Evaluation of the “Accelerating the Implementation of the Investment Case for Maternal, Newborn and Child Health in Asia and the Pacific” Programme

Baseline findings: INDONESIA

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Authors: Silvia Devina and Prof Don Matheson
# Table of Contents

Table ofContents ................................................................................................................. 2  
List of Abbreviations ........................................................................................................... 4  
Executive Summary .............................................................................................................. 6  
Introduction ......................................................................................................................... 8     
  Millennium Development Goals 4 and 5 with Equity ......................................................... 8  
  Objectives of the evaluation ................................................................................................. 9  
  Evaluation process .............................................................................................................. 10  
  Country background ........................................................................................................... 11  
Child Health Status ........................................................................................................... 12  
  MDG 4 in doubt .................................................................................................................. 12  
  Equity data ......................................................................................................................... 13  
  Percent of children under-5 who are underweight ............................................................... 15  
Maternal Health Status ....................................................................................................... 16  
  MDG 5 target will not be met. ............................................................................................... 16  
  Birth by skilled birth attendants .......................................................................................... 16  
  Contraception ..................................................................................................................... 17  
  Antenatal care ..................................................................................................................... 18  
  Equity of interventions to address maternal mortality. ....................................................... 18  
  Equity in contraceptive use: ............................................................................................... 19  
Inequities on MDG 4 and 5 indicators ................................................................................. 20  
Health System Actions to address MDG 4 and 5 ............................................................... 22  
Policy and decision making for MNCH and Nutrition in Indonesia .................................. 25  
  Planning and budgeting cycle ............................................................................................. 25     
    Musrenbang process ......................................................................................................... 25     
    Central government health sector planning and budgeting cycle .................................. 28  
  Specific Government Funding mechanisms ........................................................................ 30
DAU (General Allocation Fund) ................................................................. 32
Otsus (Special Autonomy Fund) ............................................................... 35
Other Government Funds for the Health Sector ........................................ 36

**Intergovernmental fiscal flows for the health sector** ................................ 38
Fiscal flow in health sector ........................................................................ 38

**Financing for RMNCH and Nutrition in Indonesia** ................................. 39
Regional government revenue ..................................................................... 39

Figure 16: Source of District/ City Revenue ................................................. 40
Source of public funds at the district level .................................................. 41
Public health expenditure by level of government ....................................... 42
District health expenditure .......................................................................... 43
Health expenditure and public health development index ............................ 44
Health expenditure for MNCH programmes .............................................. 45

Past Evidence Based Planning activity in Indonesia ..................................... 47

Programme logic for the investment case work in Indonesia ....................... 48

Appendix 1: ................................................................................................. 49
References .................................................................................................. 51
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>APBN</td>
<td>Anggaran Pendapatan Belanja Negara (State Budget)</td>
</tr>
<tr>
<td>APBD</td>
<td>Anggaran Pendapatan Belanja Daerah (Regional Government Budget)</td>
</tr>
<tr>
<td>AIPD</td>
<td>Australia Indonesia Partnership for Decentralisation</td>
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<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
</tr>
<tr>
<td>BAPPEDA</td>
<td>Badan Perencana Pembangunan Daerah (Regional body for planning and development)</td>
</tr>
<tr>
<td>DAK</td>
<td>Dana Alokasi Khusus (Special Allocation Fund)</td>
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<tr>
<td>DAU</td>
<td>Dana Alokasi Umum (General Allocation Fund)</td>
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<tr>
<td>DTPS</td>
<td>District Team Problem Solving</td>
</tr>
<tr>
<td>DPT3</td>
<td>Diphteria, Pertussus, Tetanus Vaccine 3rd vaccine.</td>
</tr>
<tr>
<td>DP</td>
<td>Development Partner</td>
</tr>
<tr>
<td>EBP</td>
<td>Evidence Based Planning</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccinations and Immunization</td>
</tr>
<tr>
<td>GF</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HSS</td>
<td>Health System Strengthening</td>
</tr>
<tr>
<td>ITN</td>
<td>Insecticide Treated Nets</td>
</tr>
<tr>
<td>IC</td>
<td>Investment Case (for Maternal, Newborn and Child Health)</td>
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<tr>
<td>IP</td>
<td>Implementation partners</td>
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<tr>
<td>KIA</td>
<td>Maternal and Child Health Book</td>
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<td>MBB</td>
<td>Marginal Budgeting for Bottlenecks</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<tr>
<td>MNCH&amp;N</td>
<td>Maternal, Newborn, and Child Health and Nutrition</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>ORT</td>
<td>Oral Rehydration Therapy</td>
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<tr>
<td>OTSUS</td>
<td>Otonomi khusus (Special Autonomy)</td>
</tr>
<tr>
<td>PAD</td>
<td>PAD pendapatan asli daerah, (revenue of regional governments)</td>
</tr>
<tr>
<td>PONED</td>
<td>Basic Emergency Obstetric and Neonatal Care</td>
</tr>
<tr>
<td>PONEK</td>
<td>Comprehensive Emergency Obstetric and Neonatal Care</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UKP4</td>
<td>Unit Kerja Presiden Bidang Pengawasan dan Pengendalian Pembangunan (the Presidential Working Unit for Supervision and Management of Development)</td>
</tr>
<tr>
<td>UQc</td>
<td>The University of Queensland consortium</td>
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<td>WHO</td>
<td>World Health Organization</td>
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EXECUTIVE SUMMARY

Indonesia appeared to be on track to achieve the under-5 child mortality indicator (MDG4). However, recent survey results suggest progress seem to have stalled and achievement of MDG 4 is now at risk.

However, there are disparities in the under-5 mortality rate due to area of residence, socio-economic status, and mother’s education level. In 2010 the rate for the poorest 20 per cent, for example, was 77 deaths per 1,000 live births while for the wealthiest 20 per cent the rate was 31 deaths per 1,000 live births. Death rates are also dissimilar between urban and rural populations.

From a nutrition perspective, the number of underweight children has reduced by one third; however, the reduction in stunting has been slow.

Although there has been considerable improvement over the last decade, it is likely that Indonesia will not reach the MDG 5 target. Maternal deaths are unequally distributed, with disparities in service provision that are greatest for the poor, the uneducated, and those in rural areas. One programme, Family Planning, stands out in its achievement of more equitable coverage. The leading cause of maternal deaths is haemorrhage, and to address this requires improvement in emergency obstetric care and the associated institutions (birthing facilities, district hospitals), attendance at birth by skilled health workers and referral systems. Quality of care is a major issue.

The Indonesian government has a level of health expenditure of US$56, which is just above what is thought to be the minimum required to deliver on the MDGs. It has a health workforce of 23 (doctors, nurses, midwives) per 10,000 people, which is also assessed as the minimum required, although the dispersed island populations require a higher density than more tightly concentrated populations.

The funding problem is not so much the levels of funding available, as the complex and clunky mechanisms by which funds move within the system, from the centre to the periphery as well as within provinces and districts. Unspent budgets, delays in budget fund release, weak accountability, and political overlay of the policy and prioritization process have a serious impact at each step of the process. These difficulties are well recognized and apply to all sectors, not just the health sector. The major challenge is improving the allocation, flow, prioritization of and accountability for resources at the periphery, a challenge that largely sits outside of the health sector.

The UNICEF country office is planning an evidence-based planning approach. At the national level it plans to explore in detail one of the funding channels, the Special Allocation Fund (DAK) to help the government resolve the bottlenecks that the lack of flow of funds creates. In addition the intention is to explore how this approach can be used to augment currently accepted district planning tools. Activities at the sub-
national level will focus on the Province of Papua, where the team hopes to build capacity for conducting evidence-based planning activities at both the district and the provincial level.
INTRODUCTION

As the countdown for the achievement of the MDGs proceeds, donors and implementation partners are asking if their efforts to accelerate improvements in maternal and child health are effective.

The Investment Case for Maternal, Newborn and Child Health (IC) in Asia and the Pacific has an ultimate goal of improving equitable progress towards achieving MDG 4 and MDG 5.

“Equitable progress” towards addressing the MDGs calls for closer attention to the progress being made by disadvantaged and marginalized groups in the country, even when their population numbers do not strongly influence the national statistics. Many countries are “on track” to achieve the MDGs while significant groups and populations within the country are being left behind. IC activities have a particular focus not only on the achievement of the MDG, but on ensuring improved maternal and child health is enjoyed by all.

In developing the IC work, a stronger equity analysis is required to determine progress and “success”. The particular populations of interest from an equity perspective differ in each country. Common groups that are described from an equity perspective include urban/rural, high/low socioeconomic status, ethnicity and caste.

MILLENIUM DEVELOPMENT GOALS 4 AND 5 WITH EQUITY.

The IC aims to provide policy-makers and development partners with the best available evidence for an equitable scaling-up of priority interventions that address the burden of Maternal, Newborn and Child mortality. It is a dynamic process that assesses the extent to which Reproductive, Maternal, Newborn, Child Health and Nutrition (RMNCH&N) variables are equitably distributed, identifies key issues, and influences impacts upon maternal and child health within a country. It involves results-based analysis to inform RMNCH&N planning, budgeting and policies, and spells out the costs and benefits of scaling-up packages of high impact interventions. The IC focuses on addressing the main health and nutrition problems of the most deprived children and families; identifying bottlenecks and barriers that contribute to this deprivation using the Tanahashi model; and identifying specific strategies to overcome the barriers that have created disparities.

This paper provides the baseline findings of an evaluation of an acceleration of the IC programme in four countries in the Asia Pacific region: Bangladesh, Indonesia, Nepal, and the Philippines. UNICEF has been supporting these countries with tools for developing the IC since before 2011, and is coordinating the planned IC works in partnership with national and sub-national governments. This work is carried out in partnership with local research institutes, and the University of Queensland consortium (UQc) has been providing additional technical assistance in Nepal, the
Philippines and Indonesia. However, given the different country contexts, processes and capacities, and variations in ways in which countries have adopted an inherently complex IC approach, there are differences in subsequent approaches and anticipated impacts and outcomes.

These four countries have been chosen because they are “early adopters” of the IC approach, and because each country has adopted the IC approach in different ways and at different levels. Within countries the focus is on specific districts or cities with the expectation that a wider system impact will result. The IC approach is designed to impact at both the national and sub-national level, such that activities may focus at the district or city level, but are expected to have an influence at the national level as well, and also impact on international partners1. This background findings paper specifically addresses the IC programme in Indonesia.

This is an independent evaluation commissioned by UNICEF and funded by AusAID. The evaluation design is described in the report titled “Inception report of the independent evaluation” October 2012 2.

OBJECTIVES OF THE EVALUATION

The purpose of the overall evaluation is to assess the impact the IC approach has on Maternal, Newborn and Child Health (MNCH) and health equity, and to understand how this occurs. It focuses on evidence-based planning for RMNCH&N.

Specifically, in each of the four countries, the evaluation will:

1. Describe and assess how planning is undertaken, programmes are delivered, policies are crafted, and what processes are used to decide budgets;
2. Determine the political and subsequent budgetary priority given to MNCH&N in four countries;
3. Document the current use being made of the IC; and
4. Compare the IC process between the countries, and put forward lessons learned and recommendations.

1 “Analysis occurs first at the district level, with potential benefits arising both through the process of improving the quality and capacity for decision-making, and through reorienting the delivery of services. By synthesizing several district analyses, there are also potential beneficial impacts upon policy and programme design at national level. These analyses are also expected to guide the allocation of budgets and priorities of national and international partners, and to eventually be reflected in actual implementation (e.g. increased expenditure and actions for prioritized populations, interventions and strategies).” IC TOR
This baseline report focuses on the first of the evaluation objectives and poses the following questions:

(A) What was the process of planning and budgeting before the introduction of the IC?

- What organizations and people were involved?
- Do political decisions on budget allocations take into account technical advice from agencies such as health or development partners such as UNICEF?
- How are priorities arrived at, both in the health bureaucracy and within the political arm of government?
- At what level of government are these decisions being made?
- How was evidence used in this process?
- How was data used in this process?
- How was equity/inequity addressed?
- How were gender issues addressed?
- What focus was there on MNCH&N?

(B) What was the understanding of the key challenges/deficiencies of existing plans and budgets, especially in terms of addressing the needs of Maternal and Child Health and of the most deprived?

EVALUATION PROCESS
This baseline findings paper forms a baseline report: it follows document reviews and introductory country visits, and an inception report describing the evaluation design. A final country case study report that assesses the outcomes of the IC work will be produced in 12 months’ time.

COUNTRY BACKGROUND

<table>
<thead>
<tr>
<th>KEY FACTS</th>
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<tbody>
<tr>
<td>Life expectancy: 67.8 years (2007)</td>
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<tr>
<td>Health Expenditure per cap: US$56</td>
</tr>
<tr>
<td>Health workers: 23 per 10,000</td>
</tr>
<tr>
<td>Maternal mortality rate per 100,000: 220</td>
</tr>
<tr>
<td>Child mortality rate per 1000: 35</td>
</tr>
<tr>
<td>Births attended by a skilled health staff: 69% (2007)</td>
</tr>
</tbody>
</table>
Indonesia is not on track to achieve MDG 4 of 28 deaths of under-5s.

Premature birth is the leading cause of under-5 deaths.

**CHILD HEALTH STATUS**

**MDG 4 IN DOUBT.**

There was a total of 151,000 under-5 deaths or 35 deaths per 1,000 live births in 2010 \(^3,4\). The main causes of under-5 deaths in Indonesia were premature birth (21 per cent), asphyxia (10 per cent), neonatal sepsis (5 per cent), other neonatal (3 per cent), congenital anomalies (6 per cent), pneumonia (14 per cent), diarrhoea (5 per cent), injuries (6 per cent), measles (5 per cent), malaria (2 per cent), meningitis (2 per cent) and other diseases (20 per cent) \(^5,6\). Other causes were malnutrition and lack of exclusive breastfeeding (less than 6 months) \(^7\).

The number of under-5 deaths decreased from 85 per 1,000 live births in 1990 to 35 per 1,000 live births in 2010. However, the preliminary results of IDHS 2012 show under-5 deaths of 40 per 1000 – a modest improvement since that last IDHS survey in 2007, but well above the 28 per 1000 goal of 2015. Other indicators related to under-5 mortality such as infant mortality rate and neonatal mortality rate were expected to reach MDG goals, but there is now some doubt in light of recent survey results. Coverage of 1-year-old children immunized against measles continues to increase \(^4\). Therefore, it is unclear whether Indonesia will achieve the MDG target to reduce under-5 deaths by two thirds between 1990 and 2015, or 28 per 1,000 live births in 2015 \(^8\).
There are disparities in the under-5 mortality rate due to area of residence, socio-economic status, and mother’s education level. In 2007 the rate for rural area was 60 deaths per 1,000 live births, while the rate for urban area was 38 deaths per 1,000 live births. Socioeconomic status is also associated with a gap in under-5 mortality rate as seen in Figure 3. Under-5s who resided in rural areas, who belonged to the poorest quintile, and who had a mother with no education had around a 1.6 to 2.5 times higher death rate compared to under-5s who resided in an urban area, belonged to the wealthiest quintile, and had a mother with secondary education or higher 4.

Disparities are also apparent between provinces. Regions differ in the levels of health determinants (e.g. socio-economic level and parents’ education level), as well as provincial government budgets for health. Together these impact on quality and access to health services, infrastructure development, and also other factors directly related to under-5 health. An example of disparity can be seen in the provision of immunization for children, which is affected by vaccine availability and parents’ situations. Children who live in urban areas, are from higher socio economic groups and who have mothers with higher education levels are more likely to get immunized 10. According to the World Health Organization 6, 44 per cent of the Indonesian population lives in urban areas.
The inequities in health outcomes are reflected in inequitable access to specific child health interventions. As an example, DPT3 coverage is higher for children who live in urban areas, come from the highest wealth quintile, and have a mother with secondary or higher education. DPT3 immunization coverage was 75 per cent in urban areas and 61 per cent in rural areas. The coverage in children from the highest wealth quintile is 1.8 times higher than children from the lowest wealth quintile (82 per cent in the highest and 45 per cent in the lowest). Similarly, children who have mothers with secondary or higher education had 2.6 times higher coverage than children whose mother has no education (76 per cent in mothers with secondary or higher and 29 per cent in mothers with no education) 11.

Table 1: DTP3 immunization coverage among 1-year-olds by place of residence, wealth quintile, and educational level of mothers (%) in 2007

<table>
<thead>
<tr>
<th>From the DHS (2007)</th>
<th>Place of residence</th>
<th>Wealth quintile</th>
<th>Educational level of mother</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP3 immunization coverage among 1-year-olds (%)</td>
<td>Rural</td>
<td>Urban</td>
<td>Lowest</td>
</tr>
<tr>
<td></td>
<td>61</td>
<td>75</td>
<td>45</td>
</tr>
</tbody>
</table>
The prevalence of children under-5 who are underweight in Indonesia decreased from 30 per cent in 1995 to 20 per cent in 2007.

Figure 4: Underweight Prevalence

Figure 5 compares percentage of underweight and stunted under-5s in Indonesia. The percentage of under-5s who were underweight fell by a third, while stunting decreased only slightly between 1995 and 2007. In 2007, the number of underweight was 20 per cent while the number of stunted under-5s was 40 per cent.
MDG 5 TARGET WILL NOT BE MET.

In 1990 the maternal mortality ratio in Indonesia was 600 per 100,000 live births. The number decreased until it reached 220 per 100,000 live births in 2010.

Figure 6: Maternal Mortality Trends

To achieve MDG 5, Indonesia needs to reduce maternal mortality to 150 per 100,000 live births in 2015. This means a decrease of 70 per 100,000 live births must be accomplished within five years (from 2010 to 2015). Indonesia’s Vice Minister of Health stated that achieving MDG goal 5 is the most challenging compare to other MDG goals. According to the Guardian report, Indonesia is among 15 countries that are set to meet MDG 4 but miss MDG 5.

The causes of maternal deaths in Indonesia in 2010 were as follows: haemorrhage (32 per cent), indirect causes (22 per cent), hypertension (17 per cent), other direct causes (10 per cent), unsafe abortion (9 per cent), sepsis (8 per cent) and embolism (2 per cent).

BIRTH BY SKILLED BIRTH ATTENDANTS

There was a significant increase in percentage of live births attended by skilled health personnel in Indonesia between 1991 and 2007 (32 per cent to 79 per cent). According to a report, 60 per cent of births occurred at home. However, these increases are not yet being reflected in reduced maternal mortality.
Between 2000 and 2007, the percentage of contraceptive use (any method) among married women aged 15 to 49 years fluctuated from around 52.5 per cent to 61.4 per cent. The percentage decreased between 2000 and 2001 (from 54.8 per cent to 52.5 per cent) and then increased in 2003 (60.3 per cent). The percentage of contraceptive use among married women decreased between 2003 and 2005 (from 60.3 per cent to 57.9 per cent) then increased in 2007 (61.4 per cent).  

Table 2: Trend in current contraceptive (any method) use among married women 15 to 49 years of age (%), 2000 to 2007

<table>
<thead>
<tr>
<th>Year</th>
<th>Current contraception (any method) use among married women 15–49 years of age (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>54.8</td>
</tr>
<tr>
<td>2001</td>
<td>52.5</td>
</tr>
<tr>
<td>2003</td>
<td>60.3</td>
</tr>
<tr>
<td>2005</td>
<td>57.9</td>
</tr>
<tr>
<td>2007</td>
<td>61.4</td>
</tr>
</tbody>
</table>
According to data from the World Health Organization, between 2005 and 2010 around 61 per cent of married women aged 15 to 49 years used contraception (any method).

**ANTENATAL CARE**

There was an increase of antenatal care coverage (at least one visit by a skilled health provider) by 17 per cent between 1991 and 2007 (from 76 per cent to 93 per cent). However, there was only a slight increase between 2002 and 2007 (from 92 per cent to 93 per cent). 

**Figure 8: Women attended by skilled health provider during pregnancy.**

![Antenatal care graph](image)

Recent reports state that the coverage of antenatal care (four or more visits) in 2007 was 82 per cent. In addition, postnatal visits for the baby were 73 per cent while postnatal visits for mother were 87 per cent in 2007. The same year, the total caesarian section rate in Indonesia was 7 per cent (11 per cent in urban areas and 4 per cent in rural areas). This means that for rural areas it was close to the minimum target of 5 per cent for caesarian sections in rural areas.

**EQUITY OF INTERVENTIONS TO ADDRESS MATERNAL MORTALITY.**

The percentage of births attended by skilled health personnel was higher in mothers from urban areas, from the highest wealth quintile, and with secondary or higher education level.

**Table 3: Percentage of birth attended by skilled health personnel (%) by place of residence, wealth quintile, and educational level of mothers in 2007**
There are significant differences in service levels to different populations. For both skilled birth attendants and antenatal care, wealth and education levels are the strongest indicators of access to these interventions. Women with no education or in the lowest wealth quintile are receiving these interventions at almost a third of the rate of women with secondary or higher education and women in the highest income quintile. There are also differences between the access levels for urban versus rural women.

**EQUITY IN CONTRACEPTIVE USE:**

Contraceptive use was more prevalent among married women aged 15 to 49 years of age in rural areas (58 per cent in rural areas and 57 per cent in urban areas), from the highest wealth quintile (58 per cent from the highest wealth quintile and 50 per cent from the lowest wealth quintile) and who had secondary or higher education level (59 per cent had secondary or higher education and 40 per cent had no education) 11.

Table 4: Percentage of current contraception (any method) use among married women 15 to 49 years of age (%) by place of residence, wealth quintile, and educational level of mothers in 2007

<table>
<thead>
<tr>
<th>From the DHS 2007 (%)</th>
<th>Place of residence</th>
<th>Wealth quintile</th>
<th>Educational level of mother</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Urban</td>
<td>Lowest</td>
</tr>
<tr>
<td>Birth attended by skilled health personnel (%)</td>
<td>63</td>
<td>88</td>
<td>44</td>
</tr>
</tbody>
</table>

| Contraceptive prevalence (%) | 58 | 57 | 50 | 58 | 40 | 59 |
Figure 9 describes the socio-economic inequities in coverage between the poorest quintile and the richest quintile in Indonesia in relation to MDG 4 and 5 indicators. Overall, the biggest gap is seen for skilled birth attendants (almost 50 per cent) while the smallest gap is seen for early initiation of breastfeeding, insecticide treated net (ITN) use among under-5s, and ORT and continued feeding. The indicators showing more than 60 per cent coverage in the poorest quintile are demand for family planning satisfied, antenatal care (at least one visit and at least four visits), and measles immunization coverage.

Concerning MDG 4, significant gaps (30 to 40 per cent) were also seen for DTP3 and measles immunization coverage between the richest and poorest quintile. The measles immunization coverage among 1-year-olds for the past five years (2006 to 2010) was between 79 and 89 per cent. The biggest measles immunization coverage was in 2010 (89 per cent)\(^6\). In relation to MDG 5, the gaps were significant (30 to 50 per cent) between the poorest and richest quintile, more specifically for antenatal care (at least four visits) and skilled birth attendant\(^5\).

Figure 9: Socioeconomic Inequalities in Coverage\(^8\).

Figure 10 shows the differences in coverage between selected interventions across three different dimensions: wealth, geography and education. The bigger the triangle, the greater the disparities in coverage in the three dimensions measured.
This demonstrates that one programme, family planning (green), has achieved more equitable distribution than others such as antenatal visits (purple) and skilled birth attendants at deliveries (blue). It also helps identify the magnitude of the disparities, with poverty and education being dominant. It is important to note that only three dimensions of disparity are included, and that these are national figures. The degree and nature of disparities will differ in each district. For these examples at least, the successful programmes are addressing all the dimensions of equity.

For contraceptive prevalence, although equity differences exist, they are much less pronounced. Educated and non-educated women are separated by 19 percentage points for contraceptive prevalence, as opposed to over 50 percentage points for antenatal care and skilled birth attendants.

Figure 10: Disparities in coverage for selected programmes.18
The government of Indonesia has made MDG goals a priority with the establishment of UKP4 (the Presidential Working Unit for Supervision and Management of Development). The committee is directly responsible to the President with support from the ministries, regional government, and other parties.

However, as noted earlier, with the current rate of improvement it is expected that maternal mortality will be 164 per 100,000 live births in 2015 and it is feared Indonesia will not be able to achieve the MDG 5 goal \(^8,19\). Therefore, the government has made maternal health a national priority and has increased its efforts in addressing MDG 5 \(^19\).

The government of Indonesia’s efforts to accelerate achievement of MDG 4 and MDG 5 goals \(^10,19-21\) are as follows:

1. **Government Financing for Maternal and Neonatal Health (Jampersal)**: In 2010 the government introduced a childbirth insurance programme (Jampersal) as part of the Health Insurance for the Poor (Jamkesmas) scheme, funded by the State budget allocated for health services. Jampersal is specifically targeted to fund mothers giving birth and their infants. This funding includes pregnancy examinations, childbirth services including postnatal family planning and care for newborns. In 2012, the government had supported around 2.5 million pregnant mothers \(^20\).

2. **Mother Classes**: The classes consist of around 10 students (mothers with husbands or family members) and are facilitated by midwives or health workers. Each session aims to increase knowledge and change attitudes and behaviour around pregnancy, body changes and complaints during pregnancy, prenatal care, delivery, child care, post-delivery family planning, newborn care, infectious disease and birth certification.

3. **Establishment of 2,800 maternity waiting home to increase coverage of births attended by skilled health personnel**: The waiting homes were intended to provide easy and quick access for mothers who had difficulties in accessing health facilities (remote areas, areas without road access, or areas without any health personnel) and a place where mothers can stay under supervision from midwives nearby. The waiting homes may be built in the following places:
• Poskesdes, which are waiting homes built at community health centres in villages and are used by non-risk expectant mothers.

• Health clinic waiting home, which is a waiting home near a health clinic used by non-risk expectant mothers or expectant mothers with risks that the health clinic has the capacity to manage.

• Hospital waiting home, which is a waiting home near a hospital used by high-risk expectant mothers.

4. **Basic Emergency Obstetric and Neonatal Care (PONED)** at community healthcare centres (*Puskesmas*) and Comprehensive Emergency Obstetric and Neonatal Care (PONEK). The minimum requirement is four PONED *Puskesmas* per district/municipality and one PONEK hospital per district/municipality.

5. **Family Planning Programme** was also strengthened to support the achievement of MDG 4 and 5 goals. By increasing understanding and awareness of family planning and reproductive health, productive-age couples will be able to plan pregnancies well so that the health and welfare of the mother and child can also be improved. Increased understanding of reproductive health in the teen group will also increase marriage age and reduce birth rates in teens.

6. **Initiatives at family and community levels**: The government of Indonesia addressed neonatal mortality and maternal mortality by providing initiatives at family and community levels, for example by the implementation of Maternal and Child Book (KIA) and community feeding centres at *Posyandu* which may help detect and address malnutrition.

7. **Major causes of under-5 deaths**: The government also specifically addressed major causes of under-5 deaths from causes such as pneumonia by distributing antibiotics in health care facilities and ORS and zinc at the community level to address diarrhoea problems. In addition the government has also targeted exclusive breastfeeding (for at least six months) success rates, complete basic immunization, hygiene and sanitation, and increased immunization coverage.

8. **Programmes to overcome disparity of health personnel in some areas**: The government established several programmes, for example stationing midwives and internship physicians in remote and under-developed areas, and scholarships to undertake specialty training (paediatric, obstetrics & gynecology, surgery, and anesthesia) for physicians working in remote and under-developed areas.

9. **Additional food and supplements were given to high-risk pregnant mothers**: In order to overcome malnutrition in pregnant mothers.
10. **Improvement of national midwifery programme:** This is done to reinvigorate maternal care in the villages, where the largest numbers of mothers die, by offering cash incentives to encourage 72,000 traditional birth attendants to partner with midwives in the remote villages.

In rural areas, specifically in remote areas, lack of health personnel is the main problem. This is because midwives would rather be stationed in urban areas with access to electricity, recreational facilities, or proper housing. As a result, deliveries in rural areas are attended by traditional birth attendants. Cultural issues also play an important part, as some mothers would rather deliver with help from a traditional birth attendant than from trained health personnel. Many mothers are still unaware of the importance of antenatal care. Some mothers only come to health facilities for deliveries and have never had any previous antenatal care.

According to the World Bank, the following points are responsible for stagnation or slow progress in MMR reduction efforts:

- The national midwifery program created in the late 1980s that trained and placed 60,000 midwives in rural villages and achieved rapid reductions in MMR in the 1990s had somehow faded, perhaps due to apathy, greed and corruption.
- Almost a quarter of births are unassisted by skilled health personnel in remote areas.
- Inequality in births attended by skilled workers. High numbers of mothers were dying while in labour without the help of skilled health attendants.
- Forty per cent of Indonesian regional hospitals lacked obstetricians and standard policies to address the main causes of maternal mortality.
- Barriers in accessing services (difficulties in accessing health services, complex referral system, or inadequate treatment).

According to an issues brief published by Unicef Indonesia, several factors were considered to be barriers to maternal and child health which are as follows:

- The poor quality of antenatal, delivery and postnatal health care services. Across all population groups, the coverage on indicators relating to service quality (i.e. quality antenatal care) is consistently lower than that relating to quantity or access (i.e. four antenatal visits).
- The need for more obstetrician-gynaecologists and facilities offering Comprehensive Emergency Obstetric and Newborn Care (PONEK) services. The ratio of PONEK facility in Indonesia is 0.84 per 500,000 which is below the ratio recommended by UNICEF, WHO and UNFPA (1 per 500,000). The ratio for obstetrician-gynaecologists is 1 per 31,000 women of reproductive age; however they are not equally distributed.
• Barriers in claiming *Jampersal* benefits which is caused by lack of awareness about the eligibility and benefits of *Jampersal*. Other cause is insufficient reimbursement levels when transport costs and complications are included.

• The need to increase government spending on health. Total health expenditure was 2.6 per cent of GDP in 2010 and public health expenditures constitute under half of total health spending. At the district level, health sector only receives 7 per cent of the total sub-national funds and DAK for health only constitute less than 1 per cent of the total budget of the local government.

• The planning processes of DAK need to become more efficient, effective, and transparent. Parliamentary representatives at the central level play significant roles in determining funding allocation for their respective districts and therefore causing delays in DAK fund.

• Mothers are not aware of the importance of breastfeeding. Less than one in three infants under the age of 6 months were breastfed exclusively. Therefore the majority of infants are not receiving the benefits of breast milk in terms of nutrition and protection against disease.

• Poor feeding and other care practices contribute to maternal and child malnutrition. One of three children is stunted and in the poorer quintiles one of four to five children is underweight, while nationally 6 per cent of young children are severely wasted, which made them at high risk of death.

• Poor sanitation and hygiene practices which are associated to diarrhoeal diseases (one of the main causes of under-5 deaths). Diarrhoea causes 31 per cent of deaths among children aged 1 month to a year and 25 per cent of deaths among children aged 1 to 4 years of age.

• Lack of knowledge on preventing and treating common childhood diseases such as fever or diarrhoea.

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**POLICY AND DECISION MAKING FOR MNCH AND NUTRITION IN INDONESIA**

**PLANNING AND BUDGETING CYCLE**

**Musrenbang process**

*Musrenbang* is a forum to gather community suggestions at the village, district and city level according to Law No.25/2004. The Musrenbang processes determine priority of needs, which become the basis of discussion in the forum between SKPD (Regional Working Unit) members at provincial and district level. Musrenbang is usually held every year and starts in January (at the village level) and ends around
April or May (at the district level). For each level of government, the house of parliament budgeting committee makes the final decision. This is where the lobbying and negotiation process plays an important role in final decision-making, and the political decisions affect the final outcome.

According to USAID, at the community level Musrenbang is conducted to reach agreement on programme priorities of SKPD to be funded from the APBD and village allocation funds, and to select the community and government representatives who will attend sub-district Musrenbang. Musrenbang at the sub-district level is held to reach consensus and agreement on: (i) priority of programmes and activities of SKPD and (ii) representatives to be sent to Musrenbang at district level.

At the district level, Musrenbang is held to reach consensus and agreement on the draft Annual Local Government Work Plan (Rencana Kerja Pemerintah Daerah/RKPD) which consists of the following:

- Direction of regional government policy
- Direction for priority programmes, activities, and indicative budget of SKPD
- Macro economic and financial framework
- Priority of programmes and activities proposed for funding by the APBD, provincial APBD, and other sources of funds
- Recommendations for regulatory support from provincial and central government
- Budget allocation for the village allocation fund

Sector-specific Musrenbang within a specific local government sectoral department (SKPD forums) such as health and education have been launched at district and sub-district levels.
In order to optimize resources and increase efficiency and effectiveness (policy and budget driven), the steps of the Musrenbang process were revitalized in 2011. The process is now simplified into seven steps described below:

Figure 11: Musrenbang process

According to Bappenas 25, 26 Musrenbang steps are described as follows:

1. **Pre-technical meeting**: at this meeting, strategic issues are set as the basis of discussion between national and sub-national technical officers.

2. **Tri-monthly consultation**: at this stage, provincial *pagu indikatif* (budget ceiling estimation) based on RKP are discussed.

3. **Technical meeting**: the outcome of this meeting is suggestions for RKP.

4. **Provincial Musrenbang**: the outcome is UPPD.

5. **Pre-national Musrenbang**: at this meeting, RKP activities initial agreement must be reached.
6. **National Musrenbang**: at this stage, agreement between national and sub-national must be reached and draft of final RKP must be submitted.

7. **Post National Musrenbang**: a meeting between Bappenas and ministries to discuss results of Musrenbang (RKP).

A public consultation forum is held to discuss the strategic issues to be examined during the trilateral national, sub-national and pre-national Musrenbang meeting. Meanwhile, UPPD and Renja meet to discuss suggestions on the work plan between ministries. The trilateral meeting is held to come up with strategic issues as the basis of synchronizing between national and sub-national level.

**Central government health sector planning and budgeting cycle**

The planning and budgeting process for the health sector can be described in the following steps 27:

1. At the central level, an indicative budget ceiling is decided by the Ministry of Finance and Bappenas based on the Ministry of health’s proposed annual work plan.

2. MoH then develops and proposes a temporary budget which is discussed at MoH senior management meeting. Each directorate at MoH will have suggestions on the budget amount that will be used to fund their programme (including for the provinces). The senior management meeting with the Minister of Health will determine the indicative budget ceiling. For 2011, the indicative budget ceiling was Rp104 billion (US$10.8 million) (Rp 24 billion for central programmes and Rp80 billion for regional programmes/deconcentration fund). The internal process of budget allocation within the MoH is both a top-down and bottom-up process. The budget allocation process within each unit is ongoing until it is agreed at all levels, including for each province. After that the budget proposal is discussed at a meeting between senior management and the Minister of Health.

3. The temporary budget proposal is then handed to MoF who decides the budget ceiling for health sector that year.

4. The budget ceiling agreed by MoH and MoF will then be proposed and discussed in Parliament. At this stage, lobbying and political negotiations dominate before confirming the definitive budget.

A study by Marhaeni 28 in 2006 discussed fiscal decentralisation in the health sector and more specifically the budget allocation process at the MoH. It was found that the central budget allocation is based on three things: namely budget history, sub-national budget proposal, and needs calculation based on population. It was also found that the MoH did not have a budget formula for health sector allocation. Moreover, there were no definite criteria in the deconcentration fund and tugas
pembantuan funds; thus it was suspected that decisions were reached through political lobbying and negotiations, rather than being technically driven. This was more apparent in the setting up of indicative budget ceilings for hospitals. Marhaeni also found that at the time of the study, in setting up budget allocation for maternal health, MoH did not use information related to fiscal capacity, population, poor population, area, number of physicians, number of Puskesmas, and number of hospitals. There was also no weighting financial resources between regions.

However, this may be changing. According to a recent interview with the Head of Standardisation Section in the Sub-Directorate for High Risk Under-5s in the Directorate of Child Health at the MoH, the priority of Dekon (Deconcentration fund) is decided using eight indicators set according to a mapping study conducted by two universities (University of Indonesia and University of Gajah Mada). The mapping study analyzed targets achieved from indicators such as: fiscal capacities, IMR, health problems in the area, number and coverage of health personnel. As a result of the study, in 2011 MoH listed 20 provinces and 150 districts as priority and was able to propose programmes aimed at low birth weight babies or food supplement programmes. It may be concluded that MoH is increasing its use of evidence-based indicators in setting up budget allocation.

Figure 12: Central government planning and budgeting cycle for the health sector
Following decentralization, according to Law No. 32/2004 and No. 33/2004 the budget mechanism from central to sub-national government is given in Figure 13.

**Figure 13: Budget mechanism from central to sub-national government**

APBN (state budget) is an annual budget plan which is approved by the legislature each year. Budget from the central government is divided into APBN and APBD. APBN is given to MoH, central hospital/MoH’s technical executing unit, Dekon, and tugas pembantuan.

The fiscal balance between the centre and the regions fund (*Dana Perimbangan*) is an APBN fund, which is allocated to regions to fund needs relating to decentralization. It is used to prevent fiscal gaps between central government and regional government, and between regional governments. The fiscal balance between the centre and regions is addressed by way of shared revenue fund, General Allocation Fund (DAU), and Special Allocation Fund (DAK). Meanwhile, APBD is an annual budget plan that is agreed by regional government and based on regional law.
Central government health expenditure (APBN) between 2006 and 2012 is on average Rp15 billion (US$1.5 million). Most of APBN is spent on individual public health services (on average Rp8.5 billion each year). Between 2006 and 2012, APBN fluctuated around Rp12 billion and Rp18 billion, and reached its highest in 2010 (almost Rp19 billion).

Table 5: Central government health expenditure by function 2006–2012 (in billions rupiah)

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical product, appliances, and equipment</td>
<td>924.0</td>
<td>884.6</td>
<td>1,388.6</td>
<td>1,274.5</td>
<td>1,329.3</td>
<td>2,239.1</td>
<td>2,352.3</td>
</tr>
<tr>
<td>Individual public health services</td>
<td>4,839.2</td>
<td>8,070.3</td>
<td>8,780.6</td>
<td>9,765.2</td>
<td>12,086.0</td>
<td>7,670.5</td>
<td>8,058.1</td>
</tr>
<tr>
<td>Society public health services</td>
<td>4,152.4</td>
<td>3,348.1</td>
<td>1,715.7</td>
<td>2,712.1</td>
<td>3,165.6</td>
<td>1,044.8</td>
<td>1,097.6</td>
</tr>
<tr>
<td>Population and family planning</td>
<td>329.2</td>
<td>433.8</td>
<td>479.7</td>
<td>623.8</td>
<td>794.8</td>
<td>2,469.0</td>
<td>2,593.7</td>
</tr>
<tr>
<td>R&amp;D defence</td>
<td>144.9</td>
<td>197.7</td>
<td>198.5</td>
<td>134.1</td>
<td>257.6</td>
<td>327.1</td>
<td>343.6</td>
</tr>
<tr>
<td>Health</td>
<td>1,799.9</td>
<td>3,070.0</td>
<td>1,475.9</td>
<td>1,233.3</td>
<td>1,159.8</td>
<td>236.0</td>
<td>248.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>12,189.7</td>
<td>16,004.5</td>
<td>14,038.9</td>
<td>15,743.1</td>
<td>18,793.0</td>
<td>13,986.6</td>
<td>14,693.3</td>
</tr>
</tbody>
</table>

Note: Rp1=US$9,600 (current exchange rate)
According to Law No. 6/2009, 5 per cent of APBN should be allocated to the health sector (excluding personnel salaries). APBN for the health sector increased between 2005 and 2012 by 167 per cent. However, between 2005 and 2012, APBN allocated for the health sector has never been more than 3 per cent of APBN which may be caused by lack of lobbying and negotiation power at the legislature. On the other hand, one member argued that the percentage was low because MoH had only 87.2 per cent budget realisation in 2011, which was lower than in 2010 (90.9 per cent). In 2012, MoH was given a sanction from MoF in the form of a reduction of Rp3 triliun (US$310 million) for not having effective/efficient budget planning.

Of a Rp31.2 triliun (US$3.2 billion) budget ceiling in 2013, only 49.3 per cent was allocated for public services while the rest (50.2 per cent) was allocated for personnel expenditure. Furthermore, there are several public services budget allocations that are questionable, for example, 10 hospitals’ Jampersal claims of Rp1.6 trillion or Rp155 billion (US$16,000) per hospital, or hospitals’ Jamkesmas claims of Rp5.8 trillion for around 2,000 claims or Rp4.7 billion per claim (US$490).

**DAU (General Allocation Fund)**

The DAU is the major funding source for health. It is a partially tied grant from central government. The majority of the fund is spent on salaries at provincial level.

**DAK (Special Allocation Fund)**

The DAK is a tied grant for specific sectors from the central government direct to district government. DAK has been mostly used for expenditure capital (previously development expenditure). The amount of DAK is relatively small compared to DAU.

The DAK for the health sector was allocated for efforts to increase access to and the quality of health services. These activities were aimed at upgrading, rehabilitating, expanding, supplying, and developing various kinds of health service units and the procurement of medical equipment to increase basic health services.

There are several limitations on DAK, including its use being limited to facilities and equipments.

According to Ministry of Finance Law No. 201/PMK.07/2012, for 2013 the central government has allocated Rp3.1 trillion (US$319 million) of total DAK for the health sector. This should be used to improve access and quality of health services in order to reach MDG goals, and focused on reducing maternal and child deaths, undernutrition, and disease prevention by providing support to basic health services, drugs, and vaccines which include the following:

-The government distributes funds to the health sector through a number of different mechanisms.

-The major allocation is through DAU (salaries) and DAK (capital).

-Otsus is a special allocation to provinces that have special autonomy – such as Papua.
1. Basic health care: Rp1.3 trillion (US$134 million). The purpose of this fund is as follows:

   - Building *Puskesmas* at sub-districts. *Puskesmas* with Basic Emergency Obstetric and Neonatal care (PONED)*Puskesmas* at remote or under-developed areas/village health posts/installation of *Puskesmas* waste systems
   - Upgrading of *Puskesmas* with treatment facilities at remote/under-developed areas
   - Rehabilitation of *Puskesmas* or service homes for physicians/dentists/paramedics
   - Facilities to increase environmental health

2. Referral care: Rp750 miliar (US$77 million) is given to provinces and districts:

   a. Province: Rp118 miliar (US$12 million)
   b. District: Rp632 miliar (US$65 million)

   This fund is to be used as follows:

   - Facility and equipment for province/district owned hospitals (RSUD) with Comprehensive Emergency Obstetric and Neonatal care (PONEK)
   - Providing treatment rooms (3rd class) at RSUDs
   - Installation of waste systems at RSUDs
   - Equipment for blood banks
   - Facility and equipment for intensive care units and emergency care units

3. Pharmaceutical: Rp1.1 triliun (US$113 million). The fund is used to provide drugs and pharmaceutical facilities.
A study was conducted by SMERU \(^{33}\) between 2007 and 2008 in three districts and one city. The study aimed to analyze the management mechanisms of the DAK: namely, its regulation, allocation processes, and responsibility for its use. The study focused on the three largest DAK recipient sectors, which were health, education, and road infrastructure. On average DAK allocated for the health sector in the four sample areas was about 15.8 per cent (2005), 21.1 per cent (2006), and 19.4 per cent (2007). The trend observed was that the biggest percentage was given to the education sector. The study analyzed the accuracy of DAK allocations by province and whether the conditions of public service infrastructure in health were in line with DAK objectives. Findings revealed that the correlation was contrary to the DAK objectives. In allocating DAK to regions, the central government gave consideration to factors that are not directly related to the health sector needs or population needs.

The study also found that the DAK allocation process was not transparent and regional government needed to lobby central government to receive a larger
allocation. The *bupati* (district head) and heads of DAK-receiving regional offices undertook the lobbying. One area in the study sample even handed the lobbying task to a private company. In addition, it found lack of coordination and communication at all levels of government. For example, very few regional governments fulfilled their obligation to report their use of DAK quarterly.

**Otsus (Special Autonomy Fund)**

The Government of Indonesia gave special autonomy status to three provinces, namely Papua in 2001, Aceh in 2008, and Papua Barat in 2009. The special autonomy status is planned to finish in 2025. Regions with special autonomy status receive Otsus (Special Allocated Fund) in addition to other funds. The fund aims to accelerate development in the regions.

For 2013, the central government has allocated Rp13.2 triliun (US$1.3 billion) for Otsus, which is an increase of about Rp1.3 triliun (US$132 million) from last year. The allocation for Papua is Rp4.3 triliun (US$436 million). For Papua, Otsus fund was around 2 per cent of total DAU.

Baseline findings from Yapen–Papua from interviews with the Head of Bappeda and Head of the District Health Office revealed that health funding for the district fluctuated in quantity between 2005 and 2012. There were problems with timeliness (delayed central government funds: DAK, DAU, and Otsus) and a limited amount of funds from central government. Conversely, in Yapen the main source of funding for the health sector was the Otsus fund. However, the Otsus fund flow experienced delays, with it not being available until the middle of the financial year, leading to unspent funds and ineffective spending.

Table describes budget source of Yapen DHO which are DAU, DAK, Otsus, Jamkesmas, Mobile Clinic, and BOK. Mobile Clinic programme was ended in 2010 and replaced with BOK. In Yapen, the main source of budget was from DAK between 2008 and 2010. However, starting 2011 the main source of budget was Otsus (28 per cent in 2011 and increased to 34 per cent in 2012).
Table 6: Yapen DHO Budget 2008 - 2012

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAU (%)</td>
<td>31</td>
<td>10</td>
<td>16</td>
<td>23</td>
<td>31</td>
</tr>
<tr>
<td>DAK (%)</td>
<td>42</td>
<td>52</td>
<td>40</td>
<td>19</td>
<td>27</td>
</tr>
<tr>
<td>Otsus (%)</td>
<td>18</td>
<td>15</td>
<td>18</td>
<td>28</td>
<td>34</td>
</tr>
<tr>
<td>Jamkesmas (%)</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Mobile Clinic (%)</td>
<td>5</td>
<td>19</td>
<td>18</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>BOK (%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>21</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Each year around 10 per cent of total Otsus was earmarked for health (DHO and hospital). The head of DHO in Yapen stated that evidence-based planning and budgeting has helped to set proportions for health budget from Otsus in which DHO managed to received a large portion of budget to fund their programme. In 2012, it was 5.5 per cent for hospital and 4.5 per cent for DHO, but for 2013 these figures are reversed.

Despite the importance of central government funds, there are delays in receiving the funds, meaning the funds are not received until the middle of the year. The DHO uses BOK funds to finance the operational costs until other funds arrive.

Other Government Funds for the Health Sector.

Appendix 1 contains a summary of the government’s health sector funding mechanisms.

Dekon fund is part of the State budget (APBN), which is channelled through the Provincial Health Offices (PHO). Some resources are used at the provincial level, while some programme funding, for example nutrition, is transferred directly from MoH to District Health Offices (Dinkes). Part of this flow consists of transfers of goods in kind rather than cash: for example, drugs, vaccines, medical equipment and vehicles are often procured centrally and then distributed to the regions. There had been plans to re-channel Dekon spending on decentralized tasks through DAK, according to Law No. 33/2004, which states that deconcentrated spending should be
gradually reduced. Therefore the amount of DAK should have been increased and its use for operational purposes allowed. However, this did not occur. The way forward lies in fiscal decentralization, which gradually diminishes central government's spending power. However, some health professionals argue that many regional governments have displayed weak commitment to health and public health services. It is central government’s willingness to spend for these purposes that ensures a minimally adequate budget for programmes such as disease surveillance and immunization.

Trisnantoro argued that according to Law No. 33/2004 verse 108, there is a possibility to alter the budgeting mechanism from Dekon to DAK but the problem is that based on the law DAK cannot be used for operational cost. In addition, DAK is very much influenced by central government. The budgeting process according to law No 17/2007 allows the legislature to have decision-making power over the use of DAK. For example, during the first few years of DAK, the legislature had the power to decide the specifications of ambulances bought using DAK. Therefore, it may be concluded that the legislature has negotiation and lobbying power in DAK.

Hence, a preferable alternative to replace deconcentrated spending is to expand DAU rather than liberalize DAK, because DAK is centrally determined.

Tugas pembantuan is a fund from APBN given to provincial government to add to or maintain government’s assets.

Jamkesmas and Jampersal are channelled to district hospitals through payments of claims, more commonly via Dinkes or in a few cases directly to a Puskesmas bank accounts. From 2008, the payment of claims has been done by MoH.
Fiscal flow in health sector

Since the implementation of decentralization in 1999, heads of regional governments (provinces and districts) are no longer accountable to the central government but are elected and accountable to local parliaments. This means that the central government allocated responsibility for the implementation of most local service delivery, including health services, to district government.

According to Trisnantoro there were differences in regions’ fiscal capacity and the population’s ability to pay which should be considered in the budget allocation process. Budget allocation is mainly based on non-technical approaches and this causes unfairness in health services.

Furthermore, it was seen that regional government spend very little on APBD for the health sector. There was a tendency to rely heavily on APBN to fund health programmes including MNCH&N.
According to the World Bank\textsuperscript{27}, in order to improve the current planning and budgeting process, the government and parliament should consider the following:

- Limit the role of parliament in providing general inputs and guidance during the deliberation of government budget and work plan.
- Refer to the agreed Work Plan (RKP) document that shows sectoral priorities and activities.
- Line ministries should be given the authority to set priorities and design activities (fewer roles are given to MoF and Bappenas).

Similarly,\textsuperscript{43} Rini discovered most of APBN (the State budget) was spent on routine expenditure and not on building infrastructure, despite the fact that infrastructure could help economic development. Expenditure capital was used for infrastructure building such as roads, bridges, irrigation, schools and hospitals. Despite its importance, the number of districts that allocate sufficient budget for expenditure capital continues to decline. In 2007, 40 per cent of districts had allocated more than 50 per cent of APBN for expenditure capital. In 2009 only 17 districts and in 2012 only 5 districts allocated more than 50 per cent of APBN for expenditure capital.

FINANCING FOR RMNCH AND NUTRITION IN INDONESIA

Regional government revenue

A recent study by Seknas Fitra and the Asia Foundation was conducted to examine APBD in 20 districts/cities in Indonesia, more specifically in the education, health and public work sectors. The study suggested that between 2008 and 2011, most of districts/cities income was from Dana Perimbangan (fiscal balance between the centre and the regions fund) in the form of shared revenue fund, DAU, and DAK (77 to 81 per cent). Meanwhile, other source revenue made up of 8 to 18 per cent between 2008 and 2011 and own source revenue made up 5 to 7 per cent of districts/cities revenue. Therefore, it may be concluded that despite decentralization, regional government relies heavily on income from central government.
According to the World Bank report, the health sector in Indonesia was financed from three main sources as follows: private spending (65 per cent), foreign aid (less than 2 per cent), and the rest from general government revenues. Seventy-five per cent of private spending was out-of-pocket expenditure.

Table 7 presents the revenue for provinces and districts/cities in 2005 extracted from the World Bank report. In the provinces the main sources of income were own-source revenue (49.2 per cent), shared taxes (16.3 per cent), and DAU (16.1 per cent). On the other hand, in the districts/cities, the main sources of income were DAU (55.9 per cent), shared natural resource revenue (12.2 per cent) and shared taxes (10.6 per cent).

The majority of budget (55.9 per cent) for health at the district level was funded by DAU (which was mainly used for routine expenditure such as salaries) while DAK only made up 3.2 per cent of total district revenue.
Table 7: Regional government revenue 2005

<table>
<thead>
<tr>
<th>Province</th>
<th>Districts/cities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amount (Rp bn)</td>
</tr>
<tr>
<td>Own-source revenue (PAD)</td>
<td>28,014</td>
</tr>
<tr>
<td>Shared taxes</td>
<td>9,312</td>
</tr>
<tr>
<td>Shared natural resource revenue (SDA)</td>
<td>6,190</td>
</tr>
<tr>
<td>DAU</td>
<td>9,180</td>
</tr>
<tr>
<td>DAK</td>
<td>16</td>
</tr>
<tr>
<td>Other revenue</td>
<td>4,260</td>
</tr>
<tr>
<td>Total revenue</td>
<td>56,973</td>
</tr>
</tbody>
</table>

Source of public funds at the district level

Tanawami collected information on public expenditure on health services in 15 districts in Java, Indonesia, in 2006. Findings revealed sources of public funds for DHOs, health centres and district hospitals. The main funder was district government for DHOs (47 per cent) and district hospitals (61 per cent). The main funder for health centres was central government (67 per cent). Overall, central government funds accounted for more than half of all public expenditure on health in the districts (52 per cent).
Table 8: Source of public funds (%) for District Health Office, Health Centres, and District Hospitals across 15 districts in West and Java in 2006

<table>
<thead>
<tr>
<th>Source</th>
<th>District Health Office (%)</th>
<th>Health Centres (%)</th>
<th>District Hospitals (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Government</td>
<td>47</td>
<td>24</td>
<td>61</td>
<td>42</td>
</tr>
<tr>
<td>Provincial Government</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Central Government</td>
<td>42</td>
<td>67</td>
<td>38</td>
<td>52</td>
</tr>
<tr>
<td>Other (loans/grants)</td>
<td>10</td>
<td>6</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

The study also discovered that at least 40 per cent of district level public expenditure was for personnel (half for permanent civil servants) and those districts may have discretion over less than one third of district public expenditure on health. Moreover, district hospitals have more discretion than DHO and health centres about their spending.45

As stated earlier in this section, since decentralization, regional government is no longer accountable to central government but is elected by and accountable to local parliaments.27 In addition, the share of DAU, SDA, and PAD are all determined by the regional government but DAK is centrally determined.

A study into the equity of intergovernmental fiscal transfers found that poor districts have been among the main beneficiaries of funding since decentralization and that the main issue was to ensure that resources are spent more efficiently rather than more equally distributed.46

Public health expenditure by level of government

Over a five-year period (2004 to 2008), most health expenditure was at sub-national level, specifically at the district level (41 per cent to 52 per cent). Spending at the provincial level was around 14 per cent to 18 per cent. In 2006 an increased proportion of public health expenditure was seen at the central level and this continued until 2008 such that it now rivals district expenditure. This may have been because of increases in social spending due to the Health Insurance for the Poor
programme (*Jamkesmas*), which is classified as central level expenditure. Although most of public health expenditure was spent at the district level, district health spending per capita was not related to critical health outcomes such as immunization coverage. Moreover, after decentralization, inefficiencies in the health sector's fiscal flow and multi-tiered development planning was apparent.  

**Table 9: Proportion of public health expenditure by level of government, 2004 - 2008**

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rp bn</td>
<td>%</td>
<td>Rp bn</td>
<td>%</td>
<td>Rp bn</td>
</tr>
<tr>
<td>Central</td>
<td>5.6</td>
<td>33</td>
<td>5.8</td>
<td>31</td>
<td>12.2</td>
</tr>
<tr>
<td>Province</td>
<td>3.0</td>
<td>18</td>
<td>3.3</td>
<td>17</td>
<td>5.1</td>
</tr>
<tr>
<td>District</td>
<td>8.1</td>
<td>49</td>
<td>10</td>
<td>52</td>
<td>13.9</td>
</tr>
<tr>
<td>Total</td>
<td>16.7</td>
<td>100</td>
<td>19.1</td>
<td>100</td>
<td>31.2</td>
</tr>
</tbody>
</table>

**District health expenditure**

According to Law No. 36/2009, 10 per cent of APBD should be allocated for the health sector. According to, there were eleven districts/cities that have not fulfilled the requirement by law during 2008-2011. Meanwhile there were three districts/cities (Luwu Utara, Kota Singkawang, and Jember) which have consistently allocated more than 10 per cent of APBD for health sector.
Figure 17: Proportion of APBD for health expenditure 2008–2011(%)

Note:
Rata-rata=average
Minimal=minimum
Maksimal=maximum

Health expenditure and public health development index

The study by Seknas Fitra and the Asia Foundation examined APBD and public health development index. Despite having low public health development index (lower than 0.5), four districts/cities (Probolinggo, Luwu, Sekadau, and Bengkayang) had low health expenditure per capita (<Rp200 thousand/US$20.6). This represented low commitment of regional government to the health sector. On the other hand, four districts/cities with low public health development index (Simeulue, Aceh Singkil, Melawi, and Aceh Tenggara) had allocated a relatively high health expenditure per capita (≥Rp250 thousand/US$25.8) which was higher than average health expenditure per capita (Rp200 thousand/US$20.6).
According to a study by Seknas Fitra, on average 4.9 per cent of health expenditure is spent on MNCH programs among 20 districts/cities. Moreover, about half of the study sample allocated less than 2 per cent of health expenditure to MNCH programmes. On the other hand, four districts/cities (Aceh Singkil, Sekadau, Bengkayang, and Barru) had allocated more than 10 per cent for MNCH programmes and one district even allocated 24 per cent for MNCH programmes.

The minimum MNCH budget per capita is Rp74 thousand (US$7.6) according to Bappenas. This study found that on average twenty districts/cities allocated Rp9 thousand (US$0.9). Furthermore, eleven districts/cities allocated less than 10 per cent of the minimum budget per capita as seen in the graph below.
In summary, the sub national funding picture has the following complexities. Different parts of government dominate the funding picture at different levels, and there are different funders for different institutions within a district. The province’s main revenue is from its own sources, whereas at the district revenue is largely from central government. District health Offices receive district and central government funding in equal share, while health centres are largely centrally funded and district hospitals are largely district government funded. As a proportion of public expenditure, central and district government are the main funders, noting that the districts funds are predominantly centrally sourced.

Per capita funding levels vary considerably, are not needs based, and show little relationship with health development index. Minimum expenditure level on MNCH is often not met.
Evidence Based Planning (EBP) activities were initially piloted at four sites, namely Merauke District (Papua), Pontianak City (West Kalimantan), Sikka District (East Nusa Tenggara), and Tasikmalaya City (West Java) in 2011. UNICEF continues to focus its work in Papua because of its special autonomy status (Otsu’s fund), the goal to accelerate development in Papua, and the fact that planning tools were relatively new in Papua.

The EBP activities in Papua have the following strengths:

- Engaged and coordinated with all levels and stakeholders
- Good buy-in and commitment from various stakeholders in the district and province
- Provided support and guidance

EBP activities so far have made significant progress such as conducting bottleneck workshops and advocacy activities, monitoring at district level, dissemination of results at the provincial level, formalization of the provincial team through a Governor’s Letter and integration into the Provincial Health Strategic Plan, and collaboration with other initiatives from development partners.

EBP activities have faced challenges in Papua such as:

- The planning activities currently only influence the process and outcome activities and not budget allocation
- Difficulties in negotiating and influencing the complex planning and budgeting structure
- Inadequate local capacity, including frequent staff changes, leading to loss of institutional memory, and subsequently weak knowledge transfer
- The importance of assessing how EBP activities fit into broader planning for the health sector (not just Maternal and Child Health) including GAVI, Global Fund HSS, and CHAI HSS.

UNICEF also continues to work at the central level, more specifically with MoH and Bappenas on evaluation of current planning mechanism/ District Team Problem Solving (DTPS), accelerating the issuance of DAK technical guidelines, and increasing the involvement of Ministry of Finance and Ministry of Home Affairs.

The evaluation of DTPS was requested by the Directorate of Maternal Health (MoH) before they would consider supporting EBP; this is because they would prefer EBP

2 ‘Evidence Based Planning’ has replaced ‘Investment Case’ as the main term used in Indonesia.
as a supplement to the current national planning tool (DTPS). Therefore, there is a possibility of developing and testing “DTPS Plus” (a combination of DTPS and EBP, with subsequent improvements using successful components of the EBP approach) in a number of provinces ⁴⁹.

**PROGRAMME LOGIC FOR THE INVESTMENT CASE WORK IN INDONESIA**

This programme logic is a roadmap that sets out how the acceleration of the implementation of the IC for MNCH project will achieve its desired outcomes. The overall desired outcome is to improve country MDG 4 and MDG 5 indicators.

Implementation of IC activities is expected to effectively reduce bottlenecks that impact upon disparities in MNCH, increase level and equity of coverage, and thereby decrease child and maternal mortality and malnutrition. While the logic of the IC approach involves these broad steps, in practice they are not necessarily carried out in a linear fashion, with steps feeding into each other and occurring in parallel.

See accompanying presentation on Programme Logic for UNICEF’s work in Indonesia.
### APPENDIX 1:

**Summary of intergovernmental fiscal flows for the health sector**

<table>
<thead>
<tr>
<th>Source</th>
<th>Flow</th>
<th>Description</th>
<th>Use</th>
<th>Targeting</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Own Source Revenue (PAD)</td>
<td>Local Revenue – included in Regional Government Budget (APBD)</td>
<td>District revenue derived from local taxes, natural resources and user charges at district hospital and health centres</td>
<td>At discretion of district/province</td>
<td>Depends on local revenue-raising capacity (health tariffs constitute a significant share)</td>
<td>Could be increased by allowing for different taxes (substantial at the provincial level)</td>
</tr>
<tr>
<td>Shared revenues</td>
<td>Ministry of Finance (MoF) through the National Budget (APBN) to district – included in APBD</td>
<td>Taxes levied by the central government (gas, oil, personal income tax)</td>
<td>Goes into APBN – up to district/province discretion</td>
<td>Address vertical imbalances</td>
<td>Substantial in some provinces</td>
</tr>
<tr>
<td>General Allocation Fund (DAU)</td>
<td>MoF through the APBN to district – included in APBD</td>
<td>Partially tied grant from central government direct to district government</td>
<td>Salaries and remainder used at discretion of province/district</td>
<td>Address horizontal imbalances</td>
<td>Majority of budget for health comes from DAU</td>
</tr>
<tr>
<td>Special Allocation Fund (DAK)</td>
<td>MoF through APBN – included in</td>
<td>Tied grant for specific sectors from the central</td>
<td>Construction or rehabilitation of primary</td>
<td>Reflects national priorities, in health,</td>
<td>Small (US$0.30 per capita/year)</td>
</tr>
<tr>
<td>Source</td>
<td>Flow</td>
<td>Description</td>
<td>Use</td>
<td>Targeting</td>
<td>Significance</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td>-------------</td>
<td>-----</td>
<td>-----------</td>
<td>--------------</td>
</tr>
<tr>
<td>APBD</td>
<td></td>
<td>government direct to district government</td>
<td>care facilities and equipment</td>
<td>deferred investment in primary care facilities</td>
<td>– health policy makers propose increase and to allow for ‘operational’ use as well</td>
</tr>
<tr>
<td>Deconcentration Funds (Dekon)</td>
<td>MoF to Ministry of Health (MoH) via APBN direct to district Health Office (DHO)</td>
<td>Tied grant from MoH for centrally-specified sectoral activities</td>
<td>Non-physical expenditures: planning, facilitation, training, monitoring.</td>
<td>Address national priorities</td>
<td>Substantial – policymakers propose a decrease (present policy goes against decentralization principles)</td>
</tr>
<tr>
<td>Tugas Pembantuan</td>
<td>MoF direct to district hospital (with approval of MoH) – included in APBN</td>
<td>Tied to physical assets, infrastructures, and equipment</td>
<td>Physical assets/infrastructure</td>
<td>Address national priorities</td>
<td>Very small</td>
</tr>
<tr>
<td>Health Insurance for the Poor (Jamkesmas)</td>
<td>MoH direct to hospital or health centres – included in APBN</td>
<td>Tied fund</td>
<td>To cover costs for providing free healthcare to the poor</td>
<td>Variety of targeting problems related to beneficiarie s</td>
<td>Non-contributory insurance scheme facing rapidly rising costs</td>
</tr>
<tr>
<td>Labour and Delivery Funds</td>
<td>MoH direct to hospital or Public Health</td>
<td>Tied fund</td>
<td>To cover free labour costs</td>
<td>New programme (2010)/part of</td>
<td>Non-contributory insurance scheme</td>
</tr>
<tr>
<td>Source</td>
<td>Flow</td>
<td>Description</td>
<td>Use</td>
<td>Targeting</td>
<td>Significance</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>(Jampersal)</td>
<td>Centres (Puskesmas) – included in APBN</td>
<td></td>
<td>Jamkesmas</td>
<td></td>
<td>facing rapidly rising costs</td>
</tr>
<tr>
<td>Health Operation Fund (BOK)</td>
<td>MoH to district to fulfil operational service standard – included in APBN</td>
<td>Fund from MoH</td>
<td>Operational costs of health centres (Puskesmas), community health centres (Posyandu), additional food for children and pregnant mothers at discretion of district/province. Must not be used for salaries, bills, preventative/curative, or medicine supply</td>
<td>To improve minimum service standards and address MDG goals. The use of funds must be approved during Puskesmas Workshop (monthly/quarterly)</td>
<td>Small</td>
</tr>
</tbody>
</table>


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