawesi often runs out of paracetamol and antibiotics and offers patients something similar or issues prescriptions for them to buy outside. The doctor here has approval from the Head to ‘*buy medicines from the provincial capital with my own money and I charge these to the patients.*’ The midwife of a *pustu* in rural N Sulawesi shared a particular problem where she ‘*couldn’t request medicine stocks when I was officially on maternity leave but was still having to provide services because I am the only one here. So I had to use what I could access myself*’. She also said that when she makes requests for medicines it takes a long time and often there is no response, ‘*I can be lucky and submit a request just when they are making the budget and will get what I need but most times it is just frustrating*’. A nurse in rural SE Maluku confides that ‘*I actually often am forced to break the stan-*

dard operating procedures, particularly in cases of emergency. For instance, an accident victim might need to be given IV and I can't do that if we don't have any syringes'.

The shortage of medicines and other consumables seems especially acute in the peri urban SE Maluku *puskesmas* and staff attribute this to the changing budget priorities of the local government, '*We cannot keep reusing syringes if we don't want something wrong to happen to our patients. Since we cannot restock based on needs, we refer patients to the hospital for treatment that we could actually have done here*'. The midwife adds, '*It is difficult to assist births here, even for normal delivery. With disposable stuff, like gloves, not being stocked regularly nor sufficiently, we are sometimes in trouble and find we have none left when needed. In the old days, we had re-usable gloves that could be washed and sterilised, so at least we knew we had some ready whenever we needed them*'.

> **"When the PTT doctors go on home leave, they bring medicines from Java as they are cheaper there.**
>
> -Puskesmas head, Rural SE Maluku

As well as priorities being dictated from the dinas, it was explained to us that medicine requests may be only made every six months. For example, in rural SE Maluku, the puskesmas head said that they check their stock monthly but only get re-stocked semi-annually. Doctors can recommend medicines that should be bought and these will have to be acquired by BOK (health operational assistance). Furthermore, requests may be supplied late, '*vaccines often come late and are insufficient so have to be bought for the puskesmas own budget*' (nurse SE Maluku).

Some find their own way round this problem, for example in rural C kalimantan, '*we nurses have our own stock and the doctor carries medicine with him all the time. All medicines in the puskesmas have to be paid for.*' (see also box 24).

> **"Dentists and doctors must supply their own anaesthetics as these are not funded by BOK.**
>
> - Doctor and dentist, SE Maluku

Box 23

"*I bring my own anaesthetic and charge patients IDR 10,000 each use so that I can top up. Even when the patients have Jamkesmas, it does not cover the anaesthetic. Medicines supplied by Dinas are only the basic ones, while gauze and other consumables are purchased from the operational health assistance (BOK). There is no particular allocation for anaesthetic*" When my mom and I were chatting on the porch, dentist Tika came over and joined us.

My mom said she actually had a tooth aching and Tika took a look at it and said "*you might want to have it taken out. It's that the only tooth aching?*" When my mom said "*yes*", she responded by saying, "*In that case, you'd probably want to wait until there are two or three problematic teeth, so that you wouldn't waste money on the anaesthetics.*"

Box 24

The doctor buys his own medicines and sells these in the puskesmas after hours. The midwife too has her own stock of medicines and goes to people's house. Both have the approval of the *puskesmas* head.

Box 25

In peri urban C Kalimantan the puskesmas government allocated budget for diarrhoea only meets 25% of its total needs. To cover this shortfall the puskesmas uses the 'civil-servant and PTT incentives from the APBD of IDR 35,000/person per day cover the rest until we receive annual reimbursement from medicine purchase of kartu (card) holders.'

In C Kalimantan we observed that large quantities of drugs were available in the local market and this is discussed further in the section on the patients below. People often tell us that the medicines they buy are '*better*' than the free ones from the *puskesmas*, whether they are bought from the market or from the puskesmas. For example people in C Kalimantan told us they preferred using the *puskesmas* after noon when the Jamkesmas was no longer accepted because '*After this we have to pay for medicines. Actually the ones we pay for are often better*'. The nurse here confirms that they pay IDR 30,000 '*out of service time*'. The Head of the *puskesmas* in peri urban SE Maluku shares patients frustrations '*we only have a minimum range of medicines*'. People in C Kalimantan (parallel RCA study 6) said simply '*there is no point in going to the puskesmas as they don't have the medicines, so we go to the kiosks in neighbouring villages*'.

The nurses of the peri-urban SE Maluku *puskesmas* share similar exasperation, '*We actually don't like to refer patients for things we would've actually been able to deal with ourselves… but how else should we get by? There was once a memo from the district hospital circulated to us which listed 150-160 types of illnesses puskesmas needs to handle itself and not rely on the referral system. But how can we handle them when we don't even have enough medicines for simple illnesses?*".

The staffing

Nobody suggested to us that the facility where they actually worked was over-resourced but those struggling to manage small facilities on their own, pointed to the large numbers of staff in the *puskesmas* who were often perceived to be doing very little. Table 10 suggests that there is a degree of over-resourcing, but even when staff knew that we could clearly see that they were not overstretched, some still persisted in suggesting they needed more staff. For example, there are at least 11 staff in the rural N Sulawesi *puskesmas* and on its busiest day, which is the market day, there can be a maximum of '*20 patients coming here*'. However, a doctor uses the official ratio argument '*there is supposed to be one doctor for 1,000 residents and here there are 6,000 residents, but we have only two doctors.*' At another time, he confirmed that he can still have a proper sleep on his night shifts as the in-patient and emergency rooms are usually empty. Using the same logic, a *puskesmas* Head elsewhere shared, '*I feel the need to have more than one doctor, as it is tiring for the doctor to take care of 3,000 people.*' (rural C Kalimantan) but when we visited the puskesmas there were less than 10 people attending the morning clinic and other conversations suggest it is never more than this.

In peri urban SE Maluku, there are twenty four staff officially posted but there are

Table 10: Puskesmas staffing

Very remote ↓ Not remote

Location	Numbers of staff	Population theoretically served	Daily out patients numbers (average)	Monthly births (average)
SEM1	20	1,000	2-7	3
CK1	18	3,000		
NS1	25	9,000	10	<1
SEM2	30	500	3-7	4
CK2	14	3,000		
NS2	50	30-34,000	<30	

> **the region needs a paediatrician and a surgeon. Even an obstetrician/gynaecologist isn't available in the district capital. So can you imagine a GP having to do an emergency Caesarean there?.**
>
> -PTT doctor, SE Maluku

actually 30 people working in the puskesmas, which serves a small village of around 500 residents. Everyone thinks the number is '*too much*' and the *puskesmas* Head already requested to the Dinas office not to assign anymore staff there. But, '*Dinas still sends some because the civil-servants themselves may request directly to Dinas to be posted in a particular place. Even now we have a freelance staff here because she requested to be assigned to accompany her army husband who was recently transferred to the area. I cannot say 'no' to such arrangements.*'

About 20 staff work in the rural SE Maluku *puskesmas* for a population of around 700 villagers with a further 300 people living in the catchment villages. Two GPs and one dentist are allocated here but their daily working schedule seems pretty relaxed and the dentist says the number of patients she has seen in nearly two years does not '*even reach the fingers of two hands*'. In peri-urban N Sulawesi, where the locals do not seem to be aware of the existence of the new *puskesmas* and still refer to the old one there are about 50 staff. Anyway here, people prefer to go into town for health services.

When a *puskesmas* is over-staffed there are higher rates of absenteeism. For example the hugely over staffed in peri urban SE Maluku *puskesmas* the Head shares, '*When a staff's child gets sick, they are absent… when their parent gets sick, they are absent… when they themselves get*

Box 26

About a year ago, the situation started to worsen when Neti's uncle's wife was posted to the puskesmas. This aunt is junior in terms of posting, but senior in terms of age and family relation, which makes it difficult for the nurse in charge (Neti), '*It is too tangled and making me stressed out. I'm already working here for quite a number of years and have a 'jabatan (good position)', but I can't do anything about my aunt who is often absent and skips her administrative tasks, it is eventually myself who has to take over.*'

SE Maluku

Since the puskesmas doesn't have a cleaner, there is a daily cleaning-rota for staff. But the older staff don't want to do cleaning, neither do those who live out of the community.

SE Maluku

There is supposed to be a rota among the midwives for the home visits but the young honor nurse who has been assigned to work with the midwives does nearly all of these. The midwives go home around noon and she carried on making visits using her own motorbike.

Peri urban C Kalimantan

Box 27

'Here we have a three day shift to cover the emergencies. There are traffic accidents here, so people are often not locals. We have a day shift from 8am-2pm on the first day, followed by 2pm-8pm on day two and then an overnight shift on day three. Overnight shifts from 8pm to 8am are easy as I simply sleep in the emergency room. Then I should get two days off but I am covering for another. I don't mind this as I can accumulate leave if I do three lots of three day shifts in a row can go home for two weeks at a time. Today I have just finished night shift so am doing the early day shift again.'

So on day 4, the doctor finished the night shift a little early, had a shower, breakfast and returned to the emergency room. He took a long lunch break of two hours and finished at 2pm. No patients came that day so he spent a little bit of the time completing the BPJS report using his own laptop. Then he watched TV.

Rural C Kalimantan

sick, they are absent.' A villager shares similar annoyance from personal experience, '*I had waited for several hours to get some medicines because the dispensary was still locked while the staff keeping the key was absent. Then I had to wait for a referral letter, but not even a piece of paper was available. What are they doing with that many staff, if such things such are what happens to me?*'.

Some staff are just not there. In both this and the parallel RCA study, people told us that one of the main reasons they did not bother to go to the *puskesmas* or *pustu* was because the staff '*were not there*'. There were several examples, including the midwife posted in the rural N Sulawesi *pustu* in this study had been '*gone for three weeks*' and nobody knew why and the environmental health specialist who was described by his colleagues as '*only coming to work when there is dengue outbreak otherwise we never see him*' (peri urban, N Sulawesi).

In peri-urban N Sulawesi and both locations in SE Muluku in particular, people talk about the cadres as '*only weighing and recording the weights in the posyandu book. While immunisation and all the outreach programmes are done by the puskesmas people.*' As there are generally five cadre in each village the work is distributed between them at the *posyandu*. In some places this means some now work with the elderly and others may cook if there are feeding programmes. Many we interacted with in this study and the parallel RCA study felt that they could work for more than this one day per month and would like to do more than the menial tasks.

Rotas and division of work/workload

Rotas operate for many of the tasks in the *puskesmas*; reception, emergency, dispensary and cleaning. Not every one is trained for job, for example an *honor* nurse is running the dispensary (peri urban C Kalimantan). Others are trained but not doing their own job, for example the nutritionist in peri-urban C Kalimantan was judged

Box 28

The Head of the puskesmas said that relations between the trained health professionals and local informal health providers used to be poor and there was jealousy. However, after much discussion, they agreed about five years ago to support each other and if patents want to use informal providers they need to be accompanied by the nurses and doctors from the puskesmas. The Head likes to include the informal providers in events and meetings at the puskesmas.

Field Notes , Peri- urban C Kalimantan

But this does not concur with the view of the TBA who shared 'TBAs are not allowed to help deliver babies without a nurse present. If I did I'd be handcuffed'

Filed Notes, peri urban C Kalimantan

Box 29

Nurses told us they had been 'very busy today'. They had just received training from someone from the dinas on how to upload patients records from their manual system to digital and so they had had to stay until 4pm. But the next day it was normal again, sitting around chatting. They rarely get more than one patient per day.

Field Notes SE Maluku

We came across the same thing in C Kalimantan. Nurses were busy the first day with updating the health card and this required two on reception but the next three says they sat around doing nothing all day.

Field Notes CK2

Observation 1

There are two nurses at the reception desk. They find the files -they know all the regulars anyway and none bring their health cards. They take the blood pressure of everyone who comes and then pass the file to the doctor or midwife. But there are never more than two patients per day.The patient sees them and then goes to the dispensary. There are always four or five staff here just chatting. Two other staff stay in the emergency room but during the four days we were staying there was only one case and she was quickly referred to the district hospital.

N Sulawesi

as '*having little work*' so is appointed to work as administrator '*the helping hand for the Head of the puskesmas*'. Even though there is a school biscuit programme, she is not involved in this and only manages the general administration.

Some *puskesmas* do not have cleaners, so this responsibility usually lies with nurses. For example in peri urban SE Maluku '*we make a weekly rota for cleaning by all staff*,' (Nurse). However, this rota is not necessarily being followed as people refuse or pull rank, so the nurse who is the only one living in the community says '*I end up doing the sweeping and cleaning every day, since I live next door*'. (NS1)

3.7. Our patients

Across study locations, both in peri-urban and rural areas, *puskemas* patients mostly consist of farmers, forest workers, plantation workers and fishermen with very small numbers of government or private sector employees. Observing several *puskesmas* morning clinics, it seems that those who use the *puskesmas* are mostly from lower socio-economic groups. They go there '*for non serious everyday things*' but most people tell us they prefer to deal with *everyday ailments* with their own treatments or buying medicines from kiosks or pharmacies in town. Where regular tests and monitoring are required, such as for diabetes or hypertension, then people like the convenience of using this local service, but will also use the same staff when they practice privately after *puskesmas* hours. In C Kalimantan diarrhoea is common and in the peri urban location there is a special budget to tackle it.

Box 30

'My' neighbour is a simple farmer who lives in a simple house without a toilet and has never has Jamkesmas. Yet she can list by name all the medicines that she needs and buys them directly from kiosks.

Field notes Study 6, N Sulawesi

"It is cheaper to buy in the market, as the *mantri* is often not available in the *puskesmas*, it would be a waste of time and transport cost to come to the *puskesmas* and then we would still have to go to the market in the end.

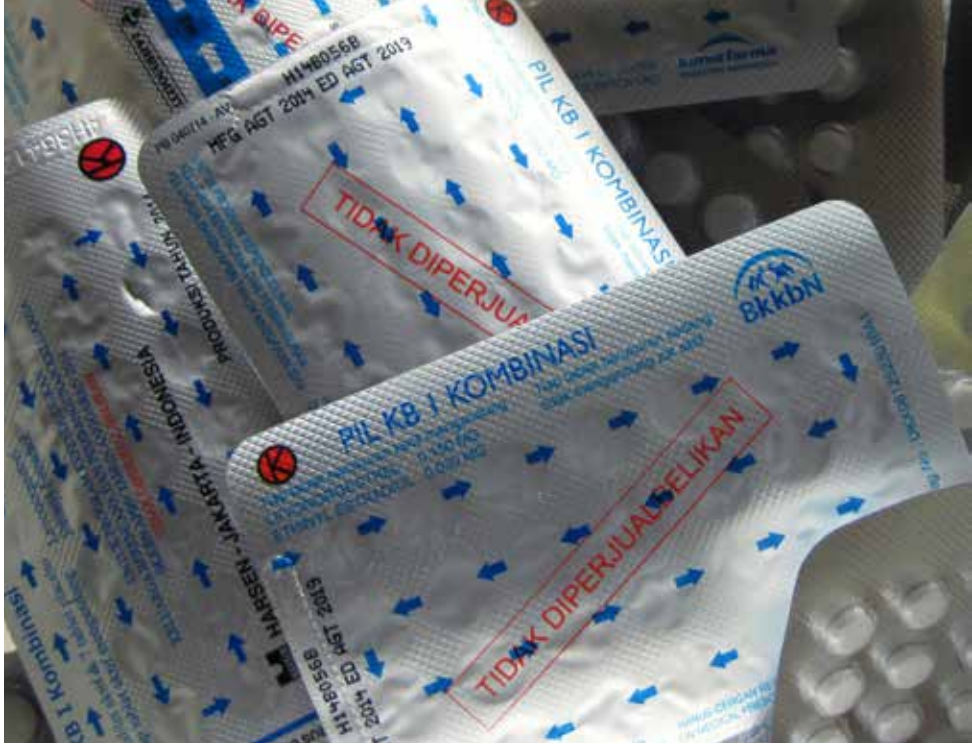
-C Kalimantan

Challenges we face with our patients

People prefer to buy their own medicines rather than come to the *puskesmas* because it is more convenient, they can buy in small amounts and they don't waste time going to a puskesmas only to be told they have run out. Some claim that the medicines they buy directly are better than those provided by the puskesmas. For example, several mothers in rural SE Maluku explained that they prefer to buy common medicines from kiosks as they believe. '*medicines sold there are more potent than the ones we can get for free in the puskesmas. We can immediately feel the effect.*'

But this preference undermines the work of the *puskesmas*. In rural C Kalimantan a huge range of medicines are available for purchase in the local market. Many have 'not for sale' stamped on them and are available at affordable prices such as IDR 3000/strip. People can also buy injections and will then get the '*mantri*' to give them the shot. They refer to these pills by colour and shape, '*green for asthma with coughing, white for regular asthma and pink for asthma with coughing and slime*' and these are sold in unmarked bags at IDR 6,000/bag. The medicine sellers told us, '*We get our stock from the city*,' . Their stalls were very popular and crowded and buyers told us, '*the sellers know about the drugs, they must have the same knowledge as the nurses.*' Kiosk owners from neighbouring villages buy from these market stalls.

The idea that medicines sold outside of the *puskesmas* are better is not always challenged by formal frontliners, especially if their own private practices benefit from this view.



Wide range of medicines readily available in weekly market, rural C. Kalimantan

Table 11: Preference for places to get medicines

Very remote ↓ Not remote

Location	Puskesmas/ other health centres	Private practice (doctor)	Private practice nurse/ midwife	kiosks	Market	traditional healers	Reason for preferences
SEM1	✔		✔ ✔	✔ ✔ ✔		✔	More readily available and/or nearer access for the locals
CK1			✔	✔ ✔	✔ ✔ ✔		
NS1	✔	✔	✔				Depending on time & kinds of meds
SEM2	✔ ✔ (Hospital)	✔	✔	✔		✔	Proximity to town, strong belief in traditional remedy & herbs of the area
CK2		✔ ✔	✔ ✔	✔	✔ ✔ ✔	✔	
NS2	✔	✔ ✔	✔ ✔	✔	✔		Private practice or hospital in town due to proximity and more variety

"I always bring my family to the private doctor whenever they are sick.

-Cadre

As well as the preference for purchasing medicines away from the *puskesmas*, informal health service providers are also often preferred. Formal providers shared different views of these and some attempts to work with them or curtail their work are discussed later in this report. In the peri–urban *puskesmas* the staff accommodated the two shamans who were summoned by the community to attend the boat captain who met an accident while we were there. '*It is fine for the shaman lady and man to come, as long as they don't interfere with the medical treatment*' and they were allowed to incant as one applied star oil. During a follow up chat with the doctor the next day, she told us that she felt the star oil may well have helped the patient.

The PTT doctor in another C Kalimantan location has learned to accept this from an early experience after being posted here, '*I was called to do some shots, and I was already preparing to give it to the patients when a local elder suddenly shouted* 'Wait… what day is it today?' 'Tuesday' … *then I had to delay my shots to Thursday as 'it is a good day for a shot*'. Another nurse in SE Maluku condoned the traditional medicines which have been passed from generation to generation in some cases, such as for a woman with cancer, saying '*She is very weak. And I can only give her vitamins and pain killers. What more can I do for cancer patient here?*'

Sometimes the *puskesmas* is simply not the most convenient choice either because of its location or opening hours. Many villagers living in the peri-urban SE Maluku location shared that the '*district hospital is so close*' and '*the hospital has a complete range of medicines and is accessible at any time*' so '*we prefer to go there instead of puskesmas.*' Men in the fishing village in this catchment area said, '*we don't mind paying for the medicines and the transport to go to hospital, as long as we know we can get well immediately. Puskesmas gives us free medicine but we still do not recover quickly. As fishermen, we rely so much on our body and health that we cannot afford being absent from the sea too long.*'

Box 31

The kiosk owner knows that some of the medicines she sells are prohibited but she gets them from her pharmacist friend in town. Everyone knows exactly what they need and she can offer substitutes if she doesn't have them in stock. She explains she has learned this from her friend. People say they like this kiosk because the medicines work and are strong- '*better than the free ones*'.

hygiene and Nutrition RCA study,
N Sulawesi

Sometimes people simply do not know what services are available in their own *puskesmas.* This seems especially true of people living in the peri–urban locations. For example, in peri-urban N Sulawesi, the locals could not tell us who the health providers are and where they are actually stationed, '*the GP is in the neighbouring village*,' says one while the doctor is actually in their village and '*The midwife works in the old puskesmas*,' but the midwife later confirms that '*the old building has not opened for service for more than 3 years*'. Local people did not know what facilities the *puskesmas* actually has claiming, for example, '*we have to go into town for a scan because they cannot do ultra-sonogram at the puskesmas*' when in fact it can. Only an hour drive from the provincial capital and half an hour drive from the district capital, access to other health providers is very easy with a number to choose from. An *angkot* (mini bus) ride to the district hospital costs only IDR 4,000. In peri urban C Kalimantan, people say there is no doctor at the puskesmas but unusually a woman we met in the market said '*people here don't know that there is a doctor at the puskesmas and it is not like you will be treated by a nurse. And you can get free medication here*'.

Health providers at *puskesmas* also explain the low numbers using their services may be because of '*laziness*'. For example, '*patients are lazy to come here -they know we are here so why don't they come? They want us to come to them*' (*puskesmas* Head rural SE Maluku) or '*encouraging people to come to the posyandu can be difficult, especially for senior citizens who find it hard to walk this far. They prefer to stay at home and want us to visit them at home*' (cadre SE Maluku) or

"In almost two years I can count the number of patients I have seen on the fingers of two hands. I used to try to encourage them to come. I think many think it will be expensive and they do have to pay for the anaesthetic.

-Dentist, SE Maluku

"The well water here tastes salty. I never drink from the houses near the beach as they don't filter their water even though I have told them many times.

-Nurse peri urban SE Maluku

'*Some older people living on own have problems going as there is no one to assist them*' (nurse, rural N Sulawesi).

Health providers also complained to us that people do not listen to their advice, a common complaint heard in the parallel RCA study on hygiene and nutrition. For example, in peri-urban SE Maluku nurse complained that she was always telling people about the dirty water they were drinking but nobody took any notice. Another midwife in rural SE Maluku shared how a woman had had a difficult labour because she had not listened to advice to take exercise during her pregnancy. A *honor* nurse we accompanied on a home visit was frustrated that the family refused to let her give their newborn a hepatitis jab and a midwife told us '*all the staff at the posyandu feel the same- we are tired of giving advice on breast feeding, nutrition and sanitation because people don't listen to us. We just take photos of the sessions now and don't bother giving any advice*'.

Others shared that they face problems with patients expecting all the services at the *puskesmas* are free. Echoing others, a doctor in peri urban SE Maluku told us, '*since the message of free health is widely known, they demand everything for free although the government budget received by the puskesmas is limited to cover only certain items.*' Another staff adds that '*programmes actually cannot all be free as some materials like gauze and syringes need to be periodically replenished, and the only way to do this is to charge people. Even though this may only be IDR 3-4,000, the understanding of 'free health' leads people not accept any charge whatsoever.*"

What patients like about us

Continuity and residence are important criteria for health service provision according to the communities. They like to feel that there is a relationship and trust with the health providers regardless of whether they are formal or informal.

Villagers in rural N Sulawesi said *'a good puskesmas is one with residential doctors.'* There are few civil-servant doctors in this district, so '*we only have PTT doctors in the village, it is difficult to get civil-servant doctors as we are far from the city.*' The villagers also think it is better that '*the nurse is always here and she will be able to refer us if she doesn't know what to do.*' Others added, '*we are very comfortable with the ones who have been staying here for a long time. These ones let us pay them later*' suggesting also the importance of trust. In rural SE Maluku the PTT doctors leave at weekends so the community appreciates the nurse couple who have been staying in the village for 13 years. We observed that people really like them and they get along well with the villagers. In a village in SE Maluku visited in the parallel RCA study on hygiene and nutrition, people were quite upset at the loss of their PTT doctor who had completed his contract. When he left (with a big party) all the programmes he started also stopped.

Being approachable, making home visits or being available for patients out of hours, being '*smiley*' and trusted were all attributes listed often across locations in both this study and the parallel RCA study on hygiene and nutrition. TBAs are often held in high esteem and affection because they fulfil these criteria.

Challenges patients face with us

Among the most often cited reasons for not using *puskesmas* services is that opening times are only in the morning (which is not so convenient) and, even then, open late and close early. For example, men in rural SE Maluku said they preferred to visit the nurse in the early evenings (around 6-7pm). Many said in peri urban SE Maluku '*the puskesmas should be open 24 hours and serve us in the evenings. We have to work first and can't go in the middle of the day- this is why we prefer the hospital in the city or private hospitals*', and opinion shared by the rural C Kalimantan who are mostly busy working during daytime. In C Kalimantan we were told '*we have to go before noon to use Jamkesmas*' and that was not always possible. Table 12 provides our observations on opening and closing times and not one facility opened for the times displayed and three facilities had no opening times displayed.

People complain that staff are often not there so feel their visits are wasted. Sometimes they turn up and the facilities are locked. Again our observations and conversations with their colleagues found that some staff were absent longer than they had agreed to be, for example extending their Lebaran holidays by several days. Throughout our C kalimantan locations there is a common practice of '*forging attendance to have a longer Eid holiday*'.

Others were absent and according to communities had been away inexplicably for long periods. In the parallel RCA study in N Sulawesi, people complained that the midwife was rarely there, '*she took a pledge for work but she does not follow this*'. In peri urban SE Maluku people living near the *pustu* prefer to go straight into town as there is only one nurse in the *pustu* and others closer to the *puskesmas* also prefer town because the contract doctor only comes on Mondays, Wednesdays and Saturdays and '*the nurse comes and goes so we are never sure if she will be there*'. In rural SE Maluku people told us they only need the *puskesmas* for referral letters but were frustrated that it was often closed.

As well as a lack of clarity about what constitutes a working day (see observation 2), coming late to work but still signing on the attendance list just as a full work-day often creates conflict. As an administrative officer in rural SE Maluku told us, '*Ijin telat*' (clearance to come late) is actually granted

Table 12: Opening time and information on it

Very remote ↓ Not remote

Location	Opening times	Actual time observed	Information on opening times?
SEM1	9:00	Depending on patients arrival	in Puskesmas board
CK1	8:00 - 15:00	08:00 - 11:00	in Puskesmas board
NS1	08:30 - 14:00 ER 24 hrs	08:30 - 12:00	no display
SEM2 PK	08:00	09:30	in Puskesmas board
SEM2 PU	08:00	09:00 - 10:00	no display
CK2	08:00 - 15:00	08:00 - 11:00	in Puskesmas board
NS2	08:00 - 14:00 Maternity unit 24 hrs	08:45 - 13:00	no display

“Staff are not disciplined in terms of work time, but there is nothing I can do as a *puskesmas* head, it has much to do with the civil-servant sanction.

-Puskesmas head, SEM-2

Box 32

On the day we visited the *puskesmas*, most workers finished working by 10 am and spent the rest of the time chatting with one another. The puskesmas head is in charge of 15 staff and said ‘usually I work between 8 – 11 am’.

Rural C Kalimantan

Most staff usually arrive at 9 am and if there are not many patients, which seems to be the case when we were there, they close at 1 pm or the latest at 2 pm.

Rural SE Maluku

‘We close on Sunday but open on Saturdays but on this day it I up to us what time we come and how long we stay’.

Peri urban C Kalimantan

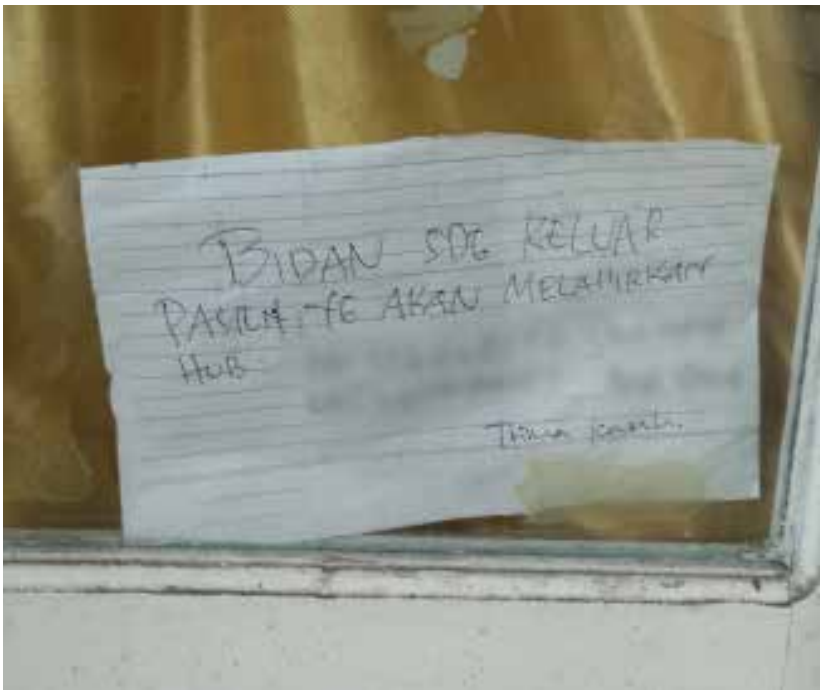
An elderly man came as the first patient at 7.30am to have his blood pressure checked but was not attended to until 10.30 am. No other staff except the ‘key-keeper’ nurse who lives next door came in before 9.30 am which is usual the arrival time of the puskesmas head.

Peri urban SE Maluku

quite flexibly and bears no financial consequences, ‘*as long as the staff informs me in advance*’. But ‘*the conflict is incited more by a little personal competition or jealousy from the ones doing an a full day’s work and who don’t come late*,’ a doctor observes.

A recurring complaint heard in this study and the parallel RCA study on hygiene and nutrition is that health staff do not provide sufficient information and advice. The following quote sums this up,

> ‘*The nurses here lack knowledge and don’t encourage the patient. They just tell them to take the drugs without any explanation. So we prefer to go to the puskesmas in town or the nurse who gives private treatment. He is very popular and everyone says he gives good service. You have to call him on the phone first and make an appointment. He uses traditional and modern medicines*’ (C Kalimantan).



Note left on the door of 24h maternity unit providing a telephone number to call, peri-urban N. Sulawesi

This is a different view from the health providers mentioned above who share their frustrations with people not listening which has resulted in giving up providing explanations.

As already noted above there is a perception that the medicines received from the *puskesmas* are '*not complete… we don't get good medicines at the puskesmas and don't get better from these*' (peri urban SE Maluku). Also mentioned above is the frustration that medicines are often not available at the *puskesmas*.

People shared that they sometimes avoid going to the *puskesmas* because of fear of unfavourable diagnosis or fear that the costs of subsequent healthcare will be too great. For example, in rural C Kalimantan a referral may entail a costly speedboat journey to the district. Health providers often get the request '*Please do not refer me*' as acceptance of the situation is '*better than burdening the family with debt.*' In peri-urban C Kalimantan, mothers worry about being referred for a Caesarean which might cost '*10 million rupiah*'. This fear of referral and the fact that '*if we don't have money we don't need to pay*' also fuels the preference for TBA assistance with births.

Going the extra mile

While there are reasons why people do not use their local health facilities and complain about staff absenteeism and lack of medicines, there are some providers who '*go the extra mile*' to serve the community as the following illustrates;

Observation 2

I was invited to join the staff meeting one morning held in the corridor of the puskesmas. The new puskesmas head addressed the staff on several issues.'As all the civil servant (PNS) staff get a daily allowance, it is important that we agree what constitutes a 'day' and what absence means.' After some long discussion it was agreed that a day meant 8.15 am until 11.45 am.

Field notes C Kalimantan

Box 33

A midwife charges IDR 500,000 – 2 million for assisting with birth at home

Peri urban C Kalimantan

'I have been checked twice by the midwife in puskesmas, for free. But I need to have IDR 500,000,- if I want her to help me to deliver at home.'

Young pregnant mother, peri urban SE Maluku

Traditional birth attendance card showing she was trained in the 90s, rural N. Sulawesi

A midwife in a sub-village in rural N Sulawesi is really liked by the villagers as '*she is always there at the pustu and unofficially provides 24 hours care*'. She rarely takes a vacation. She is a local, so she says '*I don't have the heart to charge after work hours, as they are my friends or my father's friends.*' In another sub village here people like the TBA as has been working for 25 years and spends time with the mother and '*she is present at actual birth and knows when to refer.*'

3.8. The services we provide

The *puskesmas* is supposed to provide a mix of curative, preventative and monitoring and surveillance services to the community. Most of the *puskesmas* within this

Observation 3

For the previous two days the staff had mostly just sat around chatting but on the third day around 2pm, there was suddenly an emergency, A boatman had been badly injured when the timber load we was transporting shifted. All the staff leave at noon and most live away from the puskesmas. The injured boat captain was brought to the *puskesmas* and the doctor summoned from her house behind the *puskesmas*. An *honor* nurse and nurse administrator who live in the community were also called on their mobiles. The IV drip was at the home of the *honor* nurse so she brought it with her but they did not use it in the end. They cleaned up the blood and bandaged his arm and spent some time arranging for his transfer to the district hospital. The ambulance was broken and so the logging company provided a car and it was waiting for this to arrive that took the time, some 2 hours.

Peri urban C Kalimantan

study and the parallel RCA study on hygiene and nutrition do have not particularly busy out-patients clinics (the busiest sees about twenty patients per day). *Posyandu* programmes are almost everywhere and are regular and the most conspicuous monitoring programmes.

Curative health

As mentioned above, the perception is from patients and health providers alike that the *puskesmas* can generally only provide basic care, either because it lacks resources or in-patient facilities[14]. Our conversations suggest that it is often seen as service for common ailments or in a kind of 'first responder' role in the case of emergencies and accidents which are generally referred on.

Attending out-patients clinics ourselves, our observations confirmed that most people who used these services were having common ailments or getting their blood pressure checked.

Given the limited facilities, the two emergency situations we witnessed were seen by those from patients family present to be dealt with efficiently.

Preventative health

Our observation from all the study locations that there seems to be more emphasis on preventative health in *puskesmas* is borne out by a doctor in rural SE Maluku, '*there are more preventive programmes here, so they go to the field more compared to Java where most activities are done in the puskesmas.*'

We came across the following programmes:

- *Biskuit Sekolah* (Biscuits for the Malnourished at School)
- Tuberculosis and Malaria detection
- *Kesehatan Ibu dan Anak* - KIA (Maternal and Child Health)
- *Perilaku Hidup Bersih & Sehat* - PHBS (Clean and Healthy Behaviours towards Life

Box 34
'*Tas Siaga* (The Alert Bag)'

Tas siaga is ready to grab anytime in case a mother in labour needs her help. Just a few weeks ago she took her bag and helped a mom give birth in the *mobil siaga* (a pick-up driven by a volunteer). This week, she had a 40-year old mom in the final countdown of her fourth child's birth. Second night we were there, the husband of the pregnant mom came to fetch her. She grabbed her bag and went straight to see the mom. Twenty minutes later she retuned to call the *puskesmas*, to make ready to refer as *'it is too risky to deliver at pustu*'.

A *siaga* pick-up was immediately sought by the father, and 15 minutes later it was ready in front of the *puskesmas*. Mom in labour was fetched from home by motorbike and soon sat besides *ibu bidan* and the driver. Forty five minutes on a bumpy road we finally reached the *puskesmas*. *Bidan* stayed with the mom until 10 a.m. the next day and came back home with an update that the mom had been further referred to the hospital and gave birth there.

Rural N Sulawesi

[14] Three *puskesmas* observed in the study had in-patients facilities

- *Senam Jantung Sehat* (Healthy-Cardio Exercise) for the elderly

The GSC (*Gerakan Sehat Cerdas – Healthy and Smart Movement*) programme encountered in SE Maluku was explained by the kecamatan-based GSC officer whom we happened to meet as:

> '*a programme funded by PNPM Mandiri under KPMD (Kader Pemberdayaan Masyarakat Desa –Empowering Village Cadres) and implemented through the kecamatan. GSC have their own food supplement/nutrition programme and other programmes depending on the request of villages to the kecamatan GSC. GSC make use of posyandu cadres who are trained by puskesmas and get incentives of IDR 50,000 for each activity.*'

But a GSC cadre in this village said of the programme, '*it is a new programme starting in their district from January 2015. But there have been no funds for 7 months so no incentives have been paid and no village programmes actually carried out*'. In peri-urban SE Maluku there had been GSC but nothing currently.

The Biskuit Sekolah (School Biscuits) programme was active in rural SE Maluku during our immersion in the villages. It is, part of the KIA (Kesehatan Ibu dan Anak – Maternal and Child Health) programme of the puskesmas but independent of GSC. It was remarked that the visits which we accompanied were '*the first time ever*'. Our parallel RCA study on hygiene and nutrition describes these sessions in more detail.

The peri-urban *puskesmas* seems to be a little more active than the rural ones as a doctor from C Kalimantan observed '*there are other programmes like KIA, PHBS (Perilaku Hidup Bersih Sehat, Health and Clean Behaviour Programme), and Senam Jantung Sehat (Heathy heart calisthenics) for the elderly. We implement such programmes in the bigger village because it has four times more residents*'. C Kalimnatan peri urban *puskesmas* had a school

Box 35

We hold the posyandu on the 15th of every month. Immunization, checking of pregnant women and sometimes supplementary feeding of babies and infants, but only if we have the budget and then we make green bean porridge or chicken porridge.

Cadre, SE Maluku

'brushing teeth' programme in August. In the peri urban SE Maluku there had been a TB programme involving house visits, '*there is no other way than for the team coming to people's houses one by one to check*,' a staff shares.

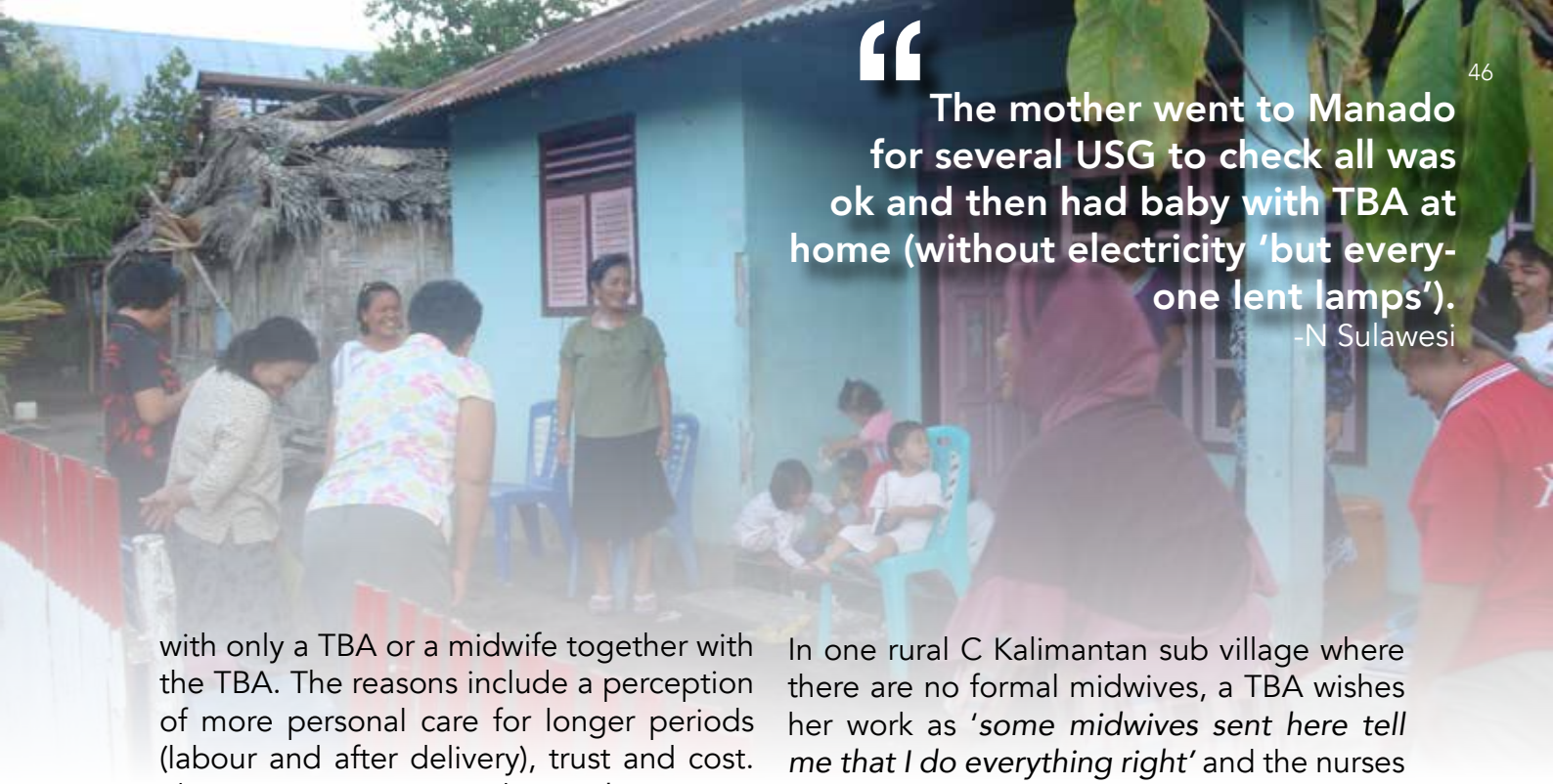
These outreach programmes are often viewed as a means to '*to attract more people making puskesmas as their first contact*.' (doctor C Kalimantan). Echoing others, the *puskesmas* Head in rural SE Maluku feels that '*penyuluhan (dissemination) programmes are successful only if they include food supplements*', although he also noted the cadres were not very active here.

The *posyandu* is held monthly for baby and toddlers, pregnant and breast feeding mothers as well as the elderly, and cadres told us '*if there is no posyandu, we don't work. Only occasionally in a year there is another programme which we are invited to be involved in, like programmes from BKKBN* (the National Agency of Demography and Family Planning*) and PKK* (Family Welfare Programme*).*'

Staff of puskesmas sometimes shared with us that specially liked implementing the outreach programmes and for some, especially those in not very busy facilities, this seemed to be because it gave them something to do and report on. Accompanying different nurses on Biskuit Sekolah they separately acknowledged that they could finish their day early and go home.

Giving birth

As other RCA studies have found, mothers often prefer to give birth at home either



"The mother went to Manado for several USG to check all was ok and then had baby with TBA at home (without electricity 'but everyone lent lamps').
-N Sulawesi

with only a TBA or a midwife together with the TBA. The reasons include a perception of more personal care for longer periods (labour and after delivery), trust and cost. The maternity units in the *puskesmas* included in the study were rarely used (see Table 10) because of this preference but also because of lack of facilities and staff as well as fear of referral (patients) and risk aversion (midwives).

Despite the national policy framework recommending collaboration between midwives and TBAs at the village level, it is only in one of peri-urban sub-village in C Kalimantan that the *puskesmas* Head talks about '*a formal arrangement of collaboration for the last 5 years*' between the two. He ensures that '*TBAs are always invited to regular meetings with the midwives.*' In other RCA locations the relationship is somewhat hostile with TBAs often feeling marginalised and persecuted.

Box 36

We do the same job as the midwives. I was trained at the sub district by the midwives at the sub district puskesmas a long time ago and we were trained how to assist with births. I can do it properly. We should get a wage form the government because we do the same job in the village as any formal midwife. The main difference is that we don't use injections or drugs but use massage and herbs. Usually people pay me with rice, coconut, sugar and sometimes some money.

TBA, peri urban C Kalimantan

In one rural C Kalimantan sub village where there are no formal midwives, a TBA wishes her work as '*some midwives sent here tell me that I do everything right*' and the nurses like her because '*she takes care of the whole pregnancy period, good at massaging and turning babies around and takes out the placenta well.*' Mothers say that '*she checks in on us three days after giving birth and will stay at least one night with us to help clean and wash*'.

In another sub-village here, the TBA is considered as one of the village elders and is respected by the nurses who say, '*We can only assist the TBA to deliver the baby, she does the main job and occasionally offers advice. We are nurses, none of us are trained in midwifery.*'

In peri-urban C Kalimantan a TBA shared, '*when there is a complication like breech*

Box 37

The TBA is in her late 60s but she has a card showing that she was trained at the district hospital. She was also trained several times at the puskesmas. She knows when to refer patients and when she attends mothers she always asks the nurse to come to give the mothers their 'TT shots'. She has a special room in her house for birthing. Mothers can stay at her place for several nights if they want to and she takes care of them. Its clear why people prefer her. She has been a TBA for more than 40 years and in all that time only three babies died and each of these were actually still births.

N Sulawesi

Observation 4

In two different provinces, we heard the experiences of midwives which suggest a higher risk aversion, and preference to refer. In rural N Sulawesi the midwife is cautious after an earlier experience of '*delivering an already dead baby. Even though the family had accepted my explanation, I couldn't sleep fearing the consequences from the Indonesian Midwife Association committee in town. I had to prove to them that I had followed operating procedures.*'

Another in rural SE Maluku chooses to avoid handling difficult labour, '*It took so long and she couldn't cope with it, so I referred her. I didn't want to be blamed if something went wrong.*'

or dystocia, families refuse to go to the puskesmas because sometimes a midwife doesn't know what to do'. Midwives sometimes tell TBAs not to massage mothers while they are in labour but '*some mothers feel massages soothe the pain*'. Other differences in service include '*midwives always cut the umbilical cord immediately, but this is not preferred by the locals. It is important that no hands go inside, it is not liked by mothers.*' And this was explained by mothers that the TBA will only '*cut when it stops beating.*'

In peri-urban SE Maluku, a TBA stopped her practice a year ago when an experienced nurse came to live in the village but still says, '*I can never reject if people come to me asking for help.*' She took part in the 'bidan terlatih' (trained midwife) programme to work with the 'bidan desa' (formal midwives sent to villages) but says '*nowadays, government regulations no longer lets the bidan terlatih assist deliveries.*'

Box 39

'Confusions often waste time as the following illustrates; a mother wanted a referral letter for her son to go to hospital. She was asked for her 'kartu' and she went home to get it. Returning with it the puskesmas head pointed out that it was not the right card as it belonged to a relative so she could not use it'

Peri urban SE Maluku

Box 38

Since 2005, there has been pressure 'from above' to reduce maternal mortality rates and so TBAs are told they must take mothers to the *pustu* and are given a small cash incentive for this. My mother only provides massages to mothers these days.

Daughter of TBA, N Sulawesi

Some are still working here as the mothers prefer to have their baby at home and it only costs them IDR 3-400,000. The puskesmas staff know this but have no relationship with them.

Field Notes, N Sulawesi

3.9. Our Supporting services

Administration headaches

Many nurses and doctors complained that they do not have clear regional regulations (*perda*) to guide their work. The lack of information extends to medicines, charges, allowances and various entitlements. The following illustrate some of these grievances;

'*we still don't have a clear information on tariffs, so that we know for sure how much we can charge if patients come outside puskesmas operating hours. Until now we charge only for medicine.*'
(nurses rural SE Maluku)

'*regarding medicines… back when there was no free health policy, puskesmas could buy its own medicine stock according to needs. It is the government who now itemises the health budget and supply, and we end up with such a limited range and quantity of medicines we cannot respond to the patients' needs. What we get are usually pretty standard like paracetamol, amphetamine and glutamate acid.*'
(nurse, peri-urban SE Maluku)

'*we don't know how a civil-servant should further study to get promoted to higher rank. There is a regulation*

which specifies a maximum age for a civil-servant to pursue further study and I've passed that age so I can no longer have the opportunity to advance my civil-servant rank until I retire. '
(nurse peri-urban SE Maluku)

The understanding and administration of health card schemes are problematic. Most formal health staff talk about 'kartu', 'Jamkesmas' or 'BPJS' and use these terms interchangeably, in a few occasions use 'JKN' is used[15].

How these operate is often unclear as well as what is provided free under the scheme and what is not. Other RCAs studies[16] have revealed the confusion from the user perspective but this study highlights that the supply side problems of understanding too. For example, a midwife in rural SE Maluku is concerned for the patients if they '*get referred to the hospital it is expensive, even if you're a Jamkesmas card holder, you still have to pay for the ambulance and the cost of lodging for the family who stay with you in town.*' In peri urban C Kalimantan people talk about the '*kartu miskin*' (poor card) which is perceived only to work in the *puskesmas* and *'if you use the same card in the hospital, the quality or service is less than what you get in the village –there are fewer nurses assisting you, longer time of queueing and low quality of meds'* (Villager-patient).

The introduction of the BPJS has added confusion and extra work. '*Colleagues assigned in the registration desk need to be extra careful, as BPJS holders from outside the coverage of this puskesmas can only use their BPJS here three times at the most. More than that, then they would need to transfer to the local BPJS or they will be considered as paying patients*'. (Peri-urban C Kalimantan). Another says '*the BPJS reporting needs to be very accurate otherwise we do not get the re-imbursement. If there are mistakes on the local health card we provide then patients cannot claim*' (Rural C Kalimantan). Another colleague there also told us '*the monthly allocation to the puskesmas in cash is based on the number of BPJS holders we have; 70% is divided among the staff each month while the remaining 30% is allocated to buy consumables. There is supposed to be an incentive from BPJS usage but I have never received it so far.*'

Health staff also shared the challenge of getting people to register for BPJS, for example, *'it is hard to make people here accept the concept of insurance. They're smarter than us in doing the calculation, "Why would we need to pay 25,000 per month for health when we don't have any health problems?" People have little cash in day-to-day life here. So, people would ask me "how come I am supposed to pay for my health even if I'm not sick?" Who can argue with that if cash is limited?'* (Rural SE Maluku).

A *puskesmas* Head in rural C Kalimantan is frustrated that he cannot use BPJS budget as the money has to be spent only on a special list of medicines but these are not available in the city so they cannot procure themselves and have to wait until these are purchased by the province and this is taking time. So the *puskesmas* retains the budget but cannot use it -and then has to charge for other medicines that they can acquire. This, in turn, means that extra journeys are needed to go to the city to get medicines to fill the gap of the non-delivery. The whole problem results in patients never getting anything for free. The Head says the '*BPJS can't work and we campaigned for BPJS uptake here but then we can't get the medicines and this is very embarrassing and difficult for me*'.

There are different interpretations across the RCA locations regarding what constitutes public and private practices. In rural N Sulawesi, all patients coming with BPJS/ JKN cards receive a free service, otherwise they will be automatically charged in advance IDR 5,000 for any service. In rural SE Maluku, if patients going to the nurse's

[15] *Jamkesmas* (Public Health Insurance) is the previous name for JKN (National Health Insurance) which is managed by BPJS (Social Security Agency).
[16] RCA studies on social assistance as well as on nutrition and hygiene.

home, '*pay for the medicine, around IDR 1,000 per capsule or tablet, and IDR 10-20,000 for injections*'. The nurse gets the stocks from the *puskesmas*, as an allowance they receive for their home visits to other villages. Similarly, in peri-urban N Sulawesi, a midwife said that for any service '*outside puskesmas hours, people will understand that I do not give out for free.*' In peri-urban SE Maluku the *puskesmas* Head says '*there should be no charge each time, unless the staff have their own private practice. Because if they don't have private practice, they take the medicines from the puskesmas supply and not their own.*' But since he does not live in the village and only is present at the *puskesmas* during official hours, he has little knowledge of what actually happens.

Paperwork

As noted above there seems to be a large amount of administrative work and staff are allocated to do this irrespective of their background and rather because they are perceived as '*able to to do it*' by the *puskesmas* Head. In some *puskesmas* we visited additional people are being appointed to help with administration from within the staff and training is being provided from the *dinas* to support the transition to BPJS, but people did not feel it was adequate.

A midwife who runs a *pustu* on her own told us she has to submit a report on the 25th of each month, but she has to do this by reconciling her medicine stock with the cash she has taken for each consultation. However, she actually never keeps records as she goes along since she is too busy.

The Head of the *puskesmas* in C Kalimantan was particularly vocal about the many meetings he was required to attend in town, many of which he felt were a waste of time. Some of these necessitated him staying over night wasting further time. Others felt that the meetings they were called to only served the function of 'socialisation' (awareness raising) and were not opportunities to raise the problems they face.

Security, cleaning and transportation

Across our study locations we met with ancillary staff such as security guards, cleaners, ambulance and/or boat drivers who also shared their own perspectives.

All the *puskesmas* have ambulance cover. As discussed above the ambulance may be a road or water vehicle and drivers may be staff or volunteers. Their competence varies as Box 40 illustrates. The '*honor*' driver assigned to the rural SE Maluku *puskesmas* has absconded despite warning letters '*but they didn't mean much to him*'. So the current driver as is a non–paid volunteer, which he does willingly as a community member with just a '*uang rokok*' (a tip to buy cigarette), on top of the cost of fuel.

The *puskesmas* security guard in rural C Kalimantan gets paid more than *honor* staff (IDR 1.5 million per month) but as well as the security work he also undertakes much of the maintenance work such as '*making the fence, repairing stairs, cementing the parking space*' and he drives the speed boat ambulance. He was told of the '*the importance of 24-hour security needed because of the expensive equipment this place has. But I'm not given any housing, so how can I do this?.*' And '*it is difficult to drive the boat with strong currents. If people die on the way, I will have to be the one reporting to the police.*' But there is no additional remuneration and '*no way to raise this*', he says

> **"There is lots of administrative works, collecting reports on programmes, checking staff attendance, internal administration. I have requested another nurse to help with this.**
>
> -Nutritionist, appointed as full time administrator at a puskesmas, Peri urban C Kalimantan

Box 40

'*I can drive fast and get to the provincial capital in 2.5 hours. I have to go fast, because it is in my blood*' brags the ambulance driver. This is half the normal time and everyone in the village complains about this, '*There is always some of us who puke, so we must take plastic bags whenever go*'. But this is also why some refuse to get into the ambulance with him '*because we are scared the patient might die*'. He gets IDR 300,000 for each trip of which two thirds for fuel and the rest for him, '*This is why I like to continue doing it.*'

Rural N Sulawesi

3.10. Our external environment

The environment in which a *puskesmas* operates has significant effect on its operations. The perception of who is in charge is key. For example, in rural C Kalimantan there is a village head who was the former *puskesmas* head, '*I know a lot about working in the puskesmas but am not involved with its problem. I see health facilities as the responsibility of the people in town (district capital) not us in the village leadership. Puskesmas has its own budget and I never see any village fund goes towards it. We in the village do not have any power to complain nor to intervene.*' In rural N Sulawesi the village head concurs, '*the puskesmas only has a direct connection with the camat (district), while village leader is subordinate of camat. So the puskesmas is part of kecamatan, not the community.*'

Peri-urban C Kalimantan is part of a rather new district which split from the original district in 2003. Regency elections have happened twice but securing few votes for the most recent winner, they feel they were punished, *'instead of our village, which is much bigger, a smaller village having only 3 RTs (neighbourhood units) become the sub-district (kecamatan) capital.*' And this affects the health provision and allocations. As explained by the *puskesmas* Head, '*we can only have one doctor in this village because we're not the kecamatan capital.*'

Similarly in peri urban SE Maluku the *puskesmas* is located in a smaller village while a village with four times the population only has a *pustu*. The Head of the latter village says, '*it is because the incumbent Regent has a link to the (smaller) village and once elected has proposed for the puskesmas to be there.*'

> **"This village did not provide many votes for the winning candidate in the last Regency elections. That is why whenever we need anything the local government always complicates things.**
>
> -Head puskesmas, C Kalimantan

Old ambulance, peri urban C. Kalimantan


ORALIT 200

IMPLICATIONS from THE FINDINGS

The study has highlighted a number of important insights into what motivates frontline health service providers and their views of their working situation and capacity to carry out their jobs. These study implications are derived from the detailed conversations and observations undertaken in the study and are presented in two sections; implications from

- the views which the health service providers shared with us about their problems and day to day reality, and
- the research team's observations and experience as well as the experiences of the clients of health service provision.

From what health providers have shared...

- Local decision making on medicinal and equipment needs; health service providers told us about what they felt was greater autonomy in the past with regard to provision of equipment and consumables for local facilities and find the current system of purchasing drugs only from, for example, the BPJS prescribed list problematic. Requests for replacement and additional equipment as well as requests for drugs which may be needed in different quantities for different contexts are difficult to raise in what health service providers feel is a distant planning system from which they feel detached. Furthermore, response for example for seasonal events such as diarrhoea outbreaks are challenging to predict when requests for medicines can only be made at one time. Some puskesmas face particular challenges because of their specific operating context which need to be considered when resourcing the facility; the most extreme example highlighted in this study being the *puskesmas* which copes with a high rate of road accidents and so is less providing the local population with basic services but more about being able to adequately provide first response services.

- Concern with growing preference for referral; the increased concern with meeting patient targets at individual health facilities, especially those related to maternal and child morbidity and mortality together with diminished 'say' in the resources at their disposal than before and rare opportunities for refresher training has led health providers to become more risk averse and to refer patients who otherwise they may have treated locally to higher level health facilities. They are concerned about the costs to patients this entails especially as it is not clear what BPJS actually convers in terms of transport and accommodation. But at the same time they worry about professional sanctions which may ensue if their targets are compromised.

- More clarity on regulations; frontline health providers in all study locations shared confusion regarding local regulations; especially around private practice, patient charges, remuneration for out of pocket expenses, entitlements to training and allowances. What BOK can and cannot be used for remains unclear and subject to local interpretation. What constitutes 'basic care', which is what is supposed to be provided free under BPJS and other health card schemes is not apparent, for example the need for anaesthetics seems basic for dental care but yet has to be paid for by the patient.

- Better integration of ancillary support, the roles, responsibilities and remuneration of ambulance drivers, security guards and cleaners are unclear and managed very differently in different locations. This lack of clarity makes it very difficult for the staff themselves to know the exact terms of employment and leaves grey areas where staff and/or patients may be taken advantage of .

- More rational sharing of tasks; health service providers are frustrated that they are often placed in locations and positions where their training is little recognised or utilised. Some have to perform administrativeand accounting tasks which they feel ill prepared for. Some members of staff of *puskesmas* teams have very little to do while others are rather busy. This would suggest a need to review staffing based on the needs of the area and to post more generalists rather than specialists. A focus on building appropriate context specific care teams should be considered.

From what the researchers have observed…

- Critical mismatch of human resources to needs; while health service providers highlighted some of these issues in relation to carrying out their own jobs, what they rarely shared was over-staffing and under-utilisation especially at *puskesmas* level which we observed in nearly all locations. For example, permanent posting of specialists who may only be required to serve a handful of patients seems inefficient (especially given the costs associated with training specialists). Mobile services with predictable schedules would provide more efficient services and enable the specialists to live in district centres, which is anyway their preferred choice. Where there is overstaffing there is also increased likelihood of absenteeism.

- Perverse incentives; the current practice of providing incentives for work on particular outreach and monitoring programmes results in health staff preferring to do these tasks, especially where there are clear records of activities (e.g. posyandu, biscuit programmes, immunization). We felt that formalhealth providers increasingly feel they exist in a blame culture which encourages them to opt more readily for referral and one which insufficiently recognises health outcomes over 'box ticking' activities.

- Client-centred service delivery; with the exception of local informal health providers, health provision seems to be skewed in favour of the supply rather than demand side. Opening hours are not optimal for people who mostly prefer to seek medical services in the afternoons and evenings. Nearly all facilities opened late and closed early. Patients have very little official information and therefore little clear basis for making

complaints. For example, not one facility posted its opening times or the times when doctors would be available, no signs were observed in any facility explaining costs of consultation, treatment or diagnostic tests. People are not aware of what services and equipment the *puskesmas* or *pustu* has. Together with continued concern that free drugs are inferior, the result of all this leads to people eschewing these local level public services in favour of higher level public services, private services (both informal and formal) or self medication, purchasing readily available medicines from the market. Furthermore, people tell us that they often find staff unavailable and not always very supportive in answering their concerns and providing advice. People are very clear that they want providers to be "smiley", kind and gentle. To increase client responsiveness and contribute to addressing some of the issues raised in the previous bullet point, means for patients to assess and rate the services of health service providers should be seriously considered as part of the official process of performance evaluation.

- Under-utilisation of the village cadres; this resource is currently mostly involved in helping run the posyandu but they could take a bigger role in what are essentially somewhat routine monitoring events and tell us they are mostly keen to do this. The parallel RCA study on hygiene and nutrition also highlighted a possible role in making house visits and helping families make behaviour changes for the health and welfare of their families in a more informal, more private and more supportive way than currently occurs, especially considering the somewhat negative attitudes we found among formal staff towards their clients regarding this.

- Better local adoption of the recommendations of the Ministry of Health regarding co-operation between midwives and traditional birth attendants. Despite the national policy framework published by the Ministry of Health in 2011 which provides guidance on collaboration between midwives and TBAs at the village level, only one sub-village in C Kalimantan in the entire study talked positively about this. Given that many of the TBAs have received official training in the past, are trusted and well respected members of the community, their inclusion in the support provided to mothers should be embraced.

- Critical mismatch between physical resources and needs; our observations together with conversations with people in communities and health providers revealed a concerning prevalence of this problem. It would seem that planning and provisioning is based on hierarchies of local administration rather than on needs, so that *puskesmas* are built where alternatives are plentiful and accessible and, in other cases, the facilities available are not necessarily in tune with what the context requires. Political and other vested interest factors are also apparent in the siting, equipping and staffing of health facilities.


SCALE
Tape Measure

ANNEX 1

RESEARCH TEAM

TEAM LEADER
Revy Sjahrial

TECHNICAL ADVISOR
Dee Jupp

TEAM MEMBER
/SEM/
Revy Sjahrial
Siti Alifah Ahyar
Putu Adi Sayoga

/NS/
Iqbal Abisaputra
Debora Tobing
Steven Ellis
Upik Sabaningrum

/CK/
Denny Firmanto Halim
Yarra Regita
Pandu Ario Bismo

Annex 2
AREAS OF CONVERSATION

Chat, explore, probe, present scenarios 'what if', introduce debate 'some people think', listen, draw, explain, dream, play

Context
Urban/rural/peri-urban. Remoteness / topography / physical access. Size of community, main livelihoods, culture/ religion, access to facilities (related to health).

Your household/family
Profile of the frontliner: age, education, gender, culture, religion, skills, dependents, nature of work, years of experience, training /certification received. (formal/informal, type of service provided), duration/frequency. Motivation for work, aspirations.
Family: (family tree), ages, gender, education, livelihoods.
House: location, building materials, layout, toilet/drinking water facilities, key assets (land, livestock, work related equipment, electrical equipment, phones.

What they do daily
What an average day involves: activities considered routine & "out of ordinary"; scheduled & unscheduled; difference between weekdays, weekends, holidays, e.g. counselling, home-visits, etc.
Range of tasks: formal vs. informal workers, who involved/interacted with, for formal: personal & public health types, combination/portion of each types.
Places of practice: own home, clinic-base, for formal: difference between their own treating of public vs. private practices
Issues faced in performing tasks: cost, physical access (transport, etc.), timing, discrimination/special treatment due to e.g. social class, religion, etc.

Access & quality
Mix of health provision available.
Referral systems practiced.
Sources of info (extent, adequacy, reliability) on which choice of service provider is made. Knowledge on service provision's rules and regulations, rights, 'bending the rules'. Extent of health providers' knowledge on systems, procedures, responsibilities, jurisdictions.
What is quality according to: standard, people & their own expectations? Cooperation/ tensions between providers, between public & private practices of the same individual provider.
Support required to achieve target quality. Quality expectations from supervisors. Frequency/adequacy of supervision.

Work environment
Recruitment process: official/unofficial. Knowledge on roles and responsibilities: before posting, current & future evolvement, opportunity to discuss /seek advice. Promotion, posting.
Training provision (past, current, future) & professional advancement: who proposes, decides, opportunity to discuss. Quality, adequacy & style of training.
Provision of equipment and supplies: who proposes, decides, maintain, opportunity to discuss them.
Supervision & grievance mechanisms: actual vs. expected. Other supports: available vs. needed. Pay & benefits, working conditions.

Local relationships
How they understand the local power structure. Relationship of frontliners with the local power, e.g. village leader, religious figures, political party members, etc. Whether status (permanent/non, formal/informal, voluntary/paid) influences relationship.
Relationship with other health providers and other public service providers e.g. school, administrative office, etc.
Relationship with patients, patients' family, whether it is different between formal & informal. For voluntary cadres: relationship with 'clients' (direct members of community served) and the formal health staff.

Household & personal dynamics
For formal, permanent/non-permanent provider whose assignment involves moving: family changes due to moving; impacts on relationships; changed roles/expectations, challenges & (dis)satisfactions faced by family members.
Status, identity; attitudes/behaviours; lifestyle; psychological and health impacts. Where they go/choose to use health services.
Domestic responsibilities. Investment in education, social, assets, business/enterprise. Aspirations of family members and the frontliners themselves.
The impacts that these have on the frontliner's motivation, concern and ability to provide service.

Annex 3

People met

Host Households		
Adults	15	25
Children	9	13
Focal Host Households		
Adults	97	66
Children	21	24
Formal Frontliners		
GP	4	5
Dentist	1	2
Nurse	4	14
Midwife	0	13
Environment health worker	0	1
Public health worker	0	1
Pharmacist	0	1
Cadre	1	6
Puskesmas head	3	1
Admin	1	3
Security and driver	5	0
Informal Frontliners		
TBA	0	5
Shaman	1	2
Medicine seller (type)		
Pharmacy/med-shop	0	1
Ordinary kiosk/stall	6	11
Others people in the villages		
Principal	2	0
Teachers (accredited)	13	9
Guru honor	2	3
Caretakers/cleaners	2	1
SD students	20	23
SMP/SMK(A) students	13	18
Kepala desa	8	1
Kepala dusun/RT	6	3
Kepala suku	3	0
Church leaders	2	1
Mosque/pesantren/wirid leader	5	3
Farmers	25	21
Fishermen	14	4
Transport operators	7	4
Shop/kiosk keepers	13	15
Local government staff	7	4
Army/police	5	0
	314	303

TOTAL : 617 people met

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