103438

WORLD BANK GROUP

Oxford Policy Management

Increasing Functionality and Compliance to Policies at Rural Health Posts: A Way Forward to Achieving Universal Access to Essential Health Care in Timor-Leste

June 2015

This briefing note presents the key findings and policy implications of the health facility survey implemented in 2014 in 69 sampled health facilities in Timor-Leste.

The key findings are:

- Hospitals are generally well equipped and Community Health Centres (CHC) were moderately equipped
- General service provision was consistently low in rural Health Posts (HPs) and was yet to comply with the Basic Service Package
- Drug supplies were inconsistent with the Essential Drug List

The following recommendations are based on the evidence gathered through this survey:

- Increase the functionality of rural health facilities in accordance with the Basic Service Package
- Improve pharmaceutical procurement (demand driven) and distribution to ensure availability of medicines on the Essential Drug List

Background

Timor-Leste had a seriously fragile health system when it became independent in 2002. During the war preceding independence more than 70% of health facilities were destroyed or seriously damaged. While the situation has gradually improved over the years, there are still a lot of obstacles to reaching international standards in Timor-Leste's health facilities.

Lack and quality of infrastructure and limited resources at health facilities are longstanding problems. According to a recent report there was no Magnetic Resonance Imaging (MRI) machine in Timor-Leste and only one quite old Computed Tomography (CT) scan machine (McCall, 2014).

Facility functionality is the worst in rural areas. A recent article reported that half of the Servisu Integrado du Saude Comunidade were not functioning (Martins & Trevena, 2014).

Lack of access is also a problem. A recent study suggested that 25% of households were more than two hours away from their usual health care provider and 12% of households in Timor-Leste did not seek health care when a household member was ill (Deen et al., 2013). The poor functionality of health facilities could also be a reason for this lack of access to formal health care.

In 2014, a study was conducted in Timor-Leste to better understand facility functionality, labour market dynamics, the preferences of health workers and the competence of doctors.

This briefing note presents the findings of the health facility survey investigating the functionality of health facilities in Timor-Leste in 2014.

Methods

The sampling frame covered 277 health facilities, including 6 hospitals (national and referral), 66 community health centres (CHCs) and 205 HPs. Sixty-nine (25%) of the 277 health facilities were sampled. Three field teams collected the survey data during July and August 2014.

The survey respondents were the head of the sampled health facility, the person in-charge of the facility, or the most senior health worker responsible for client services present at the facility at the time of the survey.

The team administered a structured questionnaire covering various dimensions of the health workers' working environment, including inpatient service availability, processing of medical equipment, supplies and storage of medicines, user fees and sources of finance, sources of water and power supply, staff management and external supervision, and disability and gender perspectives.

Key Findings

Sample distribution

The team visited 69 health facilities in all 13 districts of Timor-Leste including 6 hospitals, 33 CHCs and 30 HPs. Among all health facilities 21 were urban and 48 were rural.

Service availability

The percentage of service availability was consistently low in HPs (which are usually located in rural areas) compared to CHCs and hospitals.

Table 1 presents the service availability of some selected services, which are supposed to be available in all types of health facilities according to the Basic Service Package 2007, which was in place at the time of the survey.

The results clearly show that HPs often lack even the basic services that they are supposed to have.

Table 1: Service Availability, by Facility Type

	Hosp.	CHC	HP
Family planning	100%	100%	88%
Antenatal care	100%	100%	93%
Malaria treatment	100%	100%	86%
STI treatment	100%	93%	38%
TB treatment	100%	100%	55%
HIV testing	100%	91%	63%
Minor surgery	100%	85%	65%
Normal delivery	100%	100%	83%

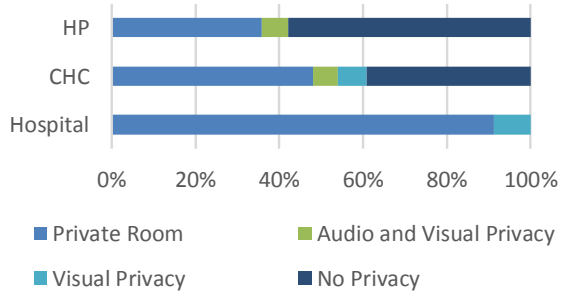
Infrastructure

Access to clean water remains a significant problem, particularly in rural areas. More than half of the CHCs and HPs did not have a water source on their premises and had to collect water from elsewhere. One-third of HPs are also not connected to the electricity grid. Uninterrupted electricity was available in 72% of hospitals, 52% of CHCs and 34% of HPs.

All hospitals were equipped with functioning landlines, cellular coverage and computers, and 70% had an internet connection. However, a considerable percentage of CHCs and HPs did not have any functioning means of communication. That said, cellular coverage was quite high: all of the hospitals, 57% of CHCs and 29% of HPs had coverage that allowed mobile phones to function.

The privacy of patients in client examination rooms meets standards in hospitals. In contrast, 58% of HPs do not have any audio or visual privacy in the client examination rooms (Figure 1).

Figure 1: Privacy of Client Examinations



Drugs and supplies

The survey data showed that the availability of drugs was generally inconsistent across the facility levels.

Table 2: Availability of Drugs

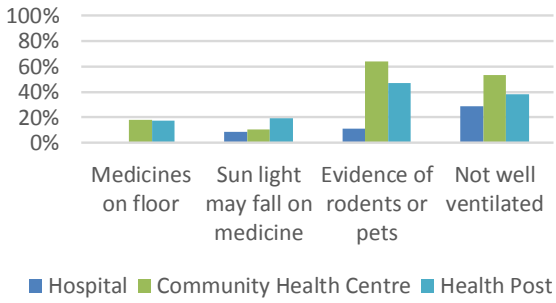
	Hosp.	CHC	HP
Should be available at all levels			
Amoxicillin tab.	100%	72%	54%
Ampicillin inj.	100%	78%	29%
Ciprofloxacin tab.	100%	54%	46%
Doxycycline cap.	100%	88%	50%
Metronidazole tab.	100%	94%	61%
Should be available at Hospitals and CHCs			
Gentamycin inj.	80%	68%	N/A
Tetracycline cap.	12%	26%	N/A
Should be available at hospital only			
Ceftriaxone inj.	91%	N/A	N/A

The survey data was matched with the Essential Drug List 2010, which should be followed for the disbursement of drugs. As shown in Table 2 above, none of the CHCs or HPs should have Ceftriaxone injections, yet 63% and 15% respectively had the drug in stock.

The storage conditions of the medicines were not ideal in the majority of facilities. Based on visual observation by the survey teams, there was evidence of rodents or pests in the medicine storage room in 50% of the health facilities, and in 41% of the facilities the store room was not well ventilated (Figure 2).

Similarly, there were shortages of supply items in HPs. Less than 10% had nebulizer machines, peak-flow meters and pulse oximeters.

Figure 2: Storage Conditions for Drugs



Equity

The survey data indicate that most of the CHCs and HPs are not user-friendly for people with a disability. The HPs should be equipped with guidelines and treatment for domestic violence (DV).

Table 3: Disability and Gender Readiness

	Hosp.	CHC	HP
Disability			
Ramps	100%	44%	3%
Handrail	100%	15%	3%
Signs	39%	4%	3%
Gender			
Guidelines for Domestic Violence(DV)	100%	50%	27%
Treatment for DV	100%	80%	46%
Maternity leave	100%	98%	98%

Policy Implications

Increasing the functionality of rural health facilities

The survey highlights some of the challenges in terms of bringing rural health infrastructure up to standard. The availability of a fixed water source and power supply is strongly associated with the tier of health facility: availability is lowest for HPs, followed by

CHCs. Hospitals have the most stable water and power supplies.

These findings highlight the urgency of equipping HPs, in particular, to mandated standards, which will not only improve patient care but also improve health staff retention and performance.

Ensuring policy compliance on drugs

Many health facilities had drugs they were not supposed to stock according to the Essential Drug List. Similarly, service availability often does not match the Basic Service Package. It is important to ensure that policies are implemented consistently across the country. At the same time, issues relating to the practicability of policies need to be identified and resolved.

The team tried to understand the push–pull mechanism contributing to the inconsistent distribution of drugs and established that, although health facilities should receive medicines and supplies based on the requests they raise, this rarely happens in practice. Often, lower-level health facilities are simply supplied with the drugs that are available and unused at the district level.

There are certain risks in having higher-level medicines in lower-level facilities, especially in regard to antibiotics. This may result in irrational use of drugs and subsequent resistance to antibiotics. On the other hand, these drugs may also be left unused and ultimately destroyed when they expire.

It is therefore important to ensure that health facilities receive drugs based on the existing policy and clear guidelines.

Using mobile phone technology

Effective means of communication is a challenge in Timor-Leste's health facilities. This 'shortage' in communication has made it difficult for staff to report urgent cases, shortages in medical supplies and pharmaceutical needs. However, a large number of health facilities were found to have functioning mobile phone coverage.

Mobile phone technology should be more widely used for inventory monitoring and other communications.

References

Deen, J. et al. (2013) Identifying national health research priorities in Timor-Leste through a scoping review of existing health data. *Health Research Policy and Systems*, 11(8).

Martins, N. & Trevena, L. (2014) Implementing what works: a case study of integrated primary health care revitalisation in Timor-Leste. *Asia Pacific Family Medicine*, 13(5).

McCall, C. (2014) East Timor striving for universal access to health care. *The Lancet*, 384(9953), pp. 1491–1492.

This project was carried out by World Bank and Oxford Policy Management (OPM) with funding from the Australian Department and European Commission. The Ministry of Health of the Government of Timor-Leste provided support at every stage of this project. Dili Institute of Technology (DIT) was the local partner. Detailed results and interpretations are available in the full report, which can be accessed at www.worldbank.org/en/country/timor-leste. If you have any queries please contact Xiaohui Hou, Senior Economist, World Bank (email: xhou@worldbank.org) or Rashid Zaman, Consultant, Health Portfolio, Oxford Policy Management (email: rashid.zaman@opml.co.uk).