RCA
Reality Check Approach

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

Being at the frontline…

With the current focus on improving public policy as well as systemic, management and bureaucratic reform, it is easy to overlook the daily reality of the very people directly providing these essential services.

In three provinces of Indonesia, Central Kalimantan, Maluku and North Sulawesi, 69 frontline health providers talked about their motivations and incentives in providing health services, their confidence and capacity to work, their work places and resources as well as their views and experience of patients. From our interaction, we learn about their work context, how they provide services and their ancillary support.

In the formal health system we interacted with men and women; nurses, midwives, cadres, doctors (general practitioners), dentists, pharmacists, environmental health specialists and nutritionists.
In the informal system we interacted with traditional birth attendants (TBAs), traditional healers/herbalists and medicine sellers.

3
Provinces

69
Frontline health providers

What they said about their motivations and incentives…

Becoming a civil servant (PNS – *Pegawai Negeri Sipil*) is a strong motivation shared by many. A PNS position means a life-time job with a status and many benefits, including housing allowance and access to credit. At times, having this status is more important than wanting to work in the health sector.

"*I applied to teaching school first but was not accepted on two occasions. My relatives suggested it would be easier to become a nurse, so I could work in the village puskesmas,*" (*Honor* nurse, C Kalimantan).

"*…originally I wanted to be a teacher,*" (Midwife, N Sulawesi)

Family wish or pressure also plays a role, as a nurse shared, "*… my dad pushed me to become a nurse, I actually wanted to be a policeman,*" (N Sulawesi).

Cadres and TBAs talked about having **a social responsibility and/or a calling** in performing their job. "Being recognised as an active member of the community," or "a role model to villagers," TBAs have often followed their mothers or grandmothers into this service to the community, inheriting "the power that should not be ignored to help people".

> "*I am a nurse but am appointed as the puskesmas's finance and accounting officer. But have never been trained for this. I don't even know why I was appointed.*"
>
> (C Kalimantan)

motivations and incentives (cont)

Apart from monetary incentives, contracted (PTT – *Pegawai Tidak Tetap*) doctors shared the potential **"to improve résumés"** following a posting to rural/remote areas. PNS health staff yearn for postings in *puskesmas* in **peri-urban or "hotspot locations"** which are not so busy as with health facilities in town but allow easy access to urban amenities for their own families.

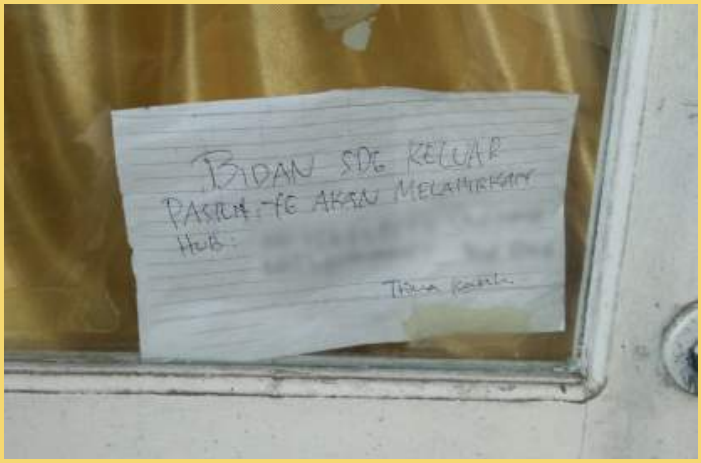
Many health providers, particularly in the formal system, felt they did not have adequate in-service training and were not updated about current developments and practices. This challenge includes not being prepared for management and administration responsibilities thrust upon them. Some doctors confided how they found midwives and nurses "*are poorly trained and don't know what they have to do." They are specially concerned about posting new nurses and midwives to remote areas and share that they need "longer periods of training…as they will have less chance to receive training once they get here.*"

> *"With inadequate and irregular stocks of disposable stuff like gloves, it can be problem even for normal births. In the old days, when reusable gloves could be washed and sterilised, at least we knew we had some ready whenever needed."*

(Midwife, rural SE Maluku)

> *"There was once a memo from the district office circulated, listing 150-160 types of illnesses the puskesmas needs to handle directly itself without resort to referral. But how can we handle them when we don't even have enough medicines for routine illnesses?"*

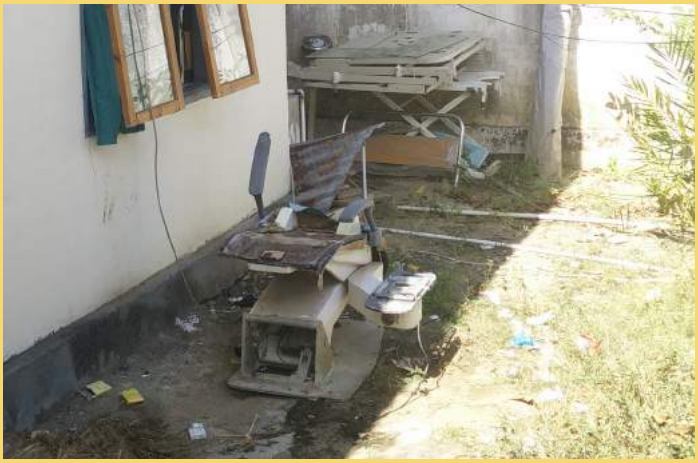
(Nurse, peri-urban SE Maluku)



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

> *"If we're in the city there are many opportunities for training, but here, not only do we have little practice because of the low number of patients, training is also rare."*

(PTT doctor, SE Maluku)



Old furniture disposed in the clinic's backyard, rural N. Sulawesi

When doing the work…

Among key challenges for *puskesmas* health workers are the **mismatch of equipment with needs** and **lack of medicines and other consumables.** We felt their sense of powerlessness when sharing experiences such as, "*I have been Head for nearly ten years, and all the while I have kept asking for replacement of some equipment but there hasn't been any,*" (SE Maluku). In stark contrast, in N Sulawesi, a *puskesmas* had old furniture piled up in their backyard, while the maternity room boasted a USG machine and other new equipment –still wrapped and unused.

There mismatch in staffing including **overstaffing**, especially in *puskesmas*. This felt acutely by those struggling on their own to keep sub-*puskesmas* facilities operating. They envied the large number of staff in the *puskesmas* who were often perceived as doing very little. Despite their underutilisation, these *puskesmas* staff still suggest the need for more staff, mostly citing the official ratio of doctors per population argument. In peri-urban SE Maluku, 24 staff are officially posted in a *puskesmas* with a further six *honor.* This means 30 working staff serve a village of only 500 people.

An overstaffed *puskesmas* tends to have a higher rate of **absenteeism**. "*The staff were not there*" is one of the main reasons local people cite for their reluctance to go to *puskesmas*. The other often cited reason is **tardiness.** While most *puskesmas* open in the morning until early afternoon, they rarely start on time and many often close early, contrary to opening times displayed on information boards, if they have one.

"*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…*" – (Locals, C Kalimantan & SE Maluku)

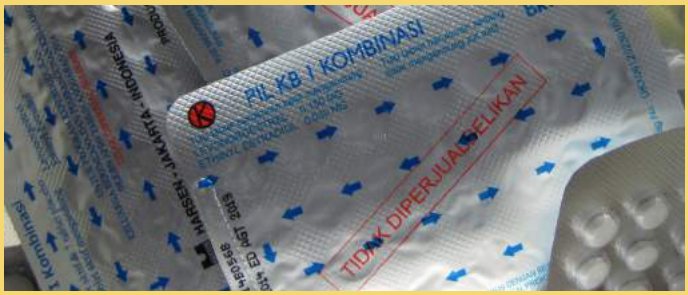
"*Staff are not time disciplined, but there is nothing I can do as a puskesmas head. It has much to do with the PNS sanction.*" – (SE Maluku)

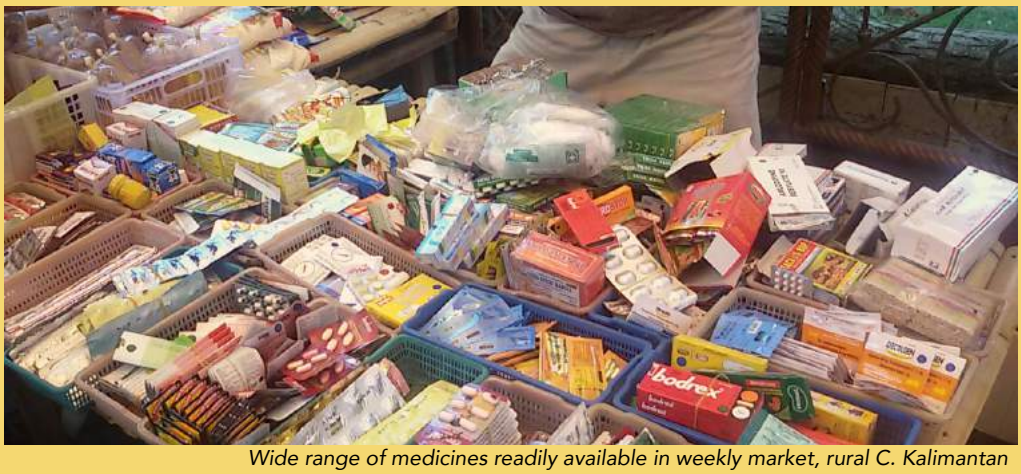
> *"There is supposed to be one doctor for 1,000 residents and there are 6,000 residents here but we only have two doctors."*
>
> (Doctor, N Sulawesi) in a *puskesmas* which on its busiest day actually only serves a maximum of about 20 patients.

The locals served…

With the challenges of supplies and staffing, many locals confided in us that they **preferred to buy their own medicines elsewhere** rather than wasting their time and money for transport to come to the *puskesmas,* especially as, in the end they still have to go to the market. It is "*cheaper to buy in the market*", and "*the nurse is often not available in the puskesmas*". Many buy common medicines from kiosks as "*the ones sold at kiosks are more potent than the free medicines the puskesmas gives us. We can immediately feel the effect.*"

However, people like those frontliners who have stayed in a facility for a long time, are responsive and where there is a **trusting relationship**. Being "approachable", "available" either for home or out-of-hours visits, as well as being "smiley" are amongst the main attributes appreciated across the study locations. The 'gems' are those who "go the extra mile" in serving their community. TBAs are often highly regarded and cited as fitting these criteria.





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

Working context and environment...

Many nurses and doctors shared how they **do not have clear *perda*** (regional regulations) to guide their work.

Before the 'free health policy', the *puskesmas* could buy its own medicine stock according to needs. Currently it is common for the local government to prepare the health budget and arrange supplies, with limited influence from the *puskesmas*. *Puskesmas* staff complain that this leads to a limited range and quantity of medicines to be able to respond patients' needs.

> *"We still don't have a clear information on tariffs to be able to know for sure how much we can charge if patients come outside puskesmas operating hours…"*
>
> (Nurses, rural SE Maluku)

> *"What we get are pretty standard like paracetamol, amphetamine and glutamate acid."*
>
> (Nurse, peri-urban SE Maluku)

"*We campaign for BPJS uptake here but then we can't get the medicines. This is very embarrassing and difficult for me.*" (Puskesmas head, C Kalimantan) when talking about not being able to use BPJS budget as it needs to be spent only on predetermined list of medicines but these are not available in the city. The puskesmas retains the unspent budget but can't use it, forcing them to charge patients for other medicines it has to buy.

The understanding and administration of health card schemes are problematic. Most formal health staff use the terms "kartu", "Jamkesmas" or "BPJS" interchangeably, while "JKN" is used only in a few occasions. Different interpretations are found across study locations about what constitutes public and private practices.

Security guards, cleaners, ambulance and ambulance-boat drivers are amongst the staff providing ancillary support to *puskesmas* services and often feel their concerns are neglected. A security guard who doubles as a boat driver whenever there is a referral or emergency, shared "*it is important to have 24-hour security necessary because we have expensive equipment in this puskesmas. But I'm not given any accommodation, so how can I do this?*" On his responsibility as an ambulance-boat driver, he said "*It is difficult to drive the boat with strong currents. If people die on the way, I will have to be one reporting to the police.*" Yet, there is no additional remuneration and no way to raise this issue.

Village leaders often regard the health facilities as the responsibility of the District as the *puskesmas* has its own budget separate from the village fund. "*We in the village don't have any power to complain or intervene.*" – (Village leader and ex-*puskesmas* head, rural C Kalimantan)

Local politics can have a significant effect on local health provisioning, for example, deciding which *desa* or *dusun* will have *puskesmas*, regardless of the population size. One incumbent Regent has a personal link to a particular village and on election proposed the *puskesmas* to be located there despite this being one of the smallest villages. Another village was 'punished' for not supporting the election of a particular Regent and were told they "*can only have one doctor in this village because you're not the kecamatan (regency) capital.*"

What these findings imply…

people said there is a need for:

- A return to more local decision making on medicinal and equipment needs, as there was greater autonomy in the past.
- More clarity on regulations especially around public servants' private practice, patient charges, remuneration for out of pocket expenses, entitlements to training and allowances.
- Better integration of ancillary support as the roles, responsibilities and remuneration of ambulance drivers, security guards and cleaners are unclear and managed very differently in different locations.
- Client-centred service delivery, as opening hours are not optimal for people who mostly seek medical services in the afternoons and evenings. Also, patients have very little official information on operating standards and, therefore, little clear basis for making complaints.
- Better matching of human resources to needs: 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.
- Better utilisation of the village cadres: they could take a bigger role in what are essentially somewhat routine monitoring events such as *posyandu*. They have a good potential for making house visits and helping families make behaviour changes, in a more informal, more private and more supportive way than currently occurs.

Perspectives and Experiences of Frontline Health Service Providers study report can be found at
http://www.reality-check-approach.com

The Reality Check Approach

This is a qualitative approach to feedback which has been used in several countries since 2007. It involves the study team living in the homes of people living in poverty and the people providing services to them; during which the team joins in their everyday lives. The relaxed environment this provides enables easy, informal conversations with all members of the family, their neighbours and others in the community. It also allows the study team member to experience and observe the realities of the family and provides a meaningful basis for joint reflection.

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