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Australian Government

Nusantara Sehat Team-based Deployment for Comprehensive Primary Health Care:

How Does the Program Influence Interprofessional Collaborative Practice and the Perception of a Primary Health Care Career in Left-Behind Areas in Indonesia?

A Qualitative Evaluation Study

September 2020

Nusantara Sehat Team-based Deployment for Comprehensive Primary Health Care:

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This research is under supervision of Bambang Widianto, Executive Secretary of TNP2K

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First publication, September 2020

ISBN: 978-602-275-205-9

Support to this publication was provided by the Australian Government through the MAHKOTA Program. The findings, interpretations and conclusions herein are those of the author(s) and do not necessarily reflect the views of the Government of Indonesia or the Government of Australia.

Suggested citation: TNP2K, 2020. ***Nusantara Sehat* Team-based Deployment for Comprehensive Primary Health Care: How Does the Program Influence Interprofessional Collaborative Practice and the Perception of a Primary Health Care Career.** Jakarta, Indonesia.

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Foreword

The adequacy of health workers in Indonesia remains a challenge to establish equality in serving comprehensive primary health care (PHC) particularly in underserved and peripheral areas. Many believes that comprehensive health care services should cover the promotive, preventive, and curative care by many disciplines of health. In line with this view, since 2015 the Ministry of Health has been initiating the *Nusantara Sehat* Team-based Deployment Program (NST), which consists of multi profession of health workers deployed at the Primary Health Care in remote areas. This study aims to explore how the NST influences the interprofessional collaboration to improve community health status and how the program affects the health workers' future career path. To explore the details of the report, below is the overview of each chapter.

Chapter 1 – Introduction

As the background of the study, this chapter highlights the definitions of the comprehensive primary health care (PHC), interprofessional care in PHC, the regulation of interprofessional coordination and collaboration in PHC in Indonesia, as well as challenges in governing human resources for health. The *Nusantara Sehat* Program overview and its problem identification also explained in this chapter.

Chapter 2 – Research Methodology

This chapter explains the methodology, data collection plan, study sites, sampling strategy, and ethical research consideration. The Qualitative methodology was employing semi-structured interviews, direct observation for 5-7 days per study site, and focus group discussion both from the NS alumni and NS current team to gather the information needed.

Chapter 3: *Nusantara Sehat Program's* Influence on Interprofessional Collaboration

This chapter explains the narratives from NS recruits' perceptions and experiences with regard to the reality they face in performing their tasks at the PHC, and how they might or might not be able to work towards achieving the targeted comprehensive care at the PHC. The story on how to develop NS Team's collaborative strategies for comprehensive PHC care, the challenges to develop collaboration between NS Team and the Host PHC staffs is explored further in this chapter.

Chapter 3: *Nusantara Sehat Program's* Influence on Interprofessional Collaboration

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Chapter 4: *Nusantara Sehat* Recruits' Career Perceptions

Chapter 4 will explain the career perception of deciding between working at remote PHC or exploring other career paths both from NS Alumni and NS current Team. Key message from this chapter is that strengthening a country's public health system not only will require strengthening its organisational structure but also understanding the motivation and decisions made by the actors involved within it. By correctly examining the existing obstacles, it is expected that we could be able to develop relevant interventions needed.

Chapter 5: Discussion and Conclusions

This chapter will further discuss the findings from the micro, meso and macro policy, and the individual factor's point of views. Micro factors highlight the team's internal relationship dynamics, their unity, interaction, communication, and common motivations. Meso and macro factors highlight the policies on health governance, and individual factor will employ the health workers perception of pursuing PHC career in remote areas. Evidence of existing discrepancy between health worker's needs and current NS' arrangements that might have some gaps will also examined.

Chapter 6: Recommendations

In this final chapter, we proposed several recommendations to minimize the obstacles faced by NS Team by strengthening the interprofessional collaboration before arrival and during their assignment as well as promote the positive career perceptions at PHC at underserved areas.

Jakarta, September 2020

Acknowledgements

This report is written by the National Team for The Acceleration of Poverty Reduction (*Tim Nasional Percepatan Penanggulangan Kemiskinan*: TNP2K) in Jakarta. Prastuti Soewondo, as the Head of Social Health Insurance Working Group at the TNP2K, leads and supervises all the study process and the development of the report. She is supported by a team consisting of Ade W. Prastyany, Adwin Sumartono, Dwi Oktiana Irawati, Retno Pujisubekti, and Halimah. This work has been successfully accomplished with the support from Executive Secretary of TNP2K - Bambang Widianto, Policy Coordinator - Elan Satriawan, as well as Communication Unit, and Knowledge Management Unit.

Financial support of this study is provided by MAHKOTA (Towards a Strong and Prosperous Indonesian Society), Department of Foreign Affairs and Trade (DFAT) of the Australian Government.

In addition, we are thankful for the continuous support provided by The Ministry of Health of the Government of Indonesia through the Center for Planning and Utilization of Human Resources for Health, Board for Development and Empowerment Human Resources of Health since the beginning of this study, as part of the external evaluation of the NS program.

Glossary

BOK	*Bantuan Operasional Kesehatan* (Health Operational Assistance Fund)
BPPSDM	*Badan Perencanaan dan Pendayagunaan SDM Kesehatan* (Board for Development and Empowerment of Human Resources of Health, a directorate-level unit within the Ministry of Health)
DinKes	*Dinas Kesehatan* (Health Office, subnational level, either provincial or regency)
JKN	*Jaminan Kesehatan Nasional* (National Social Health Insurance)
KIA	*Kesehatan Ibu dan Anak* (Maternal, Neonatal, and Child Health)
KUKPRI-*MDG*	*Kantor Urusan Khusus Presiden untuk Millenium Development Goals* (President's Special Management Office for MDGs)
Lansia	*Lanjut usia* (the elderly)
MoH	Ministry of Health
NS	*Nusantara Sehat*
Permenkes	*Peraturan Menteri Kesehatan* (Minister of Health Regulation)
PHC	Primary Health Care
Puskesmas	*Pusat Kesehatan Masyarakat* (Community Health Centre)
PNS	*Pegawai Negeri Sipil* (Permanent Civil Servants)
Posyandu	*Pos Pelayanan Terpadu* (Integrated Health Posts, often referring exclusively to community-based maternal and child health care posts)
Posbindu PTM	*Pos Pembinaan Terpadu Penyakit Tidak Menular* (Integrated Health Posts for Non-Communicable Diseases)
STR	*Surat Tanda Registrasi* (Registration Certificate)
Sukarela	Volunteer staff
THL	*Tenaga Harian Lepas* (Daily Staff)
TKD	*Tenaga Kontrak Daerah* (Regional Contract Staff)

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Executive Summary

Quality, comprehensive primary health care (PHC) is the node of hope to improve community health and welfare (Kringos et al. 2010; Plochg et al. 2012; Starfield 2005). The structure for *puskesmas (Pusat Kesehatan Masyarakat, or community health centre)* embodies this dream for the delivery of ideal, comprehensive PHC in Indonesia. Interprofessional collaboration is a strategy to achieve this form of comprehensive PHC–the staffing of every *puskesmas* must have (at minimum) nine health professions, namely medical doctors, dentists, nurses, midwives, public health workers, environmental health workers, medical laboratory technicians, nutritionists, and pharmacy workers.

The Indonesian Ministry of Health (MoH) continually supports the improvement of *puskesmas* performance and has formulated *Nusantara Sehat* (NS) as a program for the special recruitment and deployment of health workers for assignment at *puskesmas* as their workstation.[1] The presence of a multi-profession NS team evidences how the NS Program tries to embody the comprehensive PHC concept. Since its initiation in 2015, the NS Program has expanded from only recruiting and deploying health workers in teams of five to six personnel (NS-Team or NST), to deploying personnel individually (NS-Individual or NSI). From mid-2015 to early 2019, there have been 11 batches of NST deployed in 131 municipalities/ regencies in 22 provinces, composed of 467 teams of 2,661 personnel. Of these, 37.6 per cent are clinicians (doctors, dentists, nurses, and midwives), while the rest (62.4 per cent) are promotive/preventive professionals (pharmacists, nutritionists, public health workers, environmental health workers, and medical laboratory workers).

The question that remained unexplored until now is the influence of the NS experience, especially in its interprofessional nature, on health workers' practices and the vision for comprehensive PHC services in Indonesia's left-behind areas.

Study Findings

NS team's collaborative strategies for comprehensive PHC

There is a strong tendency in the wider society to value curative services over promotive/preventive services. There is an expectation in the community that curative services must be ready at all times, and members of the community have little interest in distinguishing between the various health professions. The promotive/preventive health professionals have learnt this through their experience working at NS sites. The NS recruits knew, therefore, that they must seize all opportunities to build the community's demand for promotive/preventive health care.

The NS team recruits were briefed to identify the demand in their assigned community first and, following that, to service it with the interventions that the *puskesmas* can deliver. With mutual understanding between the clinical professions and the promotive/preventive health professions, they acquiesced to the public demand because, during the adaptation period, they needed to first be accepted by the community. After

[1] *NS: Nusantara Sehat: Healthy Archipelago.*

gaining their trust, NST recruits and the *puskesmas* staff use this advantage to deliver health promotive/preventive services. With experience and empathy, they acknowledged the influence of other structural determinants of health.

By orienting their analysis towards the community's needs, they have also started to recognise the roles of other professions and developed the skill to collaborate with other health professions in a comprehensive manner. This is manifested even more in the presence of complex cases in the communities, such as cases of children with stunting. The recognition of each other's role is also a slow growth process for many teams, but this has changed over time.

Awareness of the need for interprofessional collaboration among NS recruits also seemed to be affected by the recruitment and pre-assignment training process. There is a high enthusiasm for NS team-based recruits to collaborate with the different professions. This is promoted by the psyche of a common mission that has been developed since the pre-assignment training to support activities that have an interprofessional nuance.

There are, however, still instances of sub-optimal interprofessional collaboration between the health workers within the team. There are professions that still feel misunderstood and underappreciated and it is apparent from some teams that professional hierarchical relations are still reproduced in daily practice, especially between doctors and other professions. While the intention behind it may not be malevolent, it still created friction in the dynamic between the NS team members.

The presence of 'leadership' in every NS team was something that was nurtured during the pre-assignment training. Unfortunately, not enough attention was paid in this phase to discussing how teams can overcome the traditional professional hierarchy. One possible reason for this is that during the pre-assignment training the material given was still less than what they needed to perform interprofessional collaborative activities in the *puskesmas*.

The structure of the training was felt, for the most part, to emphasise physical fitness and mental readiness of the health workers, at the cost of the recruits' understanding for field-specific content on professional as well as health system management skills and knowledge. These kinds of remarks were generally found throughout the study's interviews, with the exception of those NS recruits from the first batch.

There has been a shift from what the initial program was envisioned to be at the beginning and what it has evolved to be in more recent practice. In addition to the change in the way the pre-assignment training was delivered, the policy for additional operational funds (*Bantuan Operasional Kesehatan*: BOK) for NS teams' host *puskesmas* was also changed after evaluating the first year of the NS Program's operations.

There is also a lack of clarity of what is expected of the NS teams, internally and externally. Most team members internalised the idea that they were to deliver innovative services in the field as a team, while some had to face the reality of being expected to perform the standard services instead, to fill the gap in existing services. Lurking in the background of the latter expectation is the disparity of employment tenure between the NS recruits and the rest of the *puskesmas* staff. This mismatch between these two perceptions of the NS team's mission has compromised the integrity of team unity.

Uncertain collaboration between NS team and the host *puskesmas* staff

NS team members attempted to practise their interprofessional collaboration–not only with fellow NS team-based recruits but also with the rest of the *puskesmas* staff. A better understanding of other *puskesmas* staff's onerous responsibilities was also created out of the human-resource constraints in *puskesmas*. As a result of understaffing, the different health professions in the *puskesmas* are inundated with additional tasks which give them a nuanced understanding of the nature of work of other health professions in the *puskesmas*.

Paradoxically, however, impediments to collaboration between the NS team recruits and their host *puskesmas* is also partly due to the *puskesmas* being disproportionately staffed. The health workers' sense of the different professional identities and boundaries and, therefore, the concept of collaboration may be confused. This is due to the overabundance of midwives and also, in some locations, an overabundance of nurses, which drove the *puskesmas* to conduct 'task shifting'. Another hindrance to collaboration is due to the lack of a sense of team unity between the NS recruits and the rest of the host *puskesmas* staff.

There are still positive examples of how initiative by *puskesmas* leadership may mitigate this. This move is also useful so that the NS team members better understand the tasks in the *puskesmas*. The experience of engaging with the host *puskesmas* staff and seeing and discussing their tasks firsthand is even deemed by some NS team recruits to be more valuable than the materials they have received during pre-assignment training.

In their engagement with host *puskesmas* staff, NS team-based recruits would often see it as one of their roles to rekindle the motivation of other *puskesmas* staff, by going above and beyond their duties. It became a point of pride to declare that they have provided care for communities that have never been previously visited by health workers. In doing so, however, there was a potential for friction between the *puskesmas* staff and the NS team-based recruits.

The NS team-based recruits have tried to carefully nurture their collaboration with the host *puskesmas* staff and adopt various strategies to mitigate the risk of problems developing. One of the strategies is to always involve the local staff in NS' innovative activities in the community that have become another avenue for host *puskesmas* staff to obtain additional income. In addition, some NS recruits saw this collaboration with the host *puskesmas* staff as an opportunity to ensure the longevity of the change they were hoping to bring to the *puskesmas*. Another potent strategy to overcome such opposition by the host *puskesmas*' staff member is to pursue financial transparency for the benefit of the staff. It helped to galvanise collegial support from the *puskesmas* staff. The NS team's 'intervention' to promote financial transparency in *puskesmas* was a welcome change. Nevertheless, the disparity in remuneration between NS recruits and the host *puskesmas* staff still became an issue. Gradually it might transpire into apathy and antipathy towards the programs NS recruits were trying to start.

The NS recruits also felt it necessary to show to the other staff that they are there for the benefit of the *puskesmas* as well. This is because of suspicion by host *puskesmas* staff that NS recruits were there to 'spy' and report on the *puskesmas*' misconduct to the MoH. NS recruits manifested their alliance to the host *puskesmas* staff generally by taking active roles in the *puskesmas* accreditation process. This tended to be accepted by the host *puskesmas* staff as the young NS recruits were better skilled for working with computers. It has been commonly reported anecdotally that *puskesmas* that host NS recruits, both in teams and individuals, fared better during accreditation than if they had not hosted NS.

Nevertheless, these strategies have not overcome the fact that the host *puskesmas* staff have

not been a significant actor in the decision for the NS recruits' assignment. For instance, the *puskesmas* staff had never been actively involved in deciding the timing and terms of the NS teams' recruitment into their *puskesmas*. The *puskesmas* have limited space to modify their activity and, consequently, budget plans. Considering that most *puskesmas* have a significant proportion of staff of 'voluntary' status who depend on the existing activity and budget space for their income, the presence of NS teams in the middle of the year automatically created discord.

There has been no structured forum to involve host *puskesmas*' staff more widely before the recruitment even took place. Unfortunately, host staff resistance towards NS recruits has reproduced and augmented the stigma against health workers, especially the civil servants, in rural and remote areas in the country. Such a stigma will be counterproductive to improving the staffing situation for health care services in the areas needing them the most. For a longer-term benefit, there needs to be a genuine interest to inquire about health workers' individual and collective motivations to build a career and life in rural and remote areas.

Nusantara Sehat Recruits' Career Perception

Many NS recruits exhibited altruistic motivations for joining the program. They have internalised the concept of "*Wawasan Nusantara*", which conceptualises the Indonesian archipelago as one nation. Recruits from various backgrounds seem to have a cultivated curiosity about the diverse life that Indonesians have, and to connect on a personal level with them. In addition, NS recruits have an acute perception of the disparity between Java and other islands outside Java in terms of access to health professionals. This has become a point of reflection for their own career choice and their strong desire to contribute to achieving health equity in Indonesia.

In addition to the altruistic motivation they have conveyed, some also were able to describe other personal motivations. Professional identity drives them to want to be able to practise their profession in full, which many of them found difficult in settings where they would be given tasks which are not aligned with their professional training. Another non-altruistic motivation that some NS recruits conveyed was the hope for a promising future career with the hope that NS work experience would be a springboard towards better opportunities. Working in remote *puskesmas* is, therefore, considered a way for them to meet all their motivational needs.

Nevertheless, NS recruits found that working in such remote locations has its drawbacks. Working in remote *puskesmas* brought with it the challenge of isolation from information technology. In addition, the deficiency in equipment and materials to deliver quality health care is compromising their work performance. Overshadowing all of the other challenges of working in a remote *puskesmas*, however, is the geographic remoteness of the *puskesmas*.

Despite the difficulties of working in remote areas, employment in the NS Program might still be one of the most viable options for many health professionals. This is because young health professionals in Indonesia view their career path options as limited by external and internal factors with limited well-paying employment opportunities for many health professionals.

The reality that many of them had to work 'voluntarily' *(sukarela*, without promise of suitable pay) has become the source of psychological stress for young health workers. There are paradoxes in working as an entry-level health professional–young health professionals need to be ready to become volunteer staff to gain

experience for future careers with proper payment, sometimes even needing to pay for the opportunity to gain experience. On the other hand, the experience they gain from sub-standard practices might be detrimental to their initial ideals and training. Through the experience of working as volunteer staff, health professionals might also internalise a sense of invisibility. This is symbolised from the total absence of standardisation in the payment structure.

Looking to the future, however, NS assignments also provide inspiration and aspirations for the NS recruits' career path. During undergraduate professional training, many NS recruits admitted to having limited exposure to community-based health care services, especially in promotive/preventive care. Work experience at the community level that the NS assignment has provided has, therefore, inspired a number of NS recruits to shift their career outlook into one that is more oriented towards PHC.

Unfortunately, the current job market and postgraduate education system has not properly valued this NS experience as an asset. NS recruits are restricted in what line of career they can pursue if they want to access further studies through an NS alumni scholarship. This is due to the policy of 'field linearity'[2] for what further studies might be granted funding which potentially also stifles potential career growth.

The structure of health workers current employment opportunities, in general, also still undervalues work experience at the community level. Through working with their colleagues, NS recruits found that the procedures put in place for NS recruitment are very effective in funneling those with high commitment and work ethic. In contrast, they see the rigid way that the current civil service recruitment is set up, with written test formats, to be insufficient to acknowledge the potential contribution they could have made as civil servants working at the local government level.

Learning about the low valuation that the current job market places on their NS experience, there is a concern that joining the NS Program might not have served them well**.** Consequently, some NS recruits have decided that they are better off working for themselves. One NS recruit, for instance, viewed his NS assignment as a time to accrue the financial capital to start his own business in health care.

Some NS recruits actually preferred to continue working in rural and remote areas. it might be expected that a substantial proportion of NS Program alumni with a penchant for PHC delivery would be working in remote areas as a health professional, however, the personal preferences of Indonesian health workers are immensely affected by societal expectations. For almost all NS health workers interviewed, family factors and gender role perceptions dominate their narratives. The presence of a person who is a family member, relative, or friend is a strong factor in deciding on work relocation. The high value of a family's opinion, while very valuable for most health workers, has limited the option of work locations for many. This is especially true for female health workers and far exceeds the consideration of salary or career progression.

Health workers who work in places far away from their family saw their NS assignment as a personal sacrifice. Many NS recruits have an expectation that their commitment to be deployed must be acknowledged. The next question they are wondering, therefore, is whether the current health human resource management can recognise the additional value of NS employment experience in a structured manner at the national and subnational level.

[2] 'Linearity' refers to the prevailing policy of monodisciplinary academic development, whereby specialisation of knowledge within a single discipline is the norm, as opposed to cross-disciplinary studies (Nugroho et al. 2016).

01

Introduction: Primary Health Care in Indonesia

Quality, comprehensive primary health care (PHC) is the node of hope to improve health and welfare of the community (Bitton et al. 2017; Kringos et al. 2010; Plochg et al. 2012; Veillard et al. 2017). Defining what constitutes comprehensive PHC has become another challenge. Various scholars of the health system have over time attempted to crystalise what constitutes PHC. Much of the current discussion agrees on a definition that includes, but goes beyond, primary care as a 'level' of health care in a multi-scalar referral system (Muldoon 2016).

An especially useful definition of a comprehensive PHC service is a health care service delivery system that allows "the integration of rehabilitative, therapeutic, preventive, and promotive interventions, and attention to local social and environmental risks" (Labonté et al. 2014). In other words, the implementation of comprehensive health care services should cover the promotive, preventive, and curative care by the many disciplines of health and should answer local needs within their respective specific context.

The Indonesian health system has always been aligned with this view, in fact, historically the structure for *puskesmas* embodies this vision for the delivery of an ideal, comprehensive PHC service in Indonesia. It was first envisioned in the Bandung Plan (*Konsep Bandung*) in 1951, an initiative of the Indonesian Department of Health (now called Ministry of Health: MoH) under the leadership of dr. Johannes Leimena (Neelakantan 2017). He advocated for the principle of unification of both promotive/preventive care and curative care in PHC facilities. Other breakthroughs contained in the Bandung Plan are the establishment of PHC facilities at the subdistrict (*kecamatan*) level and the need to distribute multiple health professions to these facilities alongside medical doctors. In 1967, dr. Achmad Dipodilogo as the Director for Health in the Department of Health, translated these principles into the structure of *puskesmas*.

The MoH understands the importance of comprehensive PHC and is continually improving and evaluating the health care system to achieve better performing and comprehensive PHC. The leverage capacity of PHC in raising the community's health condition is also believed to be multiplied in areas with special needs, such

as those categorised as remote areas (*Daerah Tertinggal, Perbatasan dan Kepulauan: DTPK or Remote, Border, and Island Areas*).

1.1. Interprofessional Care in *Puskesmas*' PHC

The Minister of Health Regulation (*Permenkes*) No. 75/2014 on *Puskesmas* gives all *puskesmas* the authority to deliver a comprehensive, continuous, and quality PHC service (Article 7 (a)) which is run using the principle of interprofessional coordination and collaboration (Article 7 (e)). Consequently, every *puskesmas* must have (at a minimum) nine categories of health professions, namely medical doctors, dentists, nurses, midwives, public health workers, environmental health workers, medical laboratory technicians, nutritionists, and pharmacy workers.

There is no nation-wide standard on the division of tasks for each of these professions in the *puskesmas*–only the standard of competence that each profession needs to have to be certified/registered (*Surat Tanda Registrasi*: STR) by the Indonesian health professional certifying bodies. There are two major certifying bodies: the Indonesian Medical Association (*Ikatan Dokter Indonesia*) for doctors and dentists and the Indonesian Health Workers Assembly (*Majelis Tenaga Kesehatan Indonesia*) for non-medical professions (MoH 2011). The *Permenkes* also allows for the minimum service standard of programs run by *puskesmas* to be differentiated between the *puskesmas*' three major categories: urban, rural, and remote/very remote.

The minimum numbers of each of the nine categories of health professions that must be employed by urban, rural, and remote/very remote *puskesmas* are also regulated by the *Permenkes* (Table 1-1). There is maldistribution in the numbers of health professionals in Indonesian *puskesmas*, which looms over the national and subnational issues of human resource management in health (discussed in Section 1.2 below).

Table 1-1: Minimum Number of Health Human Resources in *Puskesmas* (Excluding Non-health Professionals)

No	Profession	Urban *Puskesmas*		Rural *Puskesmas*		Remote/Very Remote *Puskesmas*	
		Outpatient care only	Outpatient and Inpatient care	Outpatient care only	Outpatient and Inpatient care	Outpatient care only	Outpatient and Inpatient care
1.	Medical doctors	1	2	1	2	1	2
2.	Dentists	1	1	1	1	1	1
3.	Nurses	5	8	5	8	5	8
4.	Midwives	4	7	4	7	4	7
5.	Public health workers	2	2	1	1	1	1
6.	Environmental health workers	1	1	1	1	1	1
7.	Medical laboratory technicians	1	1	1	1	1	1
8.	Nutritionists	1	2	1	2	1	2
9.	Pharmacy workers	1	2	1	1	1	1
	Total	**17**	**26**	**16**	**24**	**16**	**24**

Source: Permenkes No. 75/2014.

1.2. The Challenges in Human Resources for Health (HRH)

The MoH's Board for Development and Empowerment of Human Resources for Health (*Badan Pengembangan dan Pemberdayaan SDM Kesehatan*: BPPSDMK) has been keeping track of the issue of human resource supply to *puskesmas*. BPPSDMK has put in place an integrated system to account for health workers by profession employed in each *puskesmas* nationwide. Utilising this database, the MoH has identified the number of health workers needed. Every *puskesmas* is identified as either meeting the standard, exceeding the standard (over-resourced with health workers) or falling short of the standard (under-resourced) for each of the nine health professions for each category of *puskesmas*.

There are high proportions of *puskesmas* that are lacking in nutritionists (45.25 per cent), dentists (43.81 per cent), laboratory technicians (42.88 per cent), public health workers (40 per cent), and environmental health workers (32.88 per cent) (Table 1-2). It is also worth noting that the number of oversupplied dentists, medical laboratory technicians, and nutritionists is still less than the number of health workers needed in under-resourced *puskesmas*. This means that, while for other professions the dominant problem is in their distribution, for dentists, medical laboratory technicians, and nutritionists, the problem is about production as well as entry of these professions into *puskesmas* employment in general.

The oversupply of nurses and midwives is roughly between 10.6 times and 22.8 times the need for these professions, respectively. The current oversupply of nursing professionals is due to overproduction from domestic tertiary education institutions, to the point that the MoH has explored avenues for managing Indonesian nursing professionals by deploying them as international migrant workers (Efendi et al. 2013; Kurniati et al. 2015).

Table 1-2: National *Puskesmas* Health Workers (by Profession) (2017)

No	Profession	*Puskesmas* with standard number of health workers	Over-resourced *Puskesmas*		Under-resourced *Puskesmas*			of % total health workers needed
			Puskesmas	Health workers oversupply	*Puskesmas*	of % *Puskesmas*	Outpatient care only	
1	Medical doctors	3,440	3,775	7,859	2,606	26.53	3,052	8.14%
2	Dentists	4,377	1,141	1,631	4,303	43.81	4,303	11.48%
3	Nurses	699	6,985	66,154	2,137	21.76	6,224	16.62%
4	Midwives	407	7,892	102,328	1,522	15.50	4,474	11.94%
5	Public health workers	2,812	3,080	7,661	3,929	40.00	3,929	10.48%
6	Environmental health workers	4,375	2,217	3,772	3,229	32.88	3,229	8.62%
7	Medical laboratory technicians	3,843	1,767	2,567	4,211	42.88	4,211	11.24%
8	Nutritionists	3,720	1,657	2,762	4,444	45.25	5,203	13.88%
9	Pharmacy workers	4,013	2,960	5,240	2,848	29.00	2,848	7.60%
	Total	**n.a.**	**n.a.**	**199,974**	**n.a.**	**n.a.**	**37,473**	**100.00**

Source: BPPSDM December 2017 database, as presented by Oos Fatimah Rosyati at FIT-IV IAKMI, Lampung, 17 October 2018.
Note: Type of employment tenure unspecified.

1.3. *Nusantara Sehat* Program Overview

The MoH runs a number of programs that aim to provide health worker availability in *puskesmas*–especially in areas that have reportedly found difficulty in recruiting health workers.

The *Nusantara Sehat* (NS) Team-Based approach is a program for special recruitment and deployment of health workers at the primary level–to be assigned to a *puskesmas* as their base workstation. The program is managed by BPPSDM in collaboration with *Badan Litbangkes* and *Direktorat Yankes*.[3] The contract is two years in duration, with no guarantee of future employment tenure. Health workers recruited by the NS Program have undergone a rigorous selection process to identify those with strong motivation to improve the health condition of community members in "left-behind" areas. In terms of remuneration, health workers contracted under the NS Program receive considerably higher salary to attract quality personnel.

The NS has made two innovations in the development and management of health workers in Indonesia: (i) the interprofessional recruitment and team-based deployment method; and (ii) additional operational funding (*Bantuan Operasional Kesehatan*: BOK) for community-based health programs. This deployment program was adopted from the program *Pencerah Nusantara* product of KURPRI MDGs.[4] In its recruitment phase, selected health workers undergo pre-deployment training for a period of nearly seven weeks, allowing them to create a team spirit, and from it were born a number of innovations in PHC in the form of planned health effort initiatives which they would attempt to apply in their respective assigned locations.

Any recruitment process must anticipate the reality that health workers in Indonesia have freedom of choice in determining their life and career trajectory. This is, in many instances, related to their motivation to pursue further education in addition to other life considerations. The former has been anticipated by MoH which has provided scholarship opportunities since 2018 to NS alumni (see Table 1-3). Whether such a strategy supports the development of PHC in Indonesia in the long term is still to be determined.

Since its initiation in 2015 (*Permenkes* No. 23/2015 on Special Assignment of Team-Based Human Resources for Health in Support of *Nusantara Sehat* Program), the NS Program has expanded (*Permenkes* No. 16/2017) from only recruiting and deploying health workers in teams of five to six personnel (NS-Team or NST), to deploying personnel individually (NS-Individual or NSI). These approaches have both similarities and differences in a number of aspects (Table 1-3).

[3] Badan Litbangkes: *Badan Penelitian dan Pengembangan Kesehatan* (Health Research and Development Agency; Direktorat Yankes: *Direktorat Pelayanan Kesehatan* (Directorate of Health Services).

[4] KUKPRI MDGs (*Kantor Urusan Khusus Presiden untuk* Millenium Development Goals: President's Special Management Office for MDGs) was a ministerial-level post in President Susilo Bambang Yudhoyono's cabinet from 2010 to 2014. The post was held by Prof. dr. Nila F. Moeloek, who was subsequently appointed by President Joko Widodo to be the Minister of Health (2014-19). This was the background to the absorption of *Pencerah Nusantara*, a KUKPRI MDGs initiative, into a ministerial program. After the end of SBY's administration, staff of KURPRI MDGs transformed their team into the Center for Indonesia's Strategic Development Initiatives, a community service organisation that carries on most of the missions held by KURPRI MDGs while focusing on youth involvement.

Table 1-3: Characteristics of Each Existing NS Program

Characteristics	NS Team-based	NS-Individual	NS-Individual 'Daerah'
Commencement Date	Starting mid-2015, an adaptation of *Pencerah Nusantara* Program by KURPRI-MDGs.	Starting mid-2017.	Starting mid-2019, a collaboration between Banten provincial government and the MoH.
Location	Only in remote *puskesmas*.	In remote *puskesmas*, rural *puskesmas*, community hospitals ('Type D' hospitals), and other types of publicly owned health facilities.	In *puskesmas* and other publicly owned health facilities in Banten province.
No. of Batches	11 batches deployed (as of February 2019).	12 batches deployed (per February 2019).	n.a.
Type of Deployment	Deployment in teams of 5-6 personnel of different professions.	Deployment of individuals, often multiple personnel at a time in one host facility.	Deployment of individuals, may be multiple personnel at a time in one host facility.
Age Limits	Maximum age of 35 years for medical doctors and dentists, 30 years for other professions. Single and willing to not get married in the first 6 months of assignment.	Maximum age of 40 years for all professions. No restriction on marital status.	Maximum age of 40 years for all professions. No restriction on marital status.
Admission Process	2 stages of admission selection process.	2 stages of admission selection process.	2 stages of admission selection process.
Salary Source	Salary from National Budget (APBN).[5] According to profession[6] (doctor/dentist and other professions) and subsequently changed to according to profession and years of education in academic degree obtained.[7]	Salary from National Budget (APBN). According to profession (for doctor and dentist) and years of education in academic degree obtained.	Salary from Banten provincial budget. Additional incentives according to distance of host *puskesmas* to provincial capital.

[5] APBN: *Anggaran Pendapatan dan Belanja Nasional*.

[6] *Keputusan Menteri Kesehatan Republik Indonesia Nomor HK.02.02/MENKES/145/2015 tentang Besaran Penghasilan Penugasan Khusus Tenaga Kesehatan Berbasis Tim (Team Based) dalam Mendukung Program NusantaraSehat* (Minister of Health Decree No. HK.02.02/MENKES/145/2015 on Salary Payments for Special Assignments of Team-based Health Workers to Support the *Nusantara Sehat* Program.

[7] *Keputusan Menteri Kesehatan Republik Indonesia Nomor HK.01.07/MENKES/484/2017 tentang Besaran Penghasilan Penugasan Khusus Tenaga Kesehatan dalam Mendukung Program Nusantara Sehat* (Minister of Health Decree No. HK.01.07/MEKES/484/2017 on Salary Payments for Special Assignment of Health Workers to Support the *Nusantara Sehat* Program.

Characteristics	NS Team-based	NS-Individual	NS-Individual 'Daerah'
Training Details	Pre-departure training for 40-45 days.	Pre-departure training for 10 days (except for NST alumni).	No information.
Briefing for Host *Puskesmas*	Heads of host *puskesmas* are invited to a week-long workshop to learn about NS Program, meet NS recruits, and present host *puskesmas*' profile to NS team.	No forum for heads of host *puskesmas* prior to NS recruits' departure.	No information.
Additional Funding	Additional BOK earmarked for NS activities, proposal combined with budget for host *puskesmas*, only to be used for items related to non-curative activities. • Rp 200 million (2017-18) • Rp 250 million (2018 - current)	No additional operational fund for *puskesmas*.	No information.
Monitoring and Evaluation	Annual monitoring and evaluation meeting of NS recruits in Jakarta.	Annual monitoring and evaluation meeting of NS recruits in regional area.	No information.
Eligibility to Rejoin NS	Eligible to re-join NS in NS-Individual, with no pre-deployment training required.	Eligible to re-join NS in NS-Individual, with no pre-deployment training required.	No information.
Eligibility for Scholarships	Eligible to apply for NS alumni scholarship.	Eligible to apply for NS alumni scholarship.	No information.

Source: Author, 2019

[8] *Peraturan Menteri Kesehatan No. 71/2016 tentang Petunjuk Teknis Penggunaan Alokasi Khusus Nonfisik Bidang Kesehatan Tahun Anggaran 2017* (Minister of Health Regulation No. 71/2016 on Technical Guidelines for the Use of Special Non-physical Health Allocations for Fiscal 2017).

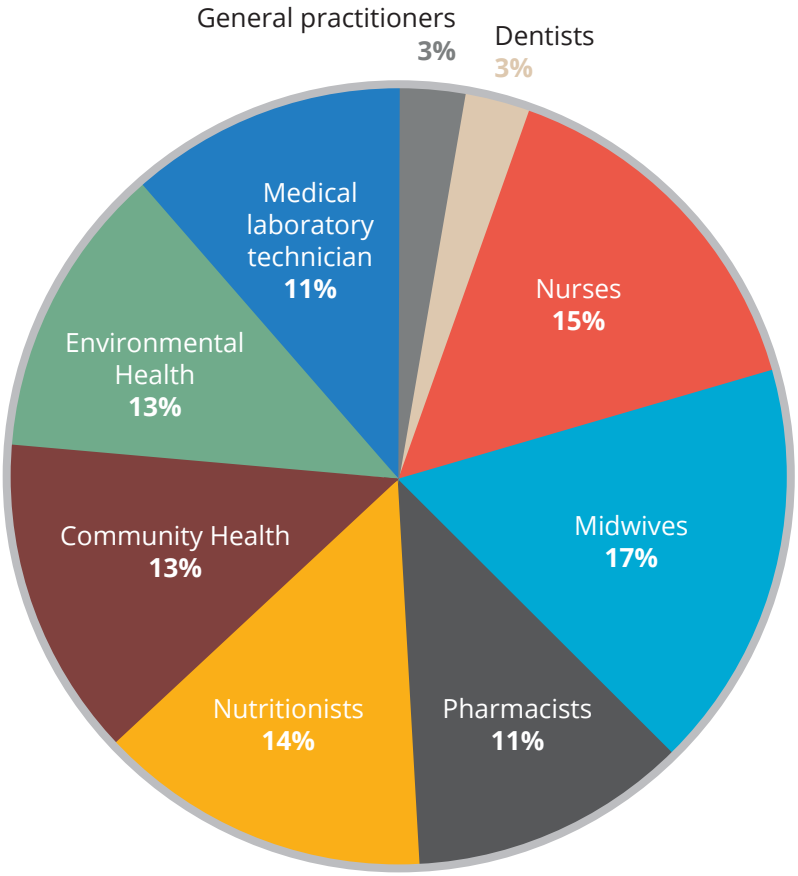
[9] *Peraturan Menteri Kesehatan No. 61/2017 tentang Petunjuk Teknis Penggunaan Alokasi Khusus Nonfisik Bidang Kesehatan Tahun Anggaran 2018* and *Peraturan Menteri Kesehatan No. 3/2019 tentang Petunjuk Teknis Penggunaan Dana Alokasi Khusus Nonfisik Bidang Kesehatan* (Minister of Health Regulation No. 61/2017 on Technical Guidelines for the Use of Special Non-physical Health Allocations for 2018 and Minister of Health Regulation No. 3/2019 on Technical Guidelines for the Use of Special Non-physical Health Allocations).

[10] *Peraturan Menteri Kesehatan No. 13/2018 tentang Penyelenggaraan Pemberian Beasiswa Bagi Tenaga Kesehatan Pasca Penugasan Khusus Tenaga Kesehatan* (Minister of Health Regulation No. 13/2018 on Provision of Scholarships for Health Workers Following Special Assignment).

1.3.1. *Nusantara Sehat* in Numbers

From its initiation in mid-2015 to early 2019, there have been 11 batches of NST deployed to 131 municipalities/regencies in 22 provinces, composed of 467 teams of 2,661 personnel. Of these, 37.6 per cent are clinicians (doctors, dentists, nurses, and midwives), while the rest (62.4 per cent) are promotive/preventive professionals (pharmacists, nutritionists, public health workers, environmental health workers, and medical laboratory workers) (Fig 1-1).

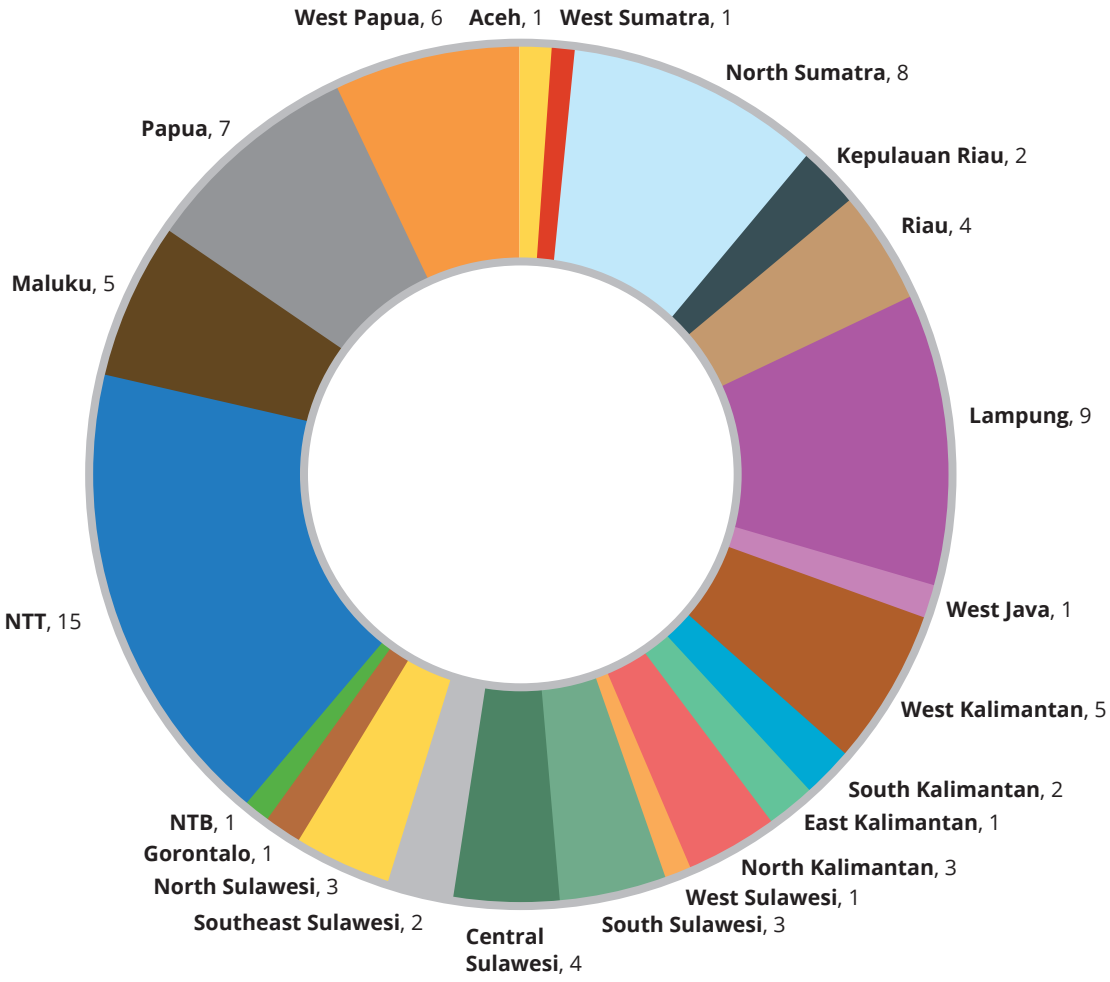
Figure 1-1: NS Team-based Recruits Batch 1-11 (by Profession)



Source: BPPSDM database February 2019.

Data on the continuation of the NS Program in host *puskesmas* can be a clue to how the host *puskesmas* and local government value the NS Program. In February 2019, 251 teams (batch 1-5) in 251 *puskesmas*, had finished their two-year NST contract. Of these 251 *puskesmas*, 91 then became second-time hosts to NST personnel, while 75 *puskesmas* were second-time hosts to NSI personnel. A total of 166 (66.1 per cent) of the 251 *puskesmas* have, therefore, been repeat recipients of NS programs, either in the form of NST or NSI. This data evidences a high level of enthusiasm among *puskesmas* that have hosted NS recruits to remain committed to, and beneficiaries of, the NS deployment program. Only 85 *puskesmas* (33.9 per cent) are no longer recipients of NS personnel of any form (Figure 1-2). The reasons behind the discontinuation are still to be explored.

Figure 1-2: Discontinued NS Locations (by Province) at *Puskesmas* After One Term



Source: BPPSDM database February 2019.

1.3.2. Knowledge Gap in Evaluating NS Program

The question that remains unexplored is the influence of NS experience, especially given its interprofessional nature, on health workers' practices and vision for a comprehensive PHC system in Indonesia's left-behind areas. This study is expected to contribute to the macro-discussion on PHC management, and the micro-discussion on the education and employment strategy of HRH in Indonesia. The study comes from the starting point that a health worker's knowledge and practice in health care is dynamic and malleable to negotiations, where the context of their profession, their workplace, and their past experience are also determinants of their perception of their current practice and future career plans.

02

Research Methodology

Interprofessional collaboration in PHC will be the main concept used in the research instrument design and analysis. Zwarenstein et al. (2009) define interprofessional collaboration as "the process in which different professional groups work together to positively impact health care" as well as "issues that arise due to different professionals working together". We, therefore, envision interprofessional collaboration itself as a black box that can be investigated and that the process of interprofessional collaboration should be assessed based on its impact on health care–as reflected from the activities that are carried out.

This study focused on two things to be studied: (i) the process of collaboration in the studied NS teams; and (ii) the health care activities they implemented. In this study we did not extend our focus into outcomes in the community's health status for we recognise that interprofessional collaboration is only an intermediary, and far from being the single determinant of health status outcome.

This study is conducted to answer the two questions that have been raised as a knowledge gap:

1. How do NST recruits collaborate interprofessionally in their work in *puskesmas*?
2. How do NST recruits perceive the program's impact on their career path, especially with regards to careers in PHC in left-behind areas?

This study is designed to capture the narratives of the different health professionals in health recruited under the NST Program, both while they were under active NST contract or alumni who have finished their contract (in their own terminology: *purna*). As the experience of their work in an already established *puskesmas* environment and adapting to coexistence with the staff of host *puskesmas* as well as life in a new community serves as an omnipresent backdrop to their work, the study incorporated this into their narratives. The analysis, therefore, takes on an anthropological aspect which recognises the health workers and their social relations as an important determinant in the performance of the health system.

2.1. Qualitative Methodology in Health System Research

The study is built upon the theoretical framework of anthropology of public health (Campbell 2011) but narrows its focus to the concept of PHC. The main assumption of the concept is that health care and the public health discipline are cultural constructs with dynamic, two-way relations with actors who have their own agency. Anthropology holds great value in studying and understanding a health policy from humanity's aspects (socio-politico-cultural) (Goldman and Borkan 2013). A critical anthropological theory takes the position that the discipline of public health must be able to reflect on its strengths and weaknesses and put concepts and practices under the microscope for it to keep on developing itself.

The historically profound concept in public health is essentially also a product of culture, always experiencing modifications over time, interpreted and practised differently by various multi-scalar institutions. These range from academics to governments, health professional groups, health care facilities, and the general public (WHO 2008; Kringos et al. 2010; Starfield 2011). In its evolution in a number of health care systems in the world, primary care has gone beyond the silos of professional categories–a number of medical specialties have been categorised by some as falling under primary care, such as family medicine, internal medicine, and pediatrics (Starfield et al. 2005) or beyond the limitations and levels of health care facilities (IOM 2012).

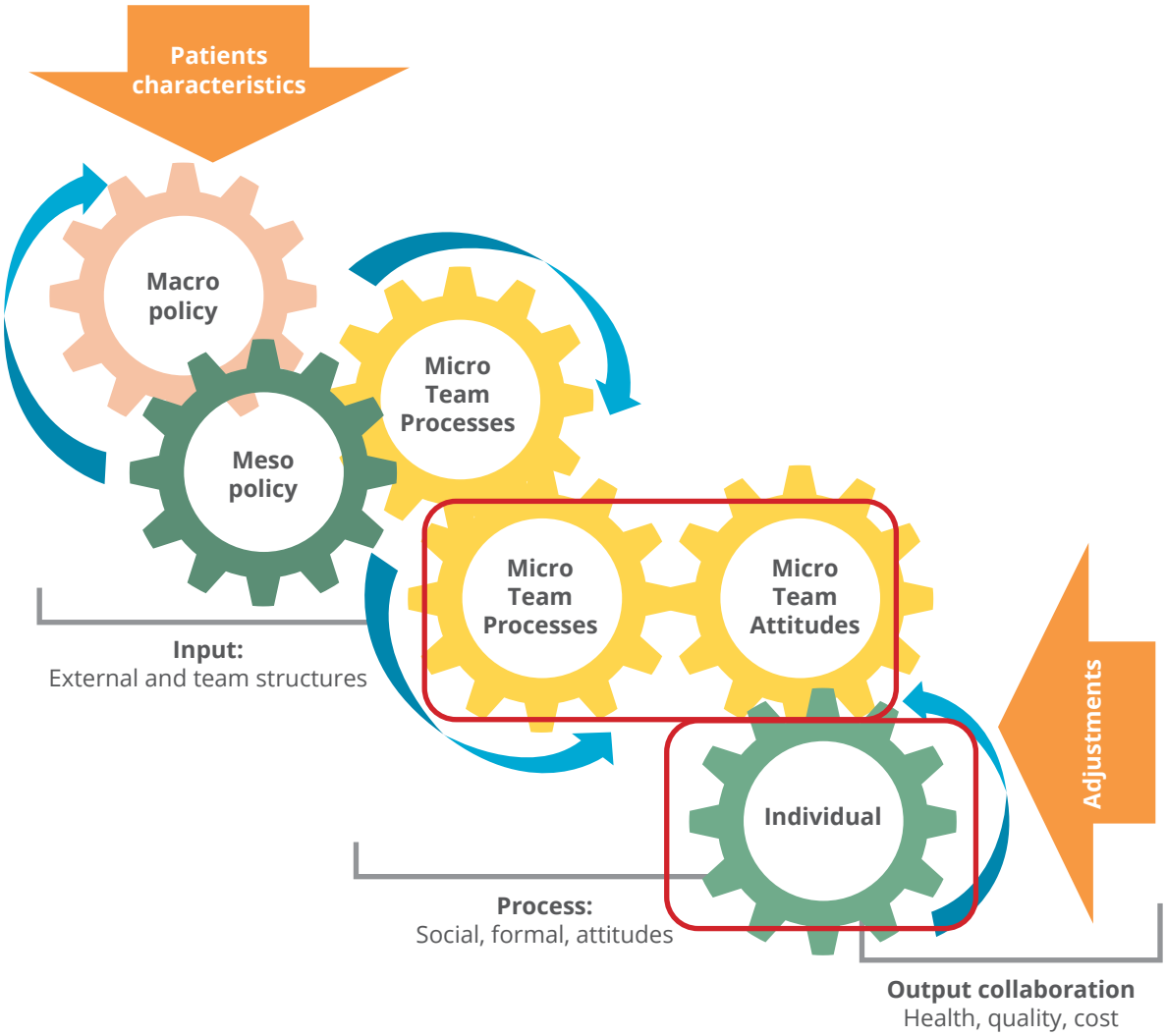
To examine how PHC is interpreted and adopted into practice by different health systems, it is important to understand how the actors in a health system shape how the concept is interpreted. These actors are driven by various motives, each one having their context and interests. This renders studies that explore the actors' insight and narratives to be very salient.

NS, especially the team-based deployment, was kick-started with the idea that comprehensive PHC can be better delivered by a cohesive team of multiple health care professions. Each team was to consist of at least five out of the nine nominated professional groups (doctors, dentists, midwives, nurses, and the five "promotive/preventive" health professions: public health workers, environmental health workers, pharmacists, laboratory technicians, and nutritionists). This study is designed to explain how the phenomenon of interprofessional collaboration in NS teams is an interplay of cultural constructs of the various health professions, and how this affects its ability to achieve its goal to provide PHC services.

In 'unboxing' interprofessional collaboration, this study is guided by the "Gears" conceptual model proposed by Mulvale et al. (2016) (Figure 2-1). This model breaks down the factors affecting the success of a collaborative process into multiple levels, from the macro level down to the individual level. The macro and meso level factors are policies affecting interprofessional collaboration, the micro level factors refer to processes and attitudes found within the teams, and individual level factors refer to personal beliefs and aspirations, retained knowledge about PHC interprofessional collaboration, and internalised professional identity.

This study is well-positioned to deconstruct the experience at the micro, team-level, and individual level and, where suitable, will enrich the discussion with macro and meso-level policies relevant to findings. In addition, to introduce a socio-anthropological nuance into the analysis, Masterson's definition of interprofessional collaboration (2002) is useful in the way that it sees the collaboration as "a willingness to share and … give up exclusive claims to specialised knowledge and authority if other professional groups can meet patient/client needs more efficiently and appropriately". We translate this into exploring the different experiences between the clinical and non-clinical professions, and even further within the clinical professions.

Figure 2-1: "Gears" Model of Factors Affecting Interprofessional Collaboration Within Interprofessional Care Teams



Note: Adapted from Mulvale et al. 2016.

2.2. Data Collection: Study Sites and Sampling Strategy

The data collection was conducted from January to March 2019. Qualitative data collection was conducted in two groups of informants, namely active NS recruits ('NS-Active') and alumni of the NST Program ('NS-Alumni').

[11] While originally the study only sought the experience of NST Program recruits, in reality many *puskesmas* hosting NS teams are also recipients of NSI recruits. Faced with this reality, the research team found that the perception and experience of interprofessional collaboration should still be investigated–not only with NST recruits but also with NSI recruits who are assigned in the same *puskesmas* as the NS teams. The study, therefore, decided to modify the inclusion criteria for NS-Active into all NS recruits (Individual and Team-based) under active contract assigned in *puskesmas* hosting NS teams.

Table 2-1: Study Informants (by Category and Inclusion/Exclusion Criteria)

	'NS-Active' Category	'NS-Alumni' Category
Subcategory	• **Clinical professions** (medical doctor, dentist, nurse, midwife) • **Promotive/preventive (non-clinical) professions** (nutritionist, pharmacy worker, public health worker, environmental health worker, medical laboratory technician)	
Inclusion criteria	• Health workers with active contract under NS Program in *puskesmas* hosting NS teams • Willing to participate voluntarily	• Health workers who have completed 2-year NST Program contract • Willing to participate voluntarily
Exclusion criteria	• Drop out from NST contract at any stage (NS Drop Out) • Refuse participation	

Source: Author, 2019

For the NST-Active group, the study was conducted through two methods: a one-week immersive experience of living in six *puskesmas* that host NST (or in their vicinity when necessary). NST-Active informants were accompanied in their daily activity and a semi-structured interview was also conducted with each of the NST members in the study sites.

The study sites for the NST-Active group were selected from the existing study sites that were used in a concurrent evaluation study on the impact of NSTs on community-level health-related behaviour. This study was conducted by TNP2K's Health Working Group in the period 2018-19. The study sites for the latter study are 18 *puskesmas* in three provinces: Bengkulu, South Sulawesi, and East Nusa Tenggara (Table 2-2). Only 12 out of the 18 *puskesmas* are hosting NSTs of varying batches. This study selected five out of the 12 *puskesmas* with active NSTs: two in Bengkulu, one in South Sulawesi, and two in East Nusa Tenggara. The selection of these provinces was deliberate to portray the different socio-cultural and geographical contexts from the western to eastern parts of Indonesia.

Table 2-2: Study Sites and Informants (by Category)

	'NS-Active' Category	'NS-Alumni' Category
Study sites	**Three provinces:** 1. Bengkulu: 2 *puskesmas* 2. South Sulawesi: 1 *puskesmas* 3. East Nusa Tenggara: 2 *puskesmas*	
Informants	• 2 teams from batch 9 • 2 teams from batch 7 • 1 team from batch 6 • 12 clinical professions • 18 promotive/preventive professions	• Snowball sampling and open-call via NST-Alumni (batch 1-4) networks • In depth interviews: 5 clinical professions and 8 promotive-preventive professions • FGD (Jakarta): 3 clinical professions and 2 promotive/preventive professions
	Total: 48 informants* (see Appendix for list of informants) • 20 clinical professions • 28 promotive/preventive professions	
Data collection methods	• Semi-structured interviews, 90-120 minutes • Observation: 5-7 days per study site location	• Focus group discussion (FGD) (for informants residing in the Greater Jakarta area - Jabodetabek), 90-120 minutes • Semi-structured interviews (per telephone), 90-120 minutes

Source: Author, 2019

Informants for the NST-Alumni group were selected by utilising the existing informal network of NST-Alumni through social media. An open call was distributed through existing networks–providing the research team with a list of prospective informants. Following that call, a snowball sampling method was occasionally carried out. From the prospective list, informants were selected purposively to represent the two subcategories of informants (clinical professions and promotive/preventive professions) to give a balanced ratio of the two subcategories.

Data collection for the 'NS Alumni' category was conducted through two means: one was an FGD (which was conducted in Jakarta in the first week of February 2019) and the other was a semi-structured interview conducted by phone. All interviews were audio-recorded with consent from each informant. A total of over 87 hours of interviews were recorded and subsequently transcribed and coded by four research team members independently, with opportunities for discussion within the team to maintain consistency and to cross-validate interpretations. From all research team members, findings were analysed and major themes composed into narrative patterns of interprofessional collaboration practice as well as career perspectives. These were written into two chapters in this report.

A grounded analysis was conducted, where the narratives from the study's informants provided the qualitative data for the major findings on the two research questions. It is noteworthy that, in a grounded, narrative-based research analysis, the study was able to find connections between different phenomena that were not envisioned at the beginning when formulating this study. In addition, in analysing the interviews and observations, this study puts great importance on putting forward the informants' own voices as the center of the narratives.

2.3. Human Research Ethical Consideration

The study's design and protocol obtained an ethical clearance from the Research Ethics Committee of the Faculty of Public Health, University of Indonesia in December 2018, with the Ethical Approval number 818/UN2.F10/PPM.00.02/2018. The main ethical consideration for the study is the vulnerability of the informants due to the nature of their contract-based employment status as well as potential future employment with the MoH. The strategy employed to overcome this ethical consideration is to uphold the confidentiality of the informants identity, as well as the specifics of the study locations, from the MoH as the main employer. All informants are assigned a code name.

Upon written and/or verbal consent of the health workers and other people in the study sites, researchers recorded the interviews and observed activities in the form of audio recording, field notes, as well as visual data (photographs and video recordings). All informants' names and specific locations of the observed activities have been de-identified in the writing of this report and subsequent publications. All photographic materials used have also gone through de-identification where appropriate.

[12] The code-name structure for NS-Active informants is [Profession].Active-[Code Number Assigned to Each *Puskesmas* Site]. The code-name structure for NS-Alumni informants is [Profession].Alumni-[Interview Order Number].

03

Nusantara Sehat Program's Influence on Interprofessional Collaboration

As mentioned in the earlier chapter, a comprehensive PHC service has a health care structure that combines the delivery of curative and rehabilitative services with promotive and preventive services (Labonté et al. 2014). Interprofessional collaboration is a strategy to achieve this form of comprehensive PHC. In addition to the structure of *puskesmas* that requires its staffing and programs to cover all of these, the presence of the multi-profession NS teams also evidences how the NS Program tries to embody this comprehensive PHC concept.

This chapter explains the narratives arising from the NS recruits' perceptions and experience with regard to the reality they face in performing their tasks in the *puskesmas*, and how they might or might not work towards achieving comprehensive PHC.

3.1. NS Team's Collaborative Strategies for Comprehensive PHC

3.1.1. Community's Demand for Curative Services

As has been the case in many parts of the world and in Indonesia for a long time, there is a strong tendency in the wider society to value curative services over promotive/preventive services. This is especially true for communities in the most remote and isolated parts of the country, including in this study's sites.

The promotive/preventive health workers have learnt, through their experience working in the field, of the phenomenon whereby the community's perception for health care need is still dominated by "illness experience" and the desire to receive medication, and not by the need for health-related knowledge to promote their health or to prevent illness itself.

"How is the situation of the community's demand for health care there?"

> *"The need... actually we have to be 'active' towards them, because health is the right for every one of them, right, while the definitions of health of the people are different... The definitions of health and illness are different... Some would say, they cannot get out of bed and only then admit to being ill. Whereas actually when they are feverish, or having symptoms, well, people are not aware... sometimes they choose to just work."*
>
> **(PublicHealth.Alumnus -1)**

Seeking promotive/preventive health care and knowledge is low in the community's list of priorities. The health professionals in *puskesmas* knew, therefore, that they must seize all opportunities to build the community's demand for promotive/preventive health care. Unfortunately, the health workers also learned from being amongst the community that members of the community have little interest in distinguishing between the various health professions.

"In health, what does the community need?"

> *"Look... habits, pattern, and other things are different between the different villages. Also, their understanding is still lacking. For instance, even for health professionals they only know midwives, doctors. ... If they're females, whether it's a midwife or a doctor... When it's a male then it's a doctor, if it's a female then it's a midwife."*
>
> **(PublicHealth.Active-5)**

It is worth noting that all the 'acknowledged' professions are largely known for the clinical/curative aspect of their services. In line with that, there is an expectation in the community that curative services must be ready at all times, in contrast to the arguably lower demand for promotive/preventive services. This demand is even strengthened when the community members are aware of the presence of new staff members at the *puskesmas*, such as when the NS teams first arrived.

One active public health worker gave us her story of adapting to such expectations by working beyond the *puskesmas*' work hours on the local community's demand for curative services.

> *"...when we arrived at that time, we were introduced to the Kecamatan (subdistrict) [office] and also to the community members, they were informed that there are already additional health workers here, from various professions. So, the community members... when in the past [they know the puskesmas to be] inpatient care... so they already are used to, I mean, come [to the puskesmas] at night time... they feel... 'There are new officers, they live there [at the puskesmas] at all times'. So they would often come at night."*
>
> **(PublicHealth.Active-3)**

In the *puskesmas* where she worked, the work hours of the *puskesmas* had been downgraded from being a 24-hour inpatient facility (*puskesmas* rawat inap) to only providing ambulatory care during daytime (*puskesmas* rawat jalan). The decision to downgrade was taken for the *puskesmas* to undergo accreditation.[13] The reason for this downgrade was that the *puskesmas* did not meet the required minimum number of staff for an inpatient *puskesmas* as determined in *Permenkes* No. 75/2014. This change in *puskesmas*' operational hours has been widely announced in the community.

Nevertheless, although the community members are demanding service outside of the *puskesmas'* announced work hours, NS team members acceded to the public demand because during the adaptation period they needed to be accepted first by the community. Instead of this community pressure creating a conflict between them, they were able to look at this organic behaviour of the community members and utilise this to gain the community's trust.

Figure 3.1 *Posyandu* in Bengkulu's Village

Source: TNP2K, 2019

In a corner of a *posyandu* in a remote Bengkulu village, the *puskesmas* team decided to open an additional 'table' for medication. Nurse-Active.3 is at the immunisation corner with her vaccine cool-box, while two midwives (neither are NS-team recruits) attend to community members who come seeking medication.

[13] To achieve the goal of improving and maintaining performance of *puskesmas*, a periodic accreditation process for *puskesmas* around the country started in 2015. This activity is run by MoH, as regulated under the ministerial regulation on the accreditation of primary care facilities (*Peraturan Menteri Kesehatan* No. 46 Tahun 2015 tentang *Akreditasi Puskesmas*, *Klinik Pratama*, *Tempat Praktik Mandiri Dokter, dan Tempat Praktik Mandiri Dokter Gigi*: Minister of Health Regulation No. 46/2015 on the Accreditation of *Puskesmas*, Primary Clinics, Independent Doctors' Practices, and Independent Dentists' Practices). To pass the accreditation process, a *puskesmas* must provide evidence that it has fulfilled all the requirements, consisting of a minimum standard of human resource availability, physical infrastructure and amenities quality, as well as standard of service and administrative management. The result of the accreditation process is graded on four levels of 'accreditation status'.

3.1.2. Incorporating Curative Care with Promotive/Preventive Health Care

After gaining such trust, NST recruits and the *puskesmas* staff use the advantage of the community's trust to deliver promotive/preventive health services that are usually in much lower demand.

> *"If we don't deliver medication during posyandu,*[14] *there will be less people showing up".*
>
> **(Nurse.Active-3)**

Nurse.Active-3 explained that, as a result of opening a 'medication table', the turnout for *posyandu* has increased which allows them to deliver promotive/preventive programs such as Posbindu PTM[15] and immunisation. Although, by programmatic design, a *posyandu* is not set up for curative services, the *puskesmas* staff understand that to achieve better attendance at *posyandu*, they must acquiesce to the existing demand for 'medication' from community members.

According to PublicHealth.Active.1, in recounting her effort to run health promotion among elderly clients with hypertension, most did not have a proactive attitude towards their blood pressure control, such as diet modification and routine control. Once the team along with other *puskesmas* staff started incorporating curative care into Posbindu PTM, however, she noticed that attitudes started to change.

> *"Slowly there has been... quite an awareness from the elderlies; they started coming to... like, Posyandu Lansia (posyandu for the elderlies). They have started to [attend] routinely because there is medication too there. Out-of-facility medication. So, finally they have started to routinely [come], every month. [We] said, 'Yeah, this is an effort from the puskesmas to bring the services closer... If it's far away, then we can make it closer, right?' But for the self-awareness... there are still community members who would rather go to their farm first, to work first, rather than going to puskesmas."*

"Posyandu Lansia provides pharmaceuticals, does it?"

> *"Yes, there is [medicine given], now we already have [a policy] for out-of-facility medication, so we give them... But only for the elderlies."*
>
> **(PublicHealth.Active-1)**

3.1.3. Orienting Service to Community's Needs

The NS team recruits were briefed to identify community demand first and then to align it with the interventions that the *puskesmas* can deliver. This public health worker, for instance, cast a critical gaze over what it was that the community needed over time after realising that their interventions did not bring the outcome as expected.

[14] *Posyandu: Pos Pelayanan Terpadu* (Integrated Health Posts

[15] *Posbindu PTM: Pos Pembinaan Terpadu Penyakit Tidak Menular (Integated Development Post for Non-communicable Diseases).*

> *"We have spoken repeatedly [on health promotion], but the community maintained their way of thinking. A small example is like the building of latrine. Their excuse was there was not enough water. At first I thought, 'We can overcome that, it should not be a hindrance to us changing our behaviour!' … That's why, I said, 'Why are they always looking for excuses? We are already trying to help!'*
>
> *"Maybe they thought, 'Well, with open defecation we would not need much water. In the forest there are places… we could even go while we go for a bath (in the river). Whereas if we have a water closet, automatically we have to prepare water in the toilet and maintain its cleanliness. Meanwhile, the need for water is not only for going to the loo… but also for cooking, for washing.' That's what they thought. And with the small water debit, they would have to store so much water.*
>
> *"Then we eventually began to understand, and we no longer forced them to have the 'healthy latrine', the swan neck latrine… I finally thought, we cannot keep on forcing the community, especially considering their economic condition. So, we turned into 'how can we change just their behaviour?' … At least now what we hoped for is, just the emergency (latrine), we would be very grateful, so as not to have open defecation. That's the key… Finally, they began to be open (to us)."*
>
> **(PublicHealth.Active-1)**

With experience and an empathetic attitude, NS respondents acknowledged the influence of other structural determinants of health. In orienting their analysis towards the community's needs, they have started to learn to recognise the roles of other professions too. Not only do they develop in the way they critically analyse their community's situation, they also developed the skill to collaborate with other health professions in a comprehensive manner.

> *"Because we are here with different professions, right? So, I… learn more what my role here is, …and to be more confident, in the community. In previous work experience in the hospital, the skills [that were developed] are only [the usual ones], whereas here, it's not like that. It's like, one must know of the other professions too… so for instance if… giving suggestions to the community, [and then finding out] oh, the community's need is this [something else]… I then give them health promotion, education first, and then… if the patient must get nutritional counselling, well then the mother I would immediately [refer] to the nutrition officer. So, I can give suggestions."*
>
> **(PublicHealth.Active-3)**

The recognition of each other's role is also a slow growth process for many teams. This pharmacy worker, for instance, conveyed that his knowledge and skill on pharmacology at first was unrecognised and, therefore, underused but this slowly changed over time.

> *"It's safe to say that pharmacists are human resources that are still considered unimportant. So sometimes when we say something, they didn't believe [me]. Not only nurses, sometimes other medical staff also did not believe me. All they know is, well, I provide for them; when they asked for pharmaceuticals, I'd give them; when they asked for medical equipment, I'd give them. They did not understand that actually I know what pharmaceuticals are about; in the sense that, 'this medicine has this side effects', and then 'this medicine may be more suitable for this use'. Slowly they began to understand, 'Oh, it turns out pharmacists can do this.' That is why now they have, more or less, when there's anything to do with medication that they did not understand or were not confident of, they would ask me".*
>
> **(Pharmacy.Active-1)**

This awareness of the need for interprofessional collaboration also seemed to be affected by the recruitment and pre-assignment training process. There is high enthusiasm amongst NST recruits to collaborate with the different professions. This is promoted by the concept of a common mission that has been developed since the pre-assignment training to support activities that have an interprofessional nuance.

> *"It's like, one activity, how can it solve [a problem] by each profession, and... Sometimes, for instance, environmental health, it cannot stand alone. Environmental health must contain health promotion. Environmental health is, in a way... For health, it cannot be medicated [by environmental health worker]... we have a midwife and a nurse [for that]. And then nutrition... the nutrition must also be good.*
>
> *Such as stunting. Stunting is multifactorial; there are environmental factors, and from health promotion's side we must give much promotion, and from health [lab] analyst also... and from nutrition even more.... Well, I mean, it seems like we were really demanded, like, how do you... in other words, six professions [come with] six [ways of] thinking, but the goal is still one goal."*
>
> **(EnvironmentalHealth.Active -5)**

This informant mentioned, as an example, that stunting is one of the clinical cases that requires the expertise of all health professionals available in a *puskesmas*. The involvement of the public health promotion and environmental health officers are just as important, if not more so, at a population level, as the medical doctors, midwives, nurses, pharmacists, nutritionists, and medical laboratory technicians/analysts. This understanding of the presence of such complex cases reflected an acute awareness of the importance of interprofessional collaboration.

Figure 3.2 Village Meeting in Bengkulu's Village

Source: TNP2K, 2019

NS team members in a Bengkulu village hold a village meeting to gather a consensus on building latrines in every household. While the environmental health worker was leading the initiative, team members of all professions contributed their time and energy into building good relations with local village stakeholders.

Figure 3.3 Morning Exercise Session in *Puskesmas*

Source: TNP2K, 2019

On Fridays, the NS team in this Bengkulu *puskesmas* held morning exercise sessions with a desk and chair with a quick blood pressure check-up before and after the session. They also prepared jelly puddings for the exercise participants.

3.1.4. Impediments to Interprofessional Collaboration

Nevertheless, there are still instances of sub-optimal interprofessional collaboration between the health workers within the team. There are professions that still feel misunderstood and underappreciated and it is apparent from some teams that professional hierarchies are still reproduced in daily practice, especially between doctors and other professions. While the intention behind it may not be malevolent, it still created frictions in the dynamic between the NS team members.

> *"(Pharmacy.Active-1) is the leader, since the beginning when we were still in Jakarta... Well, we already could guess that it was going to be problematic during assignment. So he seemed to position himself as the leader, whereas when we're in a team, he could be the leader in NS, but in the puskesmas I am more of the leader than he is, because I am the person in charge of the pharmacy unit, I am his superior. So, we cannot mix one with another. Eventually... I don't know, since the beginning we never had the same perception."*
>
> **(Physician.Active-1)**

The sense of 'leadership' in every NST was something that was nurtured during the pre-assignment training, however, unfortunately, not enough attention was paid in this phase to discussing how teams can overcome the traditional professional hierarchy. The abovementioned pharmacy worker in an NTT *puskesmas*' NS team felt as if the role of leadership that was given to him during training was undermined by the more traditional leadership position with which the doctor challenged him. An NST public health worker from another NTT *puskesmas* felt that one possible reason for professional jealousies is that during the pre-assignment training the material given was still less than what they needed, at least in the support that they needed to engage in interprofessional collaborative activities in the *puskesmas*.

> *"...when we were still at Ciloto (the location for pre-assignment training), what we got from it, well... it's not exactly useless, but too little... That's why when we arrived here, [the situation here] is also different from the materials given by the Ministry of Health. Even many of the dentists complain because they were not provided materials at all."*
>
> **(PublicHealth.Active-4)**

This might be because of the structure of the training that, for the most part, emphasised physical fitness and mental readiness of the health workers. This came at the cost of the recruits' understanding of field-specific content on professional as well as health system management skills and knowledge.

"From the training, what do you take from it the most?"

> *"Nothing. Nothing for me. All is physical activity only. Because from 10 (in the morning) we were made to listen. Of course we were sleepy! We had to wake up before dawn, with so much struggle because sometimes the water (in the shower) would die. And then we had to do all kinds of exercise. So of course by 9 or 10 in the morning we would be sleepy when we had to listen to boring 'slides'."*
>
> **(Nutritionist.Alumnus-2)**

These kinds of remarks are generally found throughout the study's interviews, with the exception of those NS recruits from the first batch.

> *"Honestly, during the training, it's all just formality, because we are [drilled] more on the physical... on the physical, because the materials that were presented, with hundreds of people in the large room... and the presenter only reading the slides... of course we understand nothing! (laughter) Sleepy!"*
>
> **(EnvironmentalHealth.Alumnus-2)**

> *"For the [content delivery], honestly, so many [of us] slept, because we were too tired during 'Bela Negara' ('Defending The State', the NS training term for physical exercise drill sessions). When someone made one mistake, [all of us were] punished to crawl... push-ups... our bodies could not do it. I was also having coughs, [my condition] was drop[ping down] at the time, so to receive materials, not so much... because we were already physically tired."*
>
> **(EnvironmentalHealth.Active-2)**

"Batch 2 was the batch with the most recruits, 500, maybe close to 600. That's why we were divided into two [training grounds]. For theory [content delivery], it was not too explanatory for a lot of it. It was only the overview. Yes, we were taught about maternal health, child health, but only an overview. About ministry's policies, we were not taught in detail, like what nutritionists are supposed to do [in puskesmas]. We were discussing more on how to make RUK (Rencana Usulan Kegiatan or Activity Plan Proposal, part of the budget plan document). Yes, in puskesmas we make this [RUK], but we were still too tired to absorb the material given. So, on RUK, not maximised."

(Nutritionist.Alumnus-2)

"Probably it's different from us... maybe it's very, very different. While the second and third (batch's pre-assignment training) are more physical, for us the emphasis was more on the materials. So, we were in Ciloto (an NS training ground in Jakarta) for one or two weeks, and the rest of the time was in Hang Jebat. We even slept in air-conditioned rooms. At 7 in the morning cars were prepared for us to go. According to our professions (we had different schedules). 'Midwives, today you'll go to the MCH's emergency care in Cipto Mangunkusumo hospital; (nutritionists), you go to the nutrition unit; nurses, you go to the workstation. After this, go to the front and we'll pick you up'. ... Five professions were taken there. And then, for the emergency care material, ATCLS and BTCLS, all of the professions were all there together. ... Day four, we learned about (childhood nutrition), and then we presented to each group about what we learned. Day five, about policy..."

(Midwife.Alumnus-4)

From changes over time in the way the pre-assignment training was delivered, it can be inferred that there has been a shift from what the initial program was envisioned to be and what it has evolved to be in more recent practice. This is compounded by the fact that the policy for additional operational funds for NS teams' host *puskesmas* (*Permenkes* No. 71/2016, *Permenkes* No. 61/2017) and the increase in NS salary in 2016 (*Kepmenkes* No. HK.02.02/MENKES/223/2016), was likely to be a result of the earlier NS team alumni's advocacy.

"[The additional fund (BOK)], there was none during my time... We talked about it when the team from Litbang (Badan Penelitian dan Pengembangan Kesehatan, or Research and Development, Ministry of Health) came to visit us, [they asked] 'What do you need?' [We told them] 'We don't have any fund'. From there they made a review and then decided that there would be funds to be disbursed. That's what's so good about being NS [in the following batches]. Two hundred [million rupiah additional fund], it started with us complaining at that time.

"... When we made the suggestion, we studied it first. We brought the regulations on human resources to compare what our rights are and what our obligations are. And then we send it to the Human Resource division. That's what we did, the first NS batch. That's why the 200 million [rupiah additional fund]. We made a letter. I remembered it clearly when we put our signatures on the materai (legal stamp), and then we scanned it, and we went directly to the regency['s Health Office]. That's why only after nine months before we were finishing [our assignment] that there was an increase in salary. But that's okay."

(Midwife.Alumnus-4)

In addition to the lack of preparation during training for interprofessional collaboration, the friction between the team members may also be stoked by the lack of clarity of what is expected of the NS teams. Teams were indoctrinated with the idea that they were to deliver innovative services in the field, but officials from one local Health Office (Dinas Kesehatan: *DinKes*) demanded that they perform the standard services instead to fill the gap in existing services. This official's complaint was demoralising to the team.

> *"The head of the Pharmacy unit (from the Regency Health Office) came here, she's a pharmacist. She said, 'How can you innovate, when you cannot even perform the standard service!' We feel very embarrassed! I have never felt so embarrassed in my whole time working here. Our pride was ruined; the image that we were trying to build, that NS recruits are always full of spirits, all destroyed because of our own 'leader'."*
>
> **(Physician.Active-1)**

This mismatch between two differing perceptions of the NS team's mission has compromised the integrity of team unity in this *puskesmas*. While the other members of the team internalised the team's mission to be performing innovative programs which are oriented towards health promotion and prevention at the community level, the pharmacist in the NS team took it upon himself to change his mission into one which is oriented towards managing the pharmacy unit, especially given the fact that he was the only person in the *puskesmas* with an actual background in pharmacy.

> *"I have said, 'Sorry, I was not the one performing this task (in the past). What could I have done, when I requested that I be involved in (pharmaceutical management) they did not let me, they did not entrust me with it.' So, because of that happening last year, starting this year I have been in charge of tasks such as pharmacy stock reporting. Although someone else (a volunteer staff) is still working with me on it too. So, bottom line, they gave me all the harder tasks. Oh well, I just do it. Because of the disparity in status (of employment). Especially when it comes to talking about volunteer staff. That will be another (conflict)."*
>
> **(Pharmacy.Active-1)**

Lurking in the background of team-level conflict is the disparity of employment tenure between the NS recruits and the rest of the *puskesmas* staff. The *puskesmas* staff are on three different types of employment tenure: (i) PNS (*Pegawai Negeri Sipil* or civil servants); (ii) fixed-term contract staff (under different headings of employment tenure, from THL (*Tenaga Harian Lepas*: Daily staff) to TKD (*Tenaga Kontrak Daerah*: Regional Contract Staff); and (iii) volunteer staff (known widely as '*tenaga sukarela*'). In discussing the phenomenon of interprofessional collaboration by NS teams, it is, therefore, imperative to analyse the situation of collaboration within the *puskesmas* hierarchy.

3.2. Uncertain Collaboration Between NS Team and Host *Puskesmas* Staff

3.2.1. Initiatives for, and Impediments to, Facility-Wide Collaboration

In the teams that we observed there were attempts to practise their interprofessional collaboration not only with fellow NS team-based recruits but also with the rest of the *puskesmas* staff. For instance, an environmental health worker stated their preference for facility-wide collaborative activities rather than planning for a single-profession activity.

> *"It's good, I like it more when I collaborate when working, instead of just focusing to one profession. I like it like that… There are those of us [NS team], and there are ones from the puskesmas… and then at the end there will be reports, what activities [we do], what innovations have been done by NS for the community members in Puskesmas. Later on, we also have NS innovations, and then there are also ones from puskesmas."*

(EnvironmentalHealth.Active -3)

There is a drive to better understand that other *puskesmas* staff's burden is also exacerbated by human resource constraints in *puskesmas*. As well as being understaffed, the different health professions in the *puskesmas* are also inundated with additional tasks which give them a nuance to their understanding of the nature of work of other health professions in *puskesmas*.

"Do you feel you understand enough the role of other health professions [in the puskesmas?]"

> *"Yes, but still not maximally. When it is about the professions' [role] only, yes, I have. But then they are given additional tasks too, because we do multiple tasks here because we don't have enough people."*

(Physician.Active-4)

The impediments to collaboration between the NS team recruits and their host *puskesmas* is partly due to the *puskesmas* being disproportionately staffed. The health workers' sense of the different professional identities and boundaries and, therefore, the concept of collaboration, may be confused. This is due to the overabundance of midwives and, in some locations, also an overabundance of nurses, which drove the *puskesmas* to conduct 'task shifting', a situation where health workers are required to perform tasks they were not originally trained to do. As an example, in this Bengkulu province *Puskesmas*, as explained by one of the NS team members in this *puskesmas*.

> *"And then for the staff, it's mostly midwives, the ones who are PNS (civil servants), all are midwives except for the head of puskesmas, the head of the admin (Tata Usaha or TU), and one nurse,… as well as the doctor and the dentist."*

(PublicHealth.Active-3)

A similar phenomenon was also found in one *puskesmas* in NTT where there are midwives and nurses who were tasked with medical record management in the registration and medical record room and pharmaceutical management in the pharmacy room.

The overabundance of midwives has created tension between NS teams and the host *puskesmas*. In a one *puskesmas*, for instance, there was even a period of open conflict between the NS midwife and the other midwives.

> *"With the coordinating midwife, I don't like her that much… There was a conflict between me and her. I was in one village that we (the NS team) have a program in, when I received a call about a patient about to give birth. I was not on shift, so I was surprised that the call was not directed to someone on shift instead. The coordinator tried to call me through (another NS team member). 'There's a patient!',*

she said in an angry tone. She protested that I was not at home (in the puskesmas' compound). … Why must I be called?! Just because I live nearby (in the NS recruits' house in the puskesmas compound). Since way back when that's how they do it, calling for midwives who live nearby the puskesmas.

"I protested to the coordinator, 'Let's just not make shifts at all, then! Because at the moment you'll only count on me! I have other tasks to do, I am not here as a contracted midwife, I am a Nusantara Sehat, which is a different program! Nusantara Sehat is mostly going to the field!', I said."

"How many midwives are here?"

"When I just arrived, 18."

(Midwife.Active-5)

Impediments to collaboration are also due to the lack of a sense of team unity between the NS recruits and the rest of the host *puskesmas* staff. In the above example, the conflict between the NS midwife and the other midwives is explained by the fact that there is an oversupply of midwives working in the *puskesmas* and confusion on the role or purpose of NS teams assigned to the *puskesmas*. For the sake of assimilation with the host *puskesmas* staff, the NS midwife was still included in the scheduled shifts of midwives, not taking into account that there is a separate mission that NS teams must carry out. Meanwhile, with the disparity in staff employment tenure and the situation where NS recruits were living in the *puskesmas*' staff house, the NS midwife found that the double responsibility she had to carry was unfair.

There are still positive examples of how a *puskesmas* leadership initiative may mitigate this. One of the observed NS teams explained that they have been reminded by the head of the *puskesmas* to mingle and build a sense of unity between the NS teams and non-NS *puskesmas* staff. This move is also useful so that the NS team members understand better the tasks in the *puskesmas*. The experience of engaging with the host *puskesmas* staff and seeing and discussing their tasks firsthand is even deemed by some NS team recruits to be more valuable than the materials they have received during pre-assignment training.

"The result of learning, and probably having chats, with the head of puskesmas… now that we're one year [working here], we understand better, what the mechanisms are like… [for instance] what the data is for our mini workshops according to the IKS (Indeks Keluarga Sehat or Healthy Family Index),[16] *and [the head of puskesmas] manage us… [For instance, he would comment], 'This has nothing to do with… the dentist.'… Well, so afterwards, in the quarterly mini workshop there would only be nurses, midwives, environmental health worker, while the next mini workshop would be nutritionist, public health workers… So, it's different attendees for every mini workshop."*

(Pharmacy.Alumnus-1)

[16] *Indeks Keluarga Sehat (IKS)* or Healthy Family Index is an index of 12 indicators that are contained in the PIS-PK Program (Family-Oriented Healthy Indonesia Program). These 12 indicators are: (i) access to clean water; (ii) complete basic immunisation for babies; (iii) family access to latrines; (iv) giving birth in health facilities; (v) monitored growth and development for under-fives; (vi) exclusive breastfeeding for babies; (vii) membership in the National Health Insurance (JKN); (viii) contraception use; (ix) smoking-free family; (x) compliant medications for any tuberculosis patient(s) in the family; (xi) routine medications for any hypertensive patient(s) in the family; and (xii) the proper attention and medication to any severe mental health patient(s) in the family.

3.2.2. The Idealist Newcomers

In their engagement with host *puskesmas* staff, NST recruits would often see it as one of their roles to rekindle the motivation of other *puskesmas* staff. They do so because they do not want their *puskesmas* to be among those poor-performing *puskesmas* in remote areas that they have heard rumours about from their friends and colleagues.

> *"Maybe we help the puskesmas so that they rise up again. 'Let's make the community around us healthy!' 'Don't just make them come here to get medication.' Mostly we get the stories from our friends in remote areas that the staff sometimes don't come in, like that, right? Maybe we are here also for that, to get the staff to come, getting them to come. 'Let's come to the puskesmas again, really for work; what is our responsibility?!' So, it must be done in this puskesmas."*
>
> **(EnvironmentalHealth.Active-3)**

They were energised to perform their role to rejuvenate the spirit of *puskesmas*' performance, going to locations that are most challenging to reach in the *puskesmas* catchment area. They would often boast about it themselves; it became a point of pride to declare that they have provided care for communities that have never previously been visited by health workers.

> *"With our presence, the programs that we made, finally the puskesmas colleagues who all these times, notably years, have been here, that was the first time they came down to the villages. And sometimes they admitted themselves, 'Today was our first time coming here!' Whereas for us, it was [not the first time]. So sometimes we found it funny. 'Oh dear, we have become the host of this place!' Sometimes, when we conducted introductions [at the beginning of community meetings], there would be village officials who already know us well, but then to the community we said, 'Do we need introductions?' … And usually they would say again, if there were officials from the health office [coming to the village], 'They're here very often, we don't know how many times'. And the kepala dusun (head of hamlet) would answer, 'Oh dear, we're already bored [of the NS recruits], hahaha'. So people here are happy… Also, I like challenges, new places… I just like it."*
>
> **(PublicHealth.Active-1)**

By extending the outreach service of the *puskesmas*, however, there was a potential for friction between the *puskesmas* staff and the NST recruits. It often started out as a harmless joke, focusing on the income gap between NS recruits and staff with other employment tenures. The issue of NS' higher salary and use of BOK funding became a sensitive topic and NST recruits have tried to tread carefully and adopt various strategies to mitigate it from becoming a problem.

"Is there any tension between fellow NS and the local staff?"

> *"Where I was assigned, Alhamdulillah there was none. Maybe just jokes… NS kids have high salary, like that, compared to those who are (PNS) civil servants. And that's why when we get assistance from the ministry, additional operational fund (BOK) we involve them too, the local puskesmas people… the money is not just for us. The activities we combine with puskesmas, so we involve each other."*
>
> **(PublicHealth.Alumnus-1)**

As told by the informant above, one of the strategies is to always involve the local staff in NS' innovative activities in the community which has become another avenue for host *puskesmas* staff to obtain additional income. In addition, some NS recruits saw this collaboration with the host *puskesmas* staff as an opportunity to ensure the longevity of the change they were hoping to bring to the *puskesmas*.

> *"... Essentially at first we combined all of our activities with the puskesmas. So, our activities were assisted by the team of the puskesmas. ... So that when we're not there anymore, they would be able to continue our activities. I mean, if we only did it on our own, it seemed like after we were gone [the activities] would be gone too."*
>
> **(Midwife.Alumnus-2)**

There are also examples, however, where the disparity in remuneration between NS recruits and the host *puskesmas* staff became an issue. At first this might be unspoken or the subject of banter, but gradually it might transpire into apathy and antipathy towards the program's NS recruits.

> *"There is jealousy from here, internally. ... For example, we have many activities, and the staff (at first) were enthusiastic to have activities. But then, there was a staff member, I shall not name the person, who started saying, 'Why is the NS team so noisy!'. The person eventually tried to influence other staff members. 'Are you not tired having to go down to the field? Let them do it, let them have their names famous in the Ministry of Health!' But it's actually the puskesmas' activity too! The puskesmas is the one who'll get famous, not the NS team members. Because of that kind of character and such mentality, that influences (the others).*

"What strategy did you take to handle that situation?"

> *"We still socialise the activity (to the staff), 'Friends, even though this is 'NS activity', it is still puskesmas activity, so everyone is also responsible. If the activities fail to absorb the fund or fail to claim the budget, the puskesmas will be impacted, not us. So don't use the term, 'this is NS Program so only NS should do it', we cannot be that way.' And also, to other colleagues we emphasise that essentially when we gather our target communities, the budget would go towards that community; when we go to the field, the budget is used for the staff's transport. It should be the staff choice, where activities should be done. So, giving the staff members the options. And they became enthusiastic. And we manage (the budget) transparently when we pay out the fund at the end of the year. So, (they realised) 'They're not lying'. You reap what you sow."*
>
> **(Physician.Active-1)**

As evident from the account given by this doctor, the most potent strategy to overcome such opposition by the host *puskesmas*' staff members is to pursue financial transparency for the benefit of the staff. It helped to galvanise collegial support from within the *puskesmas*' staff. This is a repeating theme, as we also found in one *puskesmas* where the NST spoke of their concern about the *puskesmas*' past financial mismanagement.

> *"In the past, in a month (the staff members) said sometimes they would only get 200,000 Rupiah... for the PNS (civil servant), sometimes 300,000, in a month. And Alhamdulillah, now it's already 2 million, 1.5 million, depending on profession. That's what we have achieved. ... One of the midwives (puskesmas*

staff), she cried. 'My pay… so this is how much payment I should have received…' "

(MedicalLabTechnician.Active-2)

The NST's 'intervention' to promote financial transparency in *puskesmas* was a welcome change. The arrival of young, idealist, human resources injected into the *puskesmas* a sense of hope for a transformation from the old way of managing the *puskesmas*.

3.2.3. Proving NS Recruits' Allegiance to Host *Puskesmas* Interests

This strategy of bringing their idealism to benefit all *puskesmas* staff might only work to a certain degree. NS recruits understand that sometimes the host *puskesmas* staff were apprehensive that NS recruits were there to 'spy' and report on the *puskesmas*' misconduct to the MoH.

"How did you adapt to working with the staff at the puskesmas?"

"… with regards to the puskesmas, it's been good. Because we [are here] on behalf of the Ministry of Health, so the old people in the puskesmas… I don't know… they became a bit hesitant or afraid of us, because as you know the fund for puskesmas is quite big. So, maybe they thought, when we just came, I happened to hear [a rumour] they were afraid that… the financial situation is 'leaked' to the Ministry of Health. Especially when there were eight of us showing up together. They were concerned… 'Ooh, our fund will be lessened because there are eight people with whom we have to split equally!' "

(EnvironmentalHealth.Alumnus-1)

Because of suspicions about the reasons for their presence, the NS recruits also took it upon themselves to show to the other staff that they were also there for the benefit of the *puskesmas*. They were keen to be more actively involved, helping out with all of the administrative work during the accreditation process for the *puskesmas*.

"Well, it can be said that we are made like a crutch. When we were there, we had the experience of being part of the puskesmas accreditation. Now, during the puskesmas accreditation up to the assessment, the assessors come from Jakarta, right? [The assessors asked], 'Well, why is it that it's all of the NS kids that are more active? I want to hear from the native staff here, where are you?' So, really, it is us that have become like a crutch. The native people those who are the original civil servants of the puskesmas do not voice out, rarely present. But, Alhamdulillah, it is over and [the puskesmas] is accredited."

(PublicHealth.Alumnus-1)

Accreditation is a very laborious process–one that many NS recruits admitted they were able to perform better than their host *puskesmas* colleagues. One of the reasons is because the young NS recruits were significantly better skilled at working with computers. This dynamic change, when NS recruits realised the *puskesmas* staff needed them, has become a tool of their advocacy for change in the organisational culture.

"Essentially, [I asked them] 'Do you want to get involved? If you do, then come along with us!' The [change in relationship with host puskesmas staff] became more felt during accreditation. At the beginning the

progress took a long time. The change was quite significant, I mean, from the work ethic's aspect. [Before, they] came at 10 [in the morning to the puskesmas], we forced them to at least [come] at 9. Even at 9 was already difficult, not to mention at 8. ... When they needed, they would ask. [When it comes to] computers, that's when it's apparent. Like, they did not understand computers... For accounting, they would trust me. When I say something, they would trust me. So, it opened up [the relationship]. [There were] questions and answers outside of work hours. So during work, they became more trusting."

(Farmasi.Alumnus-1)

Our own observation in one of the two *puskesmas* that have not undergone any accreditation noted that the NST was a large part of the ongoing effort. We noted that, for one working week of observation, almost all of the NST members in the observed *puskesmas* had to stay until past midnight every night to work on past activity reports that were prepared by other staff members as well as themselves. It is generally acknowledged that host *puskesmas* for both NS teams and individuals fared better during accreditation than if they had not hosted NS.

3.3. Recognition of Receiving Facilities

As mentioned earlier in this chapter, there is a mismatch between the perception of NST recruits on what their purpose is in the *puskesmas* with that of the host *puskesmas* staff. This resulted in the initial rejection or hesitant acceptance of newly arrived NST recruits by the host *puskesmas* staff. It took them a while to warm up to each other.

"Never mind collaborating inter-professionally with puskesmas staff, even interacting with them we rarely do."

(Nurse.Active-5)

"The puskesmas [staff]... they also felt that NS... at the beginning were really rejected. [Only after] we can, let's just say [prove] trustworthiness, like so, then they could really accept us..."

(Midwife.Alumnus-2)

A number of NS informants interpreted the hesitance as being related to the fear by *puskesmas* staff that associating with the NS recruits' placed them under the ministry's watchful eyes. It brought a sense of anxiety that they might be judged for what they had been doing in the past.

"For the puskesmas, it is good, [the impact of NS presence]... Because we were there on behalf of the Ministry of Health. I don't know, maybe they are hesitant or fearful, because the fund for puskesmas is big. So, when we proposed [activities in the budget], there were many problems that came up from it. Because they thought, 'Why would they (the NS team) make other programs, while we already have programs in the puskesmas, which obviously were proposed by the district's own health office'. So, actually, the work that had been done in the puskesmas at that time, almost all had been decided."

(EnvironmentalHealth.Alumnus-1)

There is a sense that the *puskesmas* staff had never been actively involved in deciding the timing and terms of the NS teams' recruitment into their *puskesmas*. NST recruitment is always conducted three times per year (April, August, and September) and, after 40-45 days of pre-assignment training (*Pembekalan*), the NST recruits would have arrived in their respective *puskesmas* in the months of June, September, and November.

Those who arrived in the months of June and September were more affected by the timing of their arrival at their host *puskesmas*. The timing of their arrival was not conducive to their adaptation to the *puskesmas* to start undertaking innovations in the community and contrasted with their high spirits that had built up during the training period. This is partly because the *puskesmas* have limited space to modify their activities and, consequently, their budget plans.

> *"From the puskesmas staff themselves... well, at the beginning their acceptance was good. They accepted us. But at the beginning they were not too open about the conditions, about the activities, about the programs [in the puskesmas]. When we started, we were confused for how many months... one month, two months... We started in September. So, September, October, November, December, we mostly just sit around. We didn't know what to do, we go home, we come, we didn't know what to do, we go home. We were confused; what should we do? So, we just joined their activities. They're going for posyandu, we went along."*
>
> **(PublicHealth.Active-1)**

Considering that most *puskesmas* have a significant proportion of 'voluntary staff' who depend on the existing activity and budget space for their income, the presence of NS teams in the middle of the year automatically created, if often concealed, discordance. The tension was not missed by the NST recruits.

> *"It's like, I don't know, maybe because the 'kids' here (referring to the voluntary staff), even though when they joined [the puskesmas] they had to sign a contract... well, not really a contract, but sign on a 'materai' (legal seal stamp) to declare they are ready not to receive any payment but ready to do their duties... sometimes they would think, 'Oh well, we already don't receive payment, so why would we have to work as hard?'"*
>
> **(PublicHealth.Active-4)**

While heads of host *puskesmas* were invited to a week-long workshop in the same place as the NST recruits' training venue, it was generally conducted during the last week of the seven-week training. When this workshop was held it was perceived as only a means for the MoH to explain about the program and for the head of the *puskesmas* to present the '*puskesmas* profile' to the NS recruits. There has been no structured forum to involve host *puskesmas*' staff more widely before the recruitment even took place.

The lack of active participation of the host *puskesmas*' existing staff in the planning of NS teams' arrival, resulted in a lethargic response from the existing *puskesmas* staff. Unfortunately, this in turn reproduced and augmented the stigma against health workers, especially the civil servants, in rural and remote areas of the country. Staff subversion has been interpreted as laziness and this exacerbated the frustration of the NS recruits themselves when working in the *puskesmas*. As one NS recruit who arrived in the host *puskesmas* in late 2018 stated:

> *"During the puskesmas accreditation in 2016, there was too much euphoria [amongst the host puskesmas' staff], so the following year in 2017 they were all 'asleep'. So, in 2018, the head of the puskesmas said, 'You should be the head [of the UKM (Upaya Kesehatan Masyarakat or Public Health Effort) Working Group]'. So, every week I hold a meeting, for all programs' person-in-charge. Sometimes they didn't show up, and that made me want to cry. I told the head of puskesmas, 'Sir, people never showed up; I wanted to hold meetings to prepare for all documents, but nobody showed up.' "4*

"Why do you think they did not show up?"

> *"Well, they're lazy!"*

(PublicHealth.Active-4)

The image of laziness is further rationalised with the notion that their motivation level is in direct correlation with financial gain–or lack thereof.

> *"It comes back to the mentality of our workers who are lazy. It's difficult [to overcome], one of the reasons is, they cannot be forced to be [working] too [much]. Because they're only paid 500,000 per month, those twenty people, the ones who are [volunteer staff]. … Whereas the [contract staff], 1.5 million."*

(Physician.Active-1)

The stigma of poor character among health workers in rural and remote areas in Indonesia is a reductive conclusion lacking in empathy that will be counterproductive to improving health care services in the areas needing them the most. For a longer-term benefit, there needs to be a genuine interest to inquire about health workers' individual and collective motivations to build a career and life in rural and remote areas. The insight that NS recruits themselves might bring to this investigation will, therefore, be invaluable in overcoming this stigma. Chapter 4 will open this line of inquiry.

04

Nusantara Sehat Recruits' Career Perceptions

As explained in Chapter 2, a country's public health system must be understood not only from its organisational structure, but also from the motivation of, and decisions made by, the actors involved within it. Utilising this framework brings an understanding of a health system from a humanistic and sociological perspective. From such a humanistic perspective, the informants' perception about careers in PHC in remote areas can be explored.

This chapter will explain the narratives on career perceptions working in remote *puskesmas* or other career paths as voiced by the NS recruits.

4.1. Motivation and Idealism of NS Recruits for Social Equity

"Wawasan Nusantara"[17] is a concept that can be utilised to understand the mindset of many of the NS recruits. Translated directly as 'Archipelagic Insight', this 'geopolitical' nationalist concept depicts the Indonesian archipelago as one nation, united in its ideological, political, economic, sociocultural, and defense perspectives; one that distinguishes the nation from the rest of the world. Although it has been known under different names, the concept has been a longstanding one with a special mention in the Declaration of Djuanda in 1957. Massively indoctrinated during basic schooling years in Indonesian schools, sometimes even in pre-schools, and especially during the New Order period, the concept has been deeply internalised in the psyche of Indonesian citizens, including amongst many of the NS recruits interviewed.

This concept shows itself in the informants' outlook with regards to parts of the country outside their home region. NST recruits come from all sorts of different personal backgrounds and geographical origins–from those who grew up in rural areas or remote islands all the way to those who had never left the national capital of Jakarta before this assignment. Nevertheless, recruits from all walks of life seem to have a cultivated curiosity about the diverse life that their fellow Indonesians have and to connect on a personal level with them.

[17] For a quick overview of the "*Wawasan Nusantara*" concept, see Situmorang (2013).

"Can you state again your motivation to join the NS team?"

> *"For my personal motivation, I really want for the community to experience a health care which must be felt... by all Indonesian communities fairly and equitably. ... It just so happened that my friend, a friend also motivated me. The friend was already accepted in NS batch 3, deployed to Nias (an island in North Sumatra province). There, in delivering health care, ... well, it was far away from one village to the next, going across forests or across islands. Now, that kind of thing made me... I mean, even in Java when I was a child I also felt like that, and now outside of Java nowadays, there are still places like that, so I'm moved to do this."*
>
> **(PublicHealth.Active-3)**

> *"[The motivation] is because I want to 'mengabdi' (serve). Firstly, I ought to be curious, because ever since I was small... Well, it's not bad, I mean [living] in Jabodetabek (a term describing the Jakarta Greater Area) which is quite urban... I'm curious of the lives of communities in the remote. Also, I like to speak in public..."*
>
> **(Nutritionist.Active-5)**

As evidenced by the NS recruits' answers quoted above, there is a mixture of internal drive to see, understand, and connect with Indonesians from other parts of the archipelago, with the desire to pursue a sense of equity in the development of Indonesia.

In addition, NS recruits have an acute perception of the disparity between Java and islands outside of Java. Some who come from Java acknowledged that living in Java is an automatic advantage due to the easy access to health professionals which forms a point of reflection for their own career choice. They have a strong desire to contribute.

> *"... even in the urban areas, there was still not enough [medical lab] analysts. Even more, I think, in villages like that, there must be none. And when I arrived (in Sulawesi where I was assigned), there were really no lab analysts. How to say... the supporting diagnostic tools for the doctors there, based on what, if not based on lab results? Doctors' diagnoses are supposed to be supported by lab examinations."*
>
> **(Analyst.Alumnus-1)**

> *"I had the thought, if I was here, in [a city in East Java], there were already so many, you know, health professionals. Whereas in left-behind areas, I think, usually I saw them on TV, it seemed like so deficient. So, I became interested... like, what does it feel like to be a health worker there? And then, to see people there who have not received health care, it's like, how to say it... I want to help them there."*
>
> **(Midwife.Alumnus-2)**

Nevertheless, a similar motivation was also shown by a nurse who comes from a very remote village on an eastern Indonesian island. His childhood perception of health care was vastly different to those of his Western Indonesian counterparts.

> *"When I was a child back then, there were people who could perform injection, even if they were not health professionals. … He was not a health professional, but I still remembered, if one goes to him to get medication, he could perform injections. …*
>
> *"… I will not try [to get employment] here, I want to try the Eastern areas… Papua. There are many communities there, right? … Because we know that the eastern parts of Indonesia are more left behind, in terms of their health development, compared to here. Maybe if we compare with the East, the roads are in different situations. Sometimes [in a puskesmas] there would only be five people. Some are like that, so limited, more so than here."*
>
> **(Nurse.Active-3)**

This nurse had no qualms with his current NST assignment to a remote village in a western Indonesian province, as long as it fits with his ideals of delivering care to the communities needing it the most.

> *"I want to bring an impact to places which have not yet received health care. I want to choose a place like this again, so I bring an influence for the communities there. So I want to join again with NS, individuals. …*
>
> *"… I join NS, never minding about the salary. The core thing is, working with NS is pleasurable, no matter how much the salary is I always feel grateful. If I don't feel grateful, it will never be enough if I think about the salary."*
>
> **(Nurse.Active-3)**

In addition to their altruistic motivation, some were also able to describe their personal motivation as wanting to be able to practise their profession in full. Such as one NS recruit with a public health degree. During her past employment as a volunteer staff after she graduated, she was tasked with a position that was beyond the scope of her field. She was put in charge of *puskesmas* administration, patient registration, and the pharmacy unit. She was aware that she learnt from those positions but she was always concerned that this kind of 'task shifting' would happen more commonly in urban areas, especially for fresh graduates with a public health degree. As she was performing tasks she did not feel competent in she was worried that she might make a mistake.

> *"The thing that motivated me the most was maybe, first and foremost, that the knowledge that I got from school can be applied. Because, honestly, when I joined a puskesmas, there was another staff with a public health degree. But her actual Diploma major was in environmental health. In the puskesmas, environmental health was a sure thing because there is environmental health program. But for public health, I am a bit confused, in puskesmas what would we do? …*
>
> *"… At the time, there was no activity I could do. I was confused, why every day I could only sit indoors, fill out the registration, and then go home. There were times, I was at the registration counter… there were other times my colleagues at the pharmacy unit also called me out [to help]. So, I was confused, what profession am I? Why am I providing pharmacy services?"*
>
> **(PublicHealth.Active-1)**

Another non-altruistic motivation that some NS recruits conveyed was the hope for promising future employment. Such as an NS midwife who graduated from a private institute for midwifery. Her family was concerned that the school she graduated from did not have a strong enough reputation to allow her to obtain a promising career. Her mother, who is a midwife with a civil servant status, therefore, suggested that she apply for NS recruitment, with the hope that joining such a reputable program would open doors for her future career.

> *"My mother never pushed me to 'merantau' (a West Sumatran term to describe travelling far from home in search of work). So, I was surprised when she told me to apply for NS. … I said, 'Is it really okay?'. She said, 'Well, [here] the employment opportunity is not as wide, dear. Mostly to enter PNS (civil service), fresh graduates who are coming from private institutes are almost non-existent."*
>
> **(Midwife.Active-5)**

The NS recruits' career choices are driven by a combination of altruism and self-interest. Working in remote *puskesmas* is, therefore, considered a way for them to meet both needs. Working in such remote locations is, however, not without its drawbacks.

4.2. Lack of Support for Remote Health Facilities

Working in remote *puskesmas* brought with it the challenge of isolation from information technology. Considering how idealist most NS recruits are, access to information becomes important to them as it is associated with being able to have continuing personal and professional development to perform their task optimally. Apart from career stability, this access to information has been stated by some NS recruits as a major consideration in their choice of employment.

> *"After I finish [NS assignment], honestly I'm still up in the air, our future career is still unsettled… We would really love to be promoted as PNS. … I don't want to move around; what's wrong with settling down?. Besides, we have 'mengabdi' (served), so [there should be] a reward for us. But, like, scholarships, I am so interested in that too.*
>
> *"… I still plan to join NS again because I love to travel. It feels good, to know that Indonesia is not only Jakarta, or Java.*
>
> *"… I am willing [to work in remote areas again], but, if possible, not too remote. Because we really feel left behind. Like, information, we get them always late, [sometimes] we even know nothing."*
>
> **(EnvironmentalHealth.Active-2)**

In addition to information isolation, the deficiency in equipment and materials for health care service is compromising their work performance. One NS recruit complained how the *puskesmas*' supply is still sub-optimal. Nevertheless, they still tried their best to perform their roles.

"According to your opinion, what's the state of the puskesmas here?"

> *"I think the quality is still low. For instance, for lab examination, there are many things that are still done manually… Meanwhile, for Hb examination… it's no longer recommended to [do it manually]. But how can I tell the head of the puskesmas, how can I ever use the Autocheck equipment?! It's hard for us to get*

the test strips… that's why, well, if there's a [request for] examination, I just do it [manually] with what we have here."

(MedicalLabTechnician.Active.4)

Overshadowing all of the other challenges of working in a remote *puskesmas* is the geographical remoteness of the *puskesmas* itself. This challenge is something they understand they must face in performing their tasks, but even more importantly, it is a challenge for the communities they want to serve.

"The access, such as the one to the [isolated village in a National Park], so far away! Even if using a motorcycle, it's [only accessible] intermittently. Cars cannot pass. Only tall cars can pass."

(EnvironmentalHealth.Active-3)

"Actually, the community['s problem] is not escaping the fact of distance of the puskesmas, because the puskesmas is not positioned strategically for all 10 villages… The ones most accessing [the puskesmas] are these four villages. And other villages, the ones at the periphery, rarely… They don't want to come to puskesmas. And when we perform posbindu, we were the ones who went there. No medication; for posbindu, there's only examination."

(Nurse.Active-5)

"Our work area is difficult, so we have to cooperate. And if we go to one location, on foot, the soonest we get there would be a day, the longest two days. So we would have to stay over. Not including bringing the medications. Not to mention when running a posyandu because we have to bring vaccines. Oh, so much things! … There are none, I mean, there is no land transportation at all. To go by motorcycle is not even available, because we had to go past the forests. No roads at all."

(Pharmacy.Alumnus-2)

"In the past, the challenge is [availability of] motorcycle, right? But, because recently we were just provided [motorcycles], that still becomes our main challenge, motorcycles. Because when all six of us wanted to go, we still could not. Have you seen the video of the three of us riding one motorcycle? The three of us! Riding from the [faraway village from where the puskesmas is in] to here [the puskesmas]… in the condition of motorcycles with red plates,[18] *with three riders. That's the main problem."*

(PublicHealth.Active-5)

Such is the reality that is still presented along with the career option of working in the PHC sector in remote Indonesia. Nevertheless, it might still be an option for many, whose breadth of career path options may be limited by external and internal factors.

[18] Red plates refer to vehicle registration plates of red colour which are reserved for official government vehicles. It is infamous that, in rural and remote areas, red plate vehicles are in poor shape due to the lack of maintenance funds.

4.3. Career Aspirations in Health Care and the Health System

4.3.1. Sacrificing Oneself as A Volunteer Staff

Employment and career paths often become a touchy subject for newly graduated health professionals. Limited employment opportunity and the reality that they often have to work 'voluntarily' (without promise of suitable pay), have become a source of psychological stress for young health workers. One NS recruit explained her emotional turmoil after finishing her degree. Not wanting to be a burden to her family, she decided to return from her uncle's home in the capital city of an eastern Indonesian province where she went for tertiary education, even if this meant her only option was working as a volunteer staff at a *puskesmas* in her semi-urban hometown.

> *"I asked my uncle… let me go home to my parents, because my position here, I am unemployed. I don't want to be a burden. …*
>
> *"… As a volunteer staff, I felt weary… We worked… I mean, even if we worked, there would be people around us, asking, 'Hey, where do you work?'. 'At a puskesmas.' 'How much do you get paid?' Silence. I could only be silent. Over time, I became fed up. I did not show up for a month. Until my parents said, 'Why are you not going to work?' Because there were friends from puskesmas who used to pass by my house, and they asked, 'Where is she? Where is she?' [My mom said], 'Just keep showing up, they'll notice you one day.' I said, 'I don't want to. I want to 'merantau'."*
>
> **PublicHealth.Active-1**

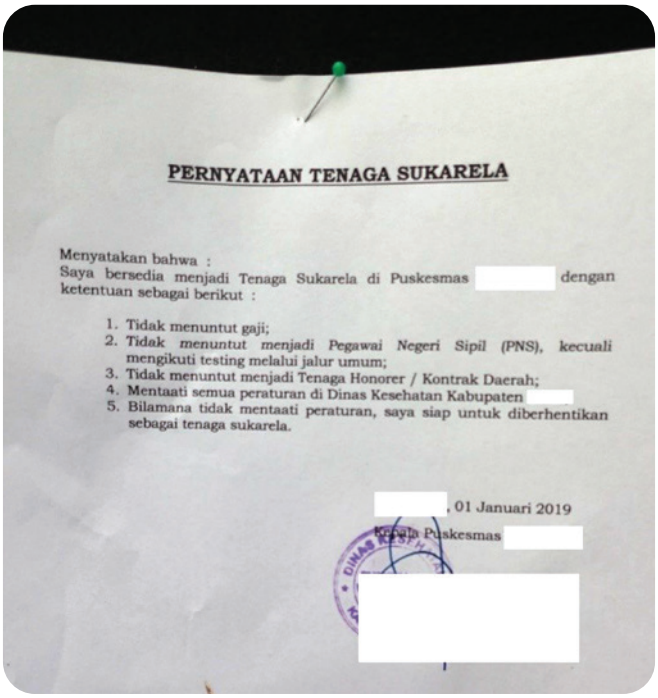
While health professionals working as volunteer staff have traditionally been viewed fondly by the general public–as shown by the NS recruit's mother in the above excerpt–due to the idea that they would be able to gain on-the-job training and networks for future prospect, the reality is there are paradoxes in working as an entry-level health professional. Firstly, young health professionals not only need to be ready to become volunteer staff to gain experience for a future career with proper remuneration but they also need to be ready to pay for the opportunity to gain experience (Figure 4-1). Secondly, the experience they gain may actually be detrimental to their initial ideals as a professional. Such was the experience of this NS midwife at the beginning of her career.

> *"After I graduated, I worked for regular independently practicing midwives, being paid 50,000 [rupiah] a month. I had to be on standby [at the clinics] for 24 hours, so it disturbed my sleeping pattern. I worked for six months. I was working for three midwives [in different areas of Jakarta]. I was never home. From all three clinics combined, I made less than one million [rupiah] a month. And I had to ride motorcycle [to get from one clinic to another].*
>
> *"And then, I interned, at a public hospital in [Banten province]. Even interning was not free. I had to pay, for six months. When I applied, the person said, 'Pay for this much money.' I asked, 'Why do I have to pay, Sir?' 'Well, you are borrowing our patients, you're using our equipment.' So, there, I paid. After that, I started thinking, midwifery and dukun (traditional medicine man/birth attendants) are all the same. It's just that one worked with a title of midwife. Because, what was that, working not using any theory. A friend said, theories are never worth anything for the senior midwives."*
>
> **(Midwife.Alumnus-3)**

This midwife lamented the lack of mentorship that is available for young health professionals, particularly for the midwifery profession–to the point of her diminishing the value of her own profession. Furthermore, through the experience of working as volunteer staff, health professionals might also internalise a sense of invisibility. This is symbolised from the total absence of standardisation in payment structure.

> *"Volunteer workers really have never been given! Never been given... That's what's so funny, looking back at it, now that it's been a year. ... When there is payment, when compared with the situation here, we here have BOK, I mean payment for service. Even that, we still divide it fairly, the BOK, between the staff, depending on how many times each person goes down [for activities/service delivery in the community]. But there [where I worked as volunteer staff], it depends on the pity of the other staff. We are dependent on how much they want to pay us. For payment [proportionate to the performance of] service, there was none. ... The last time I was there, for a year, I only received 200,000 [rupiah]. I said, 'It's okay, maybe it's God's blessing, so I cannot turn it down.' (laughter) But when I received that money, I was eventually called up to join NS pre-assignment training. (laughter)."*
>
> **(PublicHealth.Active-1)**

Figure 4.1: "Statement of Voluntary Staff" on a *Puskesmas*' Information Board



PERNYATAAN TENAGA SUKARELA

Menyatakan bahwa :
Saya bersedia menjadi Tenaga Sukarela di Puskesmas [redacted] dengan ketentuan sebagai berikut :

1. Tidak menuntut gaji;
2. Tidak menuntut menjadi Pegawai Negeri Sipil (PNS), kecuali mengikuti testing melalui jalur umum;
3. Tidak menuntut menjadi Tenaga Honorer / Kontrak Daerah;
4. Mentaati semua peraturan di Dinas Kesehatan Kabupaten [redacted]
5. Bilamana tidak mentaati peraturan, saya siap untuk diberhentikan sebagai tenaga sukarela.

[redacted], 01 Januari 2019

Kepala Puskesmas [redacted]

[redacted]

Source: TNP2K, 2019

Note: Its translation in English: "Statement of Voluntary Staff" Declaring that: I am willing to be Voluntary Staff at *Puskesmas* xxx under the following conditions: 1. Do not demand any payment; 2. Do not demand to be employed as civil servant (PNS), unless I undergo testing through the general path; 3. Do not demand to be employed as 'Honorary'/Local Government Contract Staff; 4. Comply with all rules in the Health Office of xxx Regency; 5. Whenever I do not comply with the rules, I am prepared to be terminated from my voluntary staff position.

4.3.2. NS Experience Inspiring Career Aspirations

During undergraduate professional training, many NS recruits admitted to having limited exposure to community-based health care services, especially in promotive/preventive care.

> *"In [my university], they have started applying interprofessional [education], but not maximally. I only got it for the last semester, so I only learned about ethical codes [of conduct]. But the students nowadays have started since the beginning, the interprofessional education. Maybe, if for bachelor degree, there was not enough practice, field wise (read: in the community). It was still formal, with facilitators from the campus. … There was not enough practice during my time."*
>
> **(Pharmacy.Alumnus-1)**

The experience of working at the community level that an NS assignment has given the NS recruits has inspired a number of NS recruits to shift their outlook for a future career into one that is more oriented towards PHC.

> *"… over time, I can see where my passion lies. In the past I used to want to go into surgical [nursing] because I saw, 'Wow!' When patients walked into the ER, for emergency [care], we had to put in this and that… It seemed cool. And I like practising my skills on clinical managements. But when I joined NS, I found that my passion actually is in going out [to the community]. I like giving health education and others, that's where [my knowledge] is materialised. In addition, as an NS recruit, I have been very respected. Because we introduce ourselves, 'We are from the ministry, we are Nusantara Sehat, assigned here for two years.' And the community here are very welcoming of newcomers, especially health workers from the ministry or from the Health Office… I've been very lucky… very lucky and I'm happy."*
>
> **(Nurse.Active-1)**

Nevertheless, the current job market and postgraduate education system has not properly valued this NS experience as an asset. For instance, this nurse, who has the ambition to pursue her academic learning at the postgraduate level, would, as an NS alumnus, have been eligible to apply for the postgraduate scholarship that the MoH has prepared. The university to which she was keen to apply, however, only recognised two-year hospital-based employment as a work experience requirement instead of valuing PHC/community-based work equally.

> *"Now, after I 'graduated' NS, I'm confused. When I want to go for postgraduate studies program, in [the university of my choice], there must be a two-year work experience in the hospital. Meanwhile, I don't have that. I have consulted to the BPPSDMK in Hang Jebat, and his answer was, 'You have to negotiate it with the university." Well, that should not be just my burden! There should be [communication] from institution to institution! I am now only 'crumbs'… "*
>
> **(Nurse.Alumnus-3)**

This phenomenon symbolises the low priority that health professional education gives to community-based promotive/preventive care and the prevailing curative perspective in the academic field. In the long run, this may result in missed opportunities to sharpen the skills for HRH who have accrued valuable community-level work experience.

In addition, NS recruits were also restricted in the line of career they could pursue if they wanted to access further studies through an NS alumni scholarship. This is due to the policy of 'field linearity' for what further studies might be granted funding. This potentially also stifles potential career growth as told by this NS alumnus.

> *"NS [policies] are still immature. Why can't they give a chance for us after we 'graduate'? … For me, to pursue a master's degree in midwifery, that can only be done in a certain institution, so far away! They make it harder for people to pass scholarship, but they also put the condition of 'linearity' in the field's lane. Whereas a health worker like me who became interested in health policy and administration… Because I know there are many things to build over the [current] health policies. Don't [restrict] me just in midwifery! I know my passion, and I know what's needed because I've worked in the rural, I've worked in the urban locations. So, I know, what I am [going to] take is relevant for me! But they must let me know my rights! Not [restrict me], 'You're a midwife, so you must teach in the field of your profession.' Wouldn't it be nice if when we finished [NS assignment] they could ask us about [linearity]. … For me, I cannot do [linearity], I must be in policy, because I understand [to produce] success, what must be taken.'*
>
> **(Midwife.Alumnus-1)**

The structure of health workers current employment opportunities, in general, also still places less value on NS work experience. As part of its effort to attract talent into the NS Program, the MoH has declared that those with NS assignment work experience will be assessed favourably when applying for civil service employment although this will still be done through the common application path. This opportunity is, however, only available when NS alumni want to apply to be a civil servant in the MoH and not to any other governmental agencies.

> *"For NS [alumni], please pay attention to our situation like this, where we're still looking for work… Those of us who don't want to rejoin the program (NS Individual). I don't understand, like my position now, what should I do? If I want to apply for scholarships, I would have to wait until month nine (September, more than nine months since finishing the contract). If I want to join NS Individual, I don't know where the location will be. So, it is better if… but I also don't know how to voice out my wish… But please for the Kemenpan RB (Ministry of Administrative and Bureaucratic Reform, the ministry in charge of organising the application to recruit civil servants) to collaborate with the Ministry of Health, so that we also know… Why should they be looking to hire someone new and inexperienced to become a civil servant, whereas people with experience are just wasted away… It's like, when we took the test (written test for civil service application). The first test we pass okay, but the second one we didn't, that's just unlucky, right?"*
>
> **(MedicalLabTechnician.Alumnus-2)**

Through working with their colleagues, NS recruits found that the procedures put in place for NS recruitments are very effective in filtering those with good commitments and work ethics. In contrast, they see the rigidity in the way that the current civil service recruitment is set up, with written test formats, to be insufficient to acknowledge the potential contribution they could have made as civil servants working at the local government level.

Nevertheless, after learning about the low valuation that the current job market has for their NS experience, one NS recruit even concluded that joining the NS Program might not always serve them well if permanent employment is what they are after.

> *"If I rejoin NS, I will just be a delayed unemployed. Because I now consider Nusantara Sehat a job with no prospect. They (the Ministry of Health) do as they please dumping people's children [in remote areas] to build the remote villages to improve their health, but after two years only to say thank you? And afterwards, we were only given the choice to go for further study's funding, that is if we get in! If not, there is no point of joining NS Individual if after two years I am only going to be unemployed. Keep on joining contracts like that, until when? Until I'm old?"*
>
> **(Midwife.Alumnus-3)**

Many NS recruits have decided that they are better off working for themselves. One NS recruit has figured out that his NS assignment is the time to accrue the financial capital to start his own business in health care for his hometown on an island in eastern Indonesia. He sees this as a way to maintain his idealism as a health worker while fulfilling the need of local communities of his hometown. Instead of merely looking at his NS experience from an altruistic perspective, he also views it pragmatically.

> *"Right before I finish [my work in Jakarta], … Firstly I was alone in Jakarta, no financial capital. Secondly, I did not get a good grasp of the situation in Jakarta. Thirdly, working for [a prominent private medical laboratory chain of clinics] was financially wasteful. In a sense that, there was more expenditure than income, it was not enough. I said to myself, 'What of this!' I then took the initiative to ask [a friend who was already in NS], 'How much is NS salary?' 'Oh, it's plentiful. For a bachelor degree, 7 to 8 [million rupiah].' That would be enough to start a clinic in my village. So the three of us [childhood friends from the island], we always communicate. So, now, Alhamdulillah, my clinic is … not yet in operation, but it is almost ready. I will return to my village and build it from there."*
>
> **(MedicalLabTechnician.Active-2)**

As can be seen from the above excerpt, some NS recruits actually preferred to return to working in the rural and remote areas. A personal background of having come from a remote or rural community would be one determinant to this preference.

"Would you be willing to work and live in remote locations?"

> *"Of course I do, because I also come from a remote location. So, living in the city is not something that I really seek after. At least, in a remote area, we can be a consultant, assisting them. … I don't set as a target to become a PNS."*
>
> **(Physician.Active-1)**

All other things being equal, it might be expected, therefore, that a substantial proportion of NS Program alumni would be working in remote areas as a health professional because they have a penchant for PHC delivery. The personal preferences of Indonesian health workers are, however, immensely affected by the societal expectation of their gender role and the need to fulfill their family's wishes.

4.3.3. Gender Role and Family Opinions as Career Determinants

For almost all NS health workers interviewed, family factors and gender role perceptions dominate their narratives. For many, the choice of work location for work has always been one that was made with strong consideration of their family's approval. Such as this NS physician whose parents have passed away.

> *"I had a chat with my senior (from university), she suggested that I should go to Banten. So I told my abang (older brother), [and asked him] what does he think? Between the choice of going to Banten and Surabaya. Well, obviously, for a place of living, in both Banten and Surabaya there is no family. So eventually I chose Banten for that consideration (read: that a senior was working in Banten)... Even if I am independent, I still have to consult and communicate with my abang."*
>
> **(Physician.Active-1)**

This physician's story of her decision-making process is a way of life shared by many health workers of all professions. The presence of a person who is a family member, relative, or family friend, is a strong influence on one's decision on work relocation. The opinion and support of a family member who is looked up to becomes important in any life decision.

"What made you decide to apply to be a PNS (civil servant) in (another city three hours from the hometown)?"

> *"Well first of all, I am a female, and my father does not allow me to join NS again. It just so happened the city opened up recruitment, so I decided to apply."*
>
> **(Pharmacy.Alumnus-1)**

The family's opinion, while valuable for most health workers, has limited the options for work locations for many. This is especially true for female health workers, such as the informant above. The following lab technician alumnus of the NS Program is another example of a female health professional affected by her family's expectations of her gender role. She had to curb her intention to work again as an NS-Individual recruit in another remote area because her family dissuaded her.

> *"Oh dear, my parents said, 'Don't prioritise that (NS Individual employment) first, what should be a priority is to get married. Even until now, you don't have anyone to get married to because you always go away, right?' So, actually it's so good to work as Nusantara Sehat, but, well, not forever we can do this, because of age. ... I want to join NS again. but because I'm a female... "*
>
> **(MedicalLabTechnician.Alumnus-2)**

Indonesian health professionals are not exempt from society's emphasis on the role of females as homemakers. This consideration far exceeds the consideration of salary or career progression. The following NS nurse, who got married to a fellow NS recruit and became pregnant while still working as an active NST recruit, told her story.

> *"I am willing [to work in remote areas] as long as not far away from [my husband]. … How to say this… I am already with a family, so if a husband is able [to work], it is not compulsory for us female to work. We get pahala (reward or blessing) from our husband. So, if we don't serve our husbands, in the future what pahala can we get, right? There is of course pahala [in working] but now I am already a wife. That's it. So, I shouldn't make so much sin… (laughter) No matter what, it is a wife's duty to serve the husband."*
>
> **(Nurse.Active-2)**

In addition to being a homemaker, a female's role as the family's caregiver is also a strong theme in NS recruits' lives. This NS midwife, for instance, told of her wish in the future to work in, or near, her hometown to be closer to her mother.

> *"If I later on join NS Individual, I would choose my own hometown, it's possible. … I pity my mother, she's sick and there's no one that can look after her. She has a heart problem; her artery is blocked so when she felt tired she would have breathing difficulty…"*
>
> **(Midwife.Active-5)**

One male NS doctor testified that many of his physician colleagues would rather work in a position with lower income if it means staying close to their family.

> *"My colleagues, they work in clinics, hospitals. Maybe it's so that they stay close to their families, even if the income is small they keep close to the family. Whereas us here, we don't get paid attention to, almost no family here, so it's doubly lonely. … I mean we're far away from the family, from the local government there's no special attention… These all affect our psychological conditions… (laughter)"*
>
> **(Physician.Active-4)**

Health workers who work in places far away from their family see themselves as having sacrificed themselves for their work. Many NS recruits, therefore, have an expectation that their commitment to deployment with the NS Program must be acknowledged.

4.4. Beyond Career: Growing Through NS Program

Overall, the experience of an NS assignment brings value to the personal and professional development of the NS recruits. The following NS recruits, for instance, described their engagement with the community and colleagues as a positive life experience.

"Up to now, what is the biggest impact of NS Program to you?"

> *"I gain so much experience here. I also get to know the community. I did not know I would get this from here, that we got to know the community, and gain new friends… And also to learn what a puskesmas is, the service flow… Alhamdulillah, more or less I already know, compared to when I started I knew nothing at all."*
>
> **(MedicalLabTechnician.Active-4)**

> *"The impact of NS, I get so much experience. More than enough even. The experience of living independently, being able to socialise with the community, with new people, gaining new family, lots of friends... I get to know many people. And the knowledge that we have obtained, we can apply well. Bottom line is, there has been so much benefit."*
>
> **(PublicHealth.Active-1)**

For many NS recruits, the experience of working and living independently in remote locations has been viewed as a journey to become a better health worker. They see this employment experience as adding value to their competence as community health-oriented professionals. The next question they are wondering, therefore, is whether the current human resource management in health at the national and subnational level can recognise this added value of NS employment experience in a structured manner.

05

Discussion and Conclusions

5.1. Comprehensive Primary Health Care Through Interprofessional Collaboration by NS Teams

Adapting from the "Gears" Model of factors affecting interprofessional collaboration within interprofessional care teams (Mulvale 2016), this study looks into the multiple influencing factors of relevance to the NS Program's recruits and how they are practised in reality.

5.1.1. Micro Factor: Team Climate

Unity within the team and its ability to carry out collaborative practices in the field is highly malleable to local factors.

To dissect health workers' teamwork practices, Agreli et al. (2017) have listed four elements to enable the teamwork climate and interprofessional collaboration and that can be utilised to understand how collaboration is practised in NS host *puskesmas*.

1. Interaction and Communication Among Team Members

In the *puskesmas*, the content of the interaction is based on:

- function (to achieve the common goal of gaining patients/clients and community trust);
- local office politics (how to strategise to gain trust from the host *puskesmas* staff); and
- professional identities (negotiating forms of collaboration to maintain or overcome professional boundaries and hierarchies).

Interaction and communication between the team members of different professions has been promoted through putting in place a six-week long NS pre-assignment training program. Nevertheless, there are still shortcomings in the format of the pre-assignment training which the NS recruits themselves admitted they wished had been different. The existing format has deviated from its original form that emphasised professional capacity building and discussions surrounding task-related contents to one that is loaded with messages surrounding nationalism, team identity, and physical capacity.

2. Common Objectives

The study found that there has been a mismatch in expectations between that of the host *puskesmas* and the NS Program policy narrative, one which affected the team's own internalisation of team objectives.

While ideally the individual and collective objectives should be well outlined, it was found that the NST recruits were often left disoriented with the tasks at hand. The significant mismatch is surrounding the question whether or not the NS teams' main objective should be to fulfill the *puskesmas*' minimum services, or to be complementary to *puskesmas*' services and emphasise community outreach.

3. Shared Responsibility for Quality Services

The responsibility to develop quality services was generally upheld as a commitment among the study's observed NST members. Their ability to follow through on their commitment has been compromised, however, by field realities, ranging from the geographical challenges of reaching the communities which severely limits the scheduling and organisation of community-based activities due to the availability of transport facilities and weather conditions, to the imperfect management of *puskesmas*' inventories–such as health promotion materials, medications, and medical equipment–that gradually demoralised the highly motivated, young NS recruits who were eager to fully perform their duties.

4. Promotion and Innovation in the Workplace

NS informants have been shown to make the effort to implement innovative activities, some of which are less of a novelty (such as reforming the *posyandu* to include medication) than others–such as holding village events to galvanise community member support to build a latrine in every household. Either way, the study found that many of the programs are initiated based on a recognition of the community's social relations, demand, and needs. This is arguably a positive move for the *puskesmas* to gain more attendance and, more importantly, trust from community members.

There has also been a structural attempt to support NS teams to carry out innovative interprofessional activities for comprehensive PHC. This is done by providing them with a space to collaborate using ample financial resources in the form of additional BOK (*Permenkes* No. 71/2016; *Permenkes* No. 61/2017). Unfortunately, the advent of additional budget funding for host *puskesmas* is not helpful for NS teams whose recruitment and arrival at their *puskesmas* sites happened in the middle of the year. The mistiming for those teams can be not only a challenge, but also counterproductive to the initial goal of promoting innovation.

Without the funding to allow them to carry out their own proposed innovative activities, NS recruits were often pushed to carry out everyday duties in the *puskesmas* instead for many months. For some, this routine task might be internalised by both NS recruits and the host *puskesmas*' staff and thus shift the perception of what the NS teams' objective in the *puskesmas* is.

In short, despite the limitations in all of these elements, the NS informants have been able to implement collaborative relationships within their teams. Most of these activities, however, only started to take shape once the NS teams were also able to collaborate with the host *puskesmas*. The collaborative relationship between the NS teams and host *puskesmas* is predominantly affected by factors external to the team.

5.1.2. Macro and Meso Factors: Policies on Health Governance and Health Care Organisational Culture

When viewed through the lens of the NS Program's goal–which is to achieve comprehensive PHC in remote areas in Indonesia (*Permenkes* No. 23/2015)–the decision to structure multi-professional teams is one

worth applauding. This allows for health workers of various skills to come together and deliver promotive and preventive health programs in conjunction with much-desired curative services. Going back even further, the policy is made possible by the existing structure of *puskesmas* (*Permenkes* No. 75/2014) which are founded on the principle that the two elements of health care must be enjoined (depicted within the current symbol of *puskesmas* by two conjoined circles).

Moreover, the quality of human resources delivering services is the foundation of successful comprehensive PHC. The policy for higher-than-average salaries for young health professionals under the NS Program (*Kepmenkes* No. 145/2015; *Kepmenkes* No. 223/2016; *Kepmenkes* No. 484/2017) has exhibited a positive result in recruiting highly motivated health professionals. Through their presence, the NS Program holds high promise for quality health services.

NS recruits ability to perform their tasks optimally to the level of their competence has, however, been defined by the lack of *puskesmas*-level availability of support. Firstly, geographical isolation and infrastructure and transportation limitations in the villages are often severe. The NS recruits' access to official vehicles to facilitate their programmed activities has been varied across the board. In many instances NS recruits had to purchase their own vehicles (mostly motorcycles) as the *puskesmas* either had none or not enough for the newly arrived NS recruits to use. Secondly, materials for health promotion, medical equipment, laboratory equipment, and medications that are available in *puskesmas* are often substandard and outside the NS recruits' authority to rectify.

There are a number of policy tools used to govern *puskesmas*' standards for facilities and equipment. The first are Ministerial Regulations on Technical Guidelines on Special Physical Health Allocations for Fiscal 2018 and Fiscal 2019 (*Permenkes* No. 66/2017; *Permenkes* No. 2/2019). The second is the new program of accreditation for *puskesmas* (*Permenkes* No. 46/2015).

Along with the facility-level human resource skill mix as well as the physical facilities and equipment, another factor shaping the organisational culture within the *puskesmas* is the tension between the incoming NS recruits and the host *puskesmas* staff, with four factors influencing this tension:

- Firstly, there are instances where the types of professions recruited through NS are different to the host *puskesmas* staff's perception of the types of professions they needed.

- Secondly, the timing of the NS recruits' arrival which, as mentioned above, interferes with the host *puskesmas*' budget planning cycle and unsettled the host *puskesmas* staff's expectation of NS recruits' role in the *puskesmas*. These two factors could be mitigated by involving *puskesmas* level management and staff in the planning for NS recruitment and pre-deployment preparation.

- Thirdly, the accountability relationship between NS recruits and the host *puskesmas*' management is unclear. While NST recruits are required to undergo annual monitoring and evaluation by the MoH in Jakarta, the head of *puskesmas* was not involved in this process. In addition, NS recruits' salary is not dependent on the head of *puskesmas* assessing the performance of NS recruits individually.

- Fourthly, salary disparity between NS recruits and other *puskesmas* staff.

There is an understandable jealousy from the host *puskesmas*' staff over the high remuneration of NS recruits. Host *puskesmas*' staff have various employment tenures, ranging from permanent civil servant status (PNS), non-permanent local government contract, to voluntary employment (sukarela). The size of health workers' salary is regulated at the ministerial level (SK Menkes No. 481/2017) which requires employers of health professionals to set the salary level according to the minimum wage standard in the local municipality/ regency. Despite this regulation, however, a national survey on HRH (Riskesnas 2017) estimated that 34.5 per cent of *puskesmas*' staff were underpaid relative to the local city's standard.

At the macrolevel, a national discourse should be constructed in a productive manner to address the trend of underpayment for health professionals. This would have brought a sense of unity between health staff of any employment tenure within the *puskesmas*. Nevertheless, the study found that, instead of highlighting this issue, the everyday interaction between NS recruits and host *puskesmas*' staff were nuanced more by the remarks on NS Program overpaying health workers.

5.2. Perception of PHC Career in Remote Areas

The study found that the appeal of NS Program to the Indonesian young health professionals is based on a number of factors: (i) nationalism doctrine; (ii) professional idealism; (iii) employment sustainability; and (iv) family expectation and gender role.

Firstly, the program title of "*Nusantara Sehat*" inadvertently evokes an inherent value within many Indonesian health workers related to the message of "*Wawasan Nusantara*". Such a value relates to the national identity and social justice ideal whereby, as part of the educated younger generation, health professionals leap at the opportunity to be part of the nation's development in the left-behind areas.

Secondly, young health professionals also still carry with them the idealism to apply their professional knowledge and to practise their skills according to the standard with which they were taught. For some, the NS Program holds the promise of them having the creative and authority space to perform their profession optimally, compared to when they worked as junior or volunteer staff in urban *puskesmas*. In reality, however, they also still cannot fully do so as a lot of support that they need to fully perform their professional skills cannot be found in remote *puskesmas*. This is possibly a demotivating factor for future work in remote areas.

Thirdly, the NS Program is considered suitable and enticing for young health professionals in two ways: (i) higher income; and (ii) career prospects. Firstly, the size of income afforded to the NS recruits, that is much higher than the regional minimum wage level, allows them to envision a future in self-employment by building their own professional practice. Secondly, there is a promise of added value that the employment experience gives them for further studies or to apply for jobs in the future. As some of the program's alumni are finding, however, the NS Program can instead be considered as a mere delay on their career path. This is because the health professional education system and the local governments' recruitment process do not place a high value on work experience in PHC in remote areas.

Lastly, a dominant proportion of NS recruits depicted their career decisions as dependent on their family's expectations. This is especially true for female health professionals. Given that the Indonesian health professions are increasingly feminised and that the Indonesian families in general still hold conservative views on gender roles–where females are to build families and abide by the male partners' career decisions–this will affect health workers' decisions against working full time in remote areas.

5.3. Discrepancy Between Health Worker Needs and Current NS Recruitment and Assignment

The main challenge in Indonesian human resource management for PHC delivery in *puskesmas* is not the number of health professionals, but the distribution of the existing stock of health professionals. The nature of this maldistribution differs by profession. There are high proportions of *puskesmas* that are lacking in the following professions: nutritionists (45.25 per cent), dentists (43.81 per cent), laboratory technicians (42.88 per cent), public health workers (40 per cent), and environmental health workers (32.88 per cent).

The number of oversupplied dentists, medical laboratory technicians, and nutritionists is still less than the number of health workers needed in under-resourced *puskesmas*. This means that, while for other professions the dominant problem is in their distribution, for dentists, medical laboratory technicians, and nutritionists the problem is about production as well as entry of these professions into *puskesmas* employment in general.

Meanwhile, despite the fact that thousands nurses and/or midwives are still needed by *puskesmas* to fulfill the minimum standard as required by *Permenkes* No. 75/2014, Indonesia clearly has an oversupply of nurses and midwives. The current oversupply of nursing professionals is due to overproduction from domestic tertiary education institutions. It is worth noting, however, that the figures reported in the BPPSDMK system might not cover many health workers who are considered 'voluntary staff' and not officially employed at the *puskesmas* under any formal term. The need to resolve the overproduction of nurses and midwives might, therefore, be more urgent than it currently seems.

As obtained through this study's findings from NS recruits' experience, the recruitment of more midwives and nurses through NS teams into host *puskesmas* that are already staffed by midwives and nurses of PNS and voluntary staff employment status created some tensions. These tensions would manifest in the periodic budget and activity planning as well as in daily practice. This is compounded even further with the clash of interpretation on the mission of NS teams' deployment, both from within the NS teams, from within the host *puskesmas*' staff, and from the *DinKes*.

06

Recommendations

6.1. Recommendations for the MoH and *DinKes* (Province and District/City)

6.1.1. Strengthen the Positive Impact of Interprofessional Collaboration Through the NS Program

The strength of interprofessional collaboration through the NS Program is the formation of a group spirit (team-spirit) of health workers from diverse professions that have been built since before arrival in the assignment location. Obstacles arise in the field when the team is faced with a surplus of workers from several professions that are already in the *puskesmas* assignment location, as well as their work program plans that were previously composed.

To overcome obstacles and strengthen the collaborative interprofessional work patterns at the *puskesmas* level in future, the following modifications are recommended.

- The first is to encourage an evaluation of the proposed mechanism for the composition of the *Nusantara Sehat* Team according to the number of workers needed and existing conditions of the *Puskesmas* to avoid potential conflicts between the *Nusantara Sehat* Team and local *puskesmas* staff, especially in the same type of profession.

- The second is joint training between *puskesmas* staff and NS officers. This kind of activity will help develop positive work relationships between old and new *puskesmas* staff for conflict prevention and align work objectives and planning.

- The third is the synchronisation of time between the preparation of work plans and the *puskesmas* budget. At present, *puskesmas*, like most government public service institutions, have two opportunities for the preparation of *puskesmas* work plans and budgets, namely at the end of the year (for the preparation of the next year's budget design) and in the middle of the year (for the preparation of a draft budget change). Determining the initial assignment time for one to two months prior to the preparation of the draft budget will optimise the assignment period for multiprofession teams.

6.1.2. Promotion of Positive Career Perceptions in Community-based Primary Health Services

Health human resource management in remote areas is often constrained by the low motivation of qualified health workers to pursue careers in remote areas.

This study has found four major factors that motivate health workers to work in remote areas: (i) idealism to contribute to communities in disadvantaged and needy areas; (ii) aligning needs at the assignment location with their expertise; (iii) continuity with career paths in the future; and (iv) attractive salary. The NS Program has succeeded in offering the first two factors mentioned above. Furthermore, the last two factors deserve discussion, as recommendations for planning assignments in the future.

For the continuation of the career path of health workers, mechanisms should be developed in various existing health professional organisations to identify competency elements for continuing professional development (CPD) obtained while carrying out their duties in remote areas. This recognition of CPD competencies can be arranged as a professional credit unit that can be used by health workers when arranging recommendations from professional organisations (in the form of their STR). Proof of CPD credit from carrying out these tasks in remote areas can be done through various forms, for example, through the writing of scientific papers, although there are obstacles, namely access to valuable literature and the opportunity to consult with experts in the topics or fields they are interested in.

To enable the acquisition of competency credits, elements of the central and regional governments inside and outside the health sector must work together to ensure adequate access to communication information technology, such as the Internet network. The Internet must be included as a minimum standard for the construction of health facilities, including in very remote *puskesmas*, and also provide a structural budget for those experts addressed by health workers in their CPD learning process.

The discussion on salary must move from the spotlight on providing high salaries for health workers undertaking temporary assignments by the MoH through the NS Program to the provision of high salaries also for health workers on other employment tenures. The preparation of the HRH remuneration structure should also be able to factor in the diversity of costs needed to support health workers' daily work performance (personal travel cost from home to site of work which would vary between different *puskesmas*) as well as the periodic expenses needed for continuing professional development to afford equal opportunity of competence-building and career progression for health workers in rural areas.

Appendix 1: Pertinent Health Regulations

Keputusan Menteri Kesehatan Republik Indonesia Nomor HK.02.02/MENKES/145/2015 tentang Besaran Penghasilan Penugasan Khusus Tenaga Kesehatan Berbasis Tim (Team Based) dalam Mendukung Program Nusantara Sehat (Minister of Health Decree No. HK.02.02/MENKES/145/2015 on Salary Payments for Special Assignment of Team-based Health Workers to Support the *Nusantara Sehat* Program).

Keputusan Menteri Kesehatan Republik Indonesia Nomor HK.02.02/MENKES/223/2016 tentang Besaran Penghasilan Penugasan Khusus Tenaga Kesehatan Berbasis Tim (Team Based) dalam Mendukung Program Nusantara Sehat (Minister of Health Decree No. HK.02.02/MENKES/223/2016 on Salary Payments for Special Assignment of Team-based Health Workers to Support the *Nusantara Sehat* Program).

Keputusan Menteri Kesehatan Republik Indonesia Nomor HK.01.07/MENKES/484/2017 tentang Besaran Penghasilan Penugasan Khusus Tenaga Kesehatan dalam Mendukung Program Nusantara Sehat (Minister of Health Decree No. HK.01.07/MENKES/484/2017 on Salary Payments for Special Assignment of Health Workers to Support the *Nusantara Sehat* Program).

Peraturan Menteri Kesehatan Republik Indonesia Nomor 75 Tahun 2014 tentang Pusat Kesehatan Masyarakat (Minister of Health Regulation No. 75/2014 on Community Health Centres).

Peraturan Menteri Kesehatan Nomor 23 Tahun 2015 tentang Penugasan Khusus Tenaga Kesehatan Berbasis Tim (Team-Based) dalam Mendukung Program Nusantara Sehat (Minister of Health Regulation No. 23/2015 on Special Assignment of Team-Based Human Resources for Health in Support of *Nusantara Sehat* Program).

Peraturan Menteri Kesehatan Republik Indonesia Nomor 33 Tahun 2015 tentang Pedoman Penyusunan Perencanaan Kebutuhan Sumber Daya Manusia Kesehatan (Minister of Health Regulation No. 33/2015 on Guideline on Human Resources for Health Planning).

Peraturan Menteri Kesehatan Nomor 46 Tahun 2015 tentang Akreditasi Puskesmas, Klinik Pratama, Tempat Praktik Mandiri Dokter, dan Tempat Praktik Mandiri Dokter Gigi (Minister of Health Regulation No. 46/2015 on the Accreditation of *Puskesmas*, Primary Clinics, Independent Doctors' Practices, and Independent Dentists' Practices).

Peraturan Menteri Kesehatan Republik Indonesia Nomor 71 Tahun 2016 tentang Petunjuk Teknis Penggunaan Dana Alokasi Khusus Nonfisik Bidang Kesehatan Tahun Anggaran 2017 (Minister of Health Regulation No. 71/2016 on Technical Guidelines for the Use of Special Non-physical Health Allocations for Fiscal 2017).

Peraturan Menteri Kesehatan Nomor 16 Tahun 2017 tentang Penugasan Khusus Tenaga Kesehatan dalam Mendukung Program Nusantara Sehat (Minister of Health Regulation No. 16/2017 on Special Assignment of Human Resources for Health in Support of *Nusantara Sehat* Program).

Peraturan Menteri Kesehatan Nomor 61 Tahun 2017 tentang Petunjuk Teknis Penggunaan Dana Alokasi Khusus Nonfisik Bidang Kesehatan Tahun Anggaran 2018 (Minister of Health Regulation No. 61/2017 on Technical Guidelines for the Use of Special Non-physical Health Allocations for Fiscal 2018).

Peraturan Menteri Kesehatan Republik Indonesia Nomor 66 Tahun 2017 tentang Petunjuk Operasional Penggunaan Dana Alokasi Khusus Fisik Bidang Kesehatan Tahun Anggaran 2018 (Minister of Health Regulation No. 66/2017 on Technical Guidelines on Special Physical Health Allocations for Fiscal 2018).

Peraturan Menteri Kesehatan Nomor 13 Tahun 2018 tentang Penyelenggaraan Pemberian Beasiswa bagi Tenaga Kesehatan Pasca Penugasan Khusus Tenaga Kesehatan (Minister of Health Regulation No. 13/2018 on Provision of Scholarships for Health Workers Following Special Assignment).

Peraturan Menteri Kesehatan Republik Indonesia Nomor 2 Tahun 2019 tentang Petunjuk Operasional Penggunaan Dana Alokasi Khusus Fisik Bidang Kesehatan Tahun Anggaran 2019 (Minister of Health Regulation No. 2/2019 on Technical Guidelines on Special Physical Health Allocations for Fiscal 2019).

Peraturan Menteri Kesehatan Nomor 3 Tahun 2019 tentang Petunjuk Teknis Penggunaan Dana Alokasi Khusus Nonfisik Bidang Kesehatan (Minister of Health Regulation No. 3/2019 on Technical Guidelines for the Use of Special Non-physical Health Allocations).

Surat Keputusan (SK) Menteri Kesehatan Nomor 481 Tahun 2017 tentang Pengangkatan Tenaga Kesehatan Sebagai Tenaga Kontrak/Sukarela/Honorer (Minister of Health Decree No. 481/2017 on Recruitment of Health Workers as Contracted /Volunteer/Honorary Labour).

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Appendix 2: Study Informants, by NS Team Employment Status, Profession, and Gender

Status of NS Employment	Location of Data Collection	Profession	Gender
Active	**Bengkulu**	Pharmacist	Female
		Nurse	Male
		Midwife	Female
		Public health worker	Female
		Nutritionist	Female
		Medical laboratory technician	Male
		Public health worker	Female
		Medical laboratory technician	Male
		Midwife	Female
		Public health worker	Female
		Nutritionist	Female
		Environmental health worker	Female
		Nurse	Male
	East Nusa Tenggara	Public health worker	Female
		Midwife	Female
		Nurse	Female
		Medical doctor	Female
		Pharmacist	Male
		Environmental health worker	Male
		Midwife	Female
		Medical doctor	Male
		Nurse	Female
		Environmental health worker	Female
		Medical laboratory technician	Female
		Public health worker	Female
	South Sulawesi	Nurse	Female
		Medical laboratory technician	Male
		Environmental health worker	Female
		Pharmacist	Female
		Midwife	Female

Status of NS Employment	Location of Data Collection	Profession	Gender
Alumni	**Jakarta – phone interview**	Medical laboratory technician	Female
		Public health worker	Female
		Nutritionist	Female
		Public health worker	Female
		Environmental health worker	Male
		Pharmacist	Female
		Nurse	Female
		Medical laboratory technician	Female
		Midwife	Female
		Pharmacist	Female
		Midwife	Female
		Nurse	Male
		Medical doctor	Male
	Jakarta – FGD	Nurse	Female
		Nurse	Female
		Midwife	Female
		Environmental health worker	Female
		Public health worker	Female

Source: TNP2K, 2019

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ISBN 978-602-275-205-9