Inisiatif "Institute for Innovation, Participatory Development & Governance"

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POLICY AND BUDGET MONITORING

OF INDONESIA GOVERNMENT'S COMMITMENTS

On *Maternal Health*

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The Government of Indonesia had pledged commitments to contribute in achieving the target as the target of reducing maternal mortality rate is also a country's top development priorities. It is important that these commitments are monitored and tracked to ensure that the government has fulfilled them. The maternal health policy and budget is proposed as part of the civil society participation in demanding government's accountability in delivering its commitments.

FINAL REPORT

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Foreword

Mother's Health is a global development issues. In several countries, especially developing countries and underdeveloped countries, birthing process is still risky for mother's health.. This situation has encouraged the international community commitment to address the problem of maternal health. This commitment mannifested by adopting maternal healthas one of MDGs target.

In Indonesia, maternal mortality rate is one of the highest in Southeast Asia region. According to UNESCAP data, maternal mortality rate in Indonesia by 220/100.000 live births is fourth highest among countries in South East Asia. This number is higher than the average number of ASEAN member countries and other South East Asia countries

The Government of Indonesia has put maternal health as one of priority on national development agenda as mentioned in the National Medium-Term Development Plan 2010-2014. In the document, the government has determined a target that the maternal mortality rate should be reduced to 102/100.000 live births by 2015.

However, the government target on maternal mortality seems difficult to achived if seen from the current achievement. As mentioned in Indonesian Demography and Health Survey (IDHS) in 2007, maternal mortality in Indonesia has been decreased gradually from 390/100.000 live births in 1991 to 228/100.000 in 2007. This number is still high. Realizing this, on UN Summit 2010 the Government of Indonesia rise a commitment to accelerate the achievement on maternal mortality target. One of the commitment is that the goverment will allocate USD 556 million in 2011 for professional health workers recruitment and capacity building.

Based on description above, Perkumpulan INISIATIF as a member of the International Budget Partnership (IBP) - Indonesia Core Team sees the need to track and monitor the Indonesia Government's commitments in accelerating the achievement of maternal mortality rate to fulfill the MDGs target by 2015. With support from Partnership Initiatives-IBP, this initiave followed by

a research activity which the result is written into a book entitled “Policy and Budget Monitoring of Indonesia Government’s Commitments on Maternal Health”. The study conducted in West Java Province with Indramayu district dan Bogor district who are two highest maternal mortality rate in Java province as a sample of the study.

This book try to track and ensure the Indonesia government’s commitments to accelerate the achievement of maternal mortality rate target as mentioned in UN Summit 2010. In general, this book consists of five sections; Section one containts about background, objectives and scope of the study. Section two contains about monitoring framework. Section three contains about the description of maternal health status and some causes of maternal mortality in Indonesia. Section four contains about analysis on government’s policy and budget on maternal health. Section five contains about some conclusions and recommendations of the study.

Many collagues and friends have contributed to the writing of this book. We are grateful to all members of IBP-*Indonesia Core Team, CSOs* network at local level and all researchers for good team work during the implementation of the study. Also to all resource persons, respondents, local governments in study areas and other collagues who gave many advices and valuable inputs..

Our special gratitude for Debbie Budlender who always gave us valuable inputs and assistances since the preparation of the study untill the completion of this book. Also, we are gratefull to Ravi Duggal, Warrent Krafchik, Helena Hofbauer and Manuela Garza from IBP for support and cooperation. In addition, we want to thank to the representatives from the Directorate’s of Health and Nutrition and Head of National Secretary of the MDGs from the National Development Planning Board (Bappenas) for their contribution and cooperation.

Our big gratitude for Adenantera Dwicaksono as a main researcher and a writter of this book for time, thought and hard work during implementation of the study and book writting. Our gratitude also for Panji Prasetyo for his hard work in doing data analysis. In addition, our gratitude to Fauzi Ridwan, Rahmat and Aang Kusmawan for their contribution in doing data gathering from local governments.

Lastly, we hope that this book could be a basic argument for some actors who work on health advocacy particularly on maternal health issues. In additon, we hope that this book could give real contributions to enhance the government of Indonesia in achieving their commiments and targets on maternal health.

March 2013

Donny Setiawan
Executive Director
Perkumpulan INISIATIF

CHAPTER 1

INTRODUCTION

THE GOVERNMENT OF INDONESIA HAD PLEDGED COMMITMENTS TO CONTRIBUTE IN ACHIEVING THE TARGET AS THE TARGET OF REDUCING MATERNAL MORTALITY RATE IS ALSO A COUNTRY'S TOP DEVELOPMENT PRIORITIES.

Chapter 1.
INTRODUCTION

1.1. Background

Maternal health is a global development issues. In many parts of the world, particularly in developing and the least developed countries, mothers are still at high risk when delivering births. This situation called for global actions to address maternal health issues. Among the MDGs, the MDG5 is one of the targets that require special attentions from the global communities. Therefore, In the UN Summit on MDG in 2010, the UN Secretary General called international actors to take actions to progressively achive MDG targets on maternal and children health. The global communities has agreed that it is a mother's right to receive quality maternal health care service. In this Summit, state parties, donor agencies, philantrophies of the world to pledge commitments in order to progressively achive MDG targets on maternal and children health, including Indonesia.

The Government of Indonesia had pledged commitments to contribute in achieving the target as the target of reducing maternal mortality rate is also a country's top development priorities. According to the IDHS 2007 reports, the maternal mortality rate in Indonesia has been decreasing from 390 deaths per 100,000 live births in 1991 to 228 deaths per 100.000 live births in 2007. Based on this trend, the government has set the target to continue to reduce the maternal mortality rate to only 102 deaths per 100,000 live births by 2015. To achieve this target, the government aims to ensure that all deliveries will be performed by skilled birth attendants by 2015. There will be approximately 1.5 million deliveries by poor women that will be fully funded by the government. The government also committed to increase funding support by USD 556 million in 2011 to support professional health personnel.

It is important that these commitments are monitored and tracked to ensure that the government has fulfilled them. The maternal health policy and budget is proposed as part of the civil society participation in demanding government's accountability in delivering its commitments.

1.2. Monitoring Objectives

The main objective of monitoring/tracking actions is to monitor Indonesia government's policy and budget at the national, provincial, and district level in order to assess the extent of government actions in fulfilling its commitment to global community in maternal health.

The specific objectives of the action are:

1. To assess the extent of the Indonesian government in mainstreaming its commitment to the MNCH Global Strategy into government's development policy framework and plans at the national level.
2. To assess whether the government has allocated adequate financial resources to fund government actions in fulfilling the commitments at national level.
3. To assess the effectiveness of the government budget implementation to deliver the programs/projects to the targeted beneficiaries.

1.3. Scope of Monitoring

The scopes of monitoring actions can be elaborated as follow:

1. The action focuses on, not only the budget allocation and implementation, but also on the government policies and development plans related to the maternal health. In order to ensure that the government commitments to the Global Strategy on Maternal Health are materialized into concrete actions, these commitments should be adopted into government policies and development plans. Based on these policies and plans, the government is able to propose budget for specific purposes to the house of representative for approval. The focus on maternal health is based on the commitments of the Global Strategy pledged by GOI, which only cover maternal health indicators.
2. The actions will be conducted at national level.
3. The level of this monitoring/tracking is at the national level.

Schematic presentation of the scope of monitoring is presented in table 1.

Table 1.
Scope of Monitoring of Government's Commitments in Maternal Health

Level of Gov't	Scope of monitoring
Central Government	**Policy and planning documents:** To track whether the commitment has been adopted in the planning and other policy documents. To track whether there have been sufficient efforts in transforming the country commitment to regional government. **Budget documents:** To track the commited health funds in the central government budget allocated through concurrent function - BOK; JAMKESMAS; JAMPERSAL. Specific Allocation Fund (DAK) To track ministerial health funds allocated through: • De-concentrated Tasks • Co-Administrated Tasks • Ministerial programs/projects

Source : Team Analysis, 2013.

THE POLICY AND BUDGET MONITORING FRAMEWORK IS ELABORATED BY A SET OF THE CRITERIA, INDICATOR AND PARAMETERS TO EXPLAIN THE PROCESS OF GOVERNMENT POLICY AND BUDGET ALLOCATION COMMITMENT TO ADDRESS MATERNAL HEALTH.

CHAPTER 2

MONITORING FRAMEWORK

THE BUDGET ANALYSIS WILL LOOK AT THE GENERAL MATERNAL HEALTH COMMITMENTS, PARTICULARLY RELATED TO THE EFFORTS TO REDUCE MATERNAL MORTALITY, AND THOSE THAT ARE RELATED TO MATERNAL HEALTH OUTPUTS COMMITMENTS.

Chapter 2.
MONITORING FRAMEWORK

Policy and Budget Monitoring to assess government actions to fulfill its commitments of maternal health focuses on the national level. Policy and Budget analysis for national government policy and budget will look at two aspects. The budget analysis will look at the general maternal health commitments, particularly related to the efforts to reduce maternal mortality, and those that are related to maternal health outputs commitments. These two aspects of analysis are linked to the assessment of Indonesia Government's Global Strategy Commitments pledged in the 2010 MDG Summit which comprises delivering three outputs[1] and achieving one outcome[2]. This report will evaluate policies that have been implemented in Indonesia to support efforts related to maternal health policy. The following is a framework used to conduct policy analysis and budget analysis.

2.1. Policy and Budget Monitoring Framework

2.1.1. Monitoring Approach

The assessment of government commitments in maternal health is conducted through monitoring the ongoing policy and budget allocation for maternal health. This is based on the thinking that the extent to which government is committed to fulfill its commitments is best assessed from the policy documents and to what extent these policies are materialized into budget decisions. Therefore, the monitoring exercise of the process of the Indonesian government's commitment to improve maternal health services will be based on analysis of policy and regulatory framework and budget allocation in maternal health.

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1 Indonesia government's output commitments are:
- to ensure all deliveries will be performed by skilled birth attendants by 2015;
- to ensure approximately 1.5 million deliveries by poor women will be fully funded by the government; and;
- to increase funding support by USD 556 million in 2011 to support professional health personel.

2 Indonesia government's outcome commitment is to reduce the maternal mortality ratio (MMR) from 228 to 102 in 2015.

Although the title of this exercise is monitoring, in essence, it is an evaluation exercise. Evaluation in this sense can be defined as the structured interpretation and giving meaning to predicted or actual actions and impacts based on specified value system. The value system in evaluation exercise can be reflected by a set of chosen criteria that are operationalized by indicators and parameter to evaluate. The approach used in this exercise is pseudo-evaluation, an approach that uses descriptive methods to produce reliable and valid information about policy outcomes, without attempting to question the worth or value of these outcomes to persons, groups, or society as a whole (Dunn, 2008). It is contrasted to formal-evaluation approach that seeks to examine policy outcomes on the basis of objectives that had been formally announced by policy makers or program administrators (Dunn, 2008).

The policy and Budget Monitoring Framework is elaborated by a set of the criteria, indicator and parameters to explain the process of government policy and budget allocation commitment to address maternal health. The parameters for the given indicator is specified in qualitative value that reflects the degree of commitment fulfillments. Each specified parameter value is assigned with ordinal score that reflects the ranking/order of value. The total score for each category of evaluation (policy and budget) will be compared to value range categories which are derived from possible maximum value from each category.

Box 1.
State Obligations Toward Realization of Rights

The Convention on the Elimination of All Forms of Discrimination Against Women requires States parties to:

"ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation" (article 12.2).

The International Covenant on Economic, Social and Cultural Rights requires States parties to take steps to provide for:

"the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child."

The UN Committee on Economic, Social and Cultural Rights, the body responsible for monitoring this treaty, has stated that this treaty obligation must be:

"understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information" (General Comment 14, para.14)

2.1.2. Policy and Budget Monitoring Criteria

In the human rights perspective, the Government of Indonesia's commitments to the global community can be seen as part of its efforts to fulfill its obligations to realize the right to health, particularly maternal health. The problems of maternal health, particularly those related to maternal mortality and morbidity, have been widely acknowledged by the global community as human rights issue. It is connected to a number of human rights, particularly the right to the highest attainable standard of health. The global community has committed that this right should be protected. The protection of this right is provided by international human rights treaties including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

Government budget plays critical roles in realizing the right to maternal health as well as fulfilling the commitments. It is the most important economic policy instrument any government produces. Through budget, government is able to generate revenue from tax and other sources to finance any government programs and activities. Although it does not always require money in fulfilling government's obligation to realize human rights, the availability of adequate financial resource often determines how the governments properly meet their rights responsibilities.

Budget reflects a government's true social and economic policy priorities, often supporting, but sometimes contrasting with, the goals, commitments, slogans, and policies articulated by political leaders. Thus, the government commitments on maternal health can be accessed through in-depth analysis of government budget. In order to assess the extent of Indonesia government's actions to fulfill its commitment in maternal health as pledged in the UN MDGs Summit 2010, the principles of human right analysis can be applied as a framework to analyze the budget.

In line with article 2 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), it is an explicit duty of the State to take deliberate steps toward the realization of ESC rights, which means that the State must not regress from levels of fulfillment previously achieved. Another important governmental obligation is "use of maximum available resources": The government has to demonstrate that it is using the maximum of available resources in order to fulfill the right to health. Applying the principle of government as the duty-bearer that holds the obligation to respect, protect,

and to provide toward the realization of maternal health rights, the budget analysis for maternal health should be aimed at assessing government action to 1) take deliberate actions toward progressive achievement of the maternal health rights; and 2) make use of maximum available resources. The government budget allocation for maternal health sector, particularly to realizing the government commitment for MDG5 in the UN Summit 2010, should indicate the aforementioned actions.

Budget analysis to assess government actions to fulfill its commitments of maternal health focuses on the national level. Budget analysis for national government budget will look at two aspects. The budget analysis will look at the general maternal health commitments, particularly related to the efforts to reduce maternal mortality, and those that are related to maternal health outputs commitments. These two aspects of analysis are linked to the assessment of Indonesia Government's Global Strategy Commitments pledged in the 2010 MDG Summit which comprises delivering three outputs[3] and achieving one outcome[4]. This report will evaluate policies that have been implemented in Indonesia to support efforts related to maternal health policy. The following is a framework used to conduct policy analysis and budget analysis.

2.2. Policy Monitoring Framework

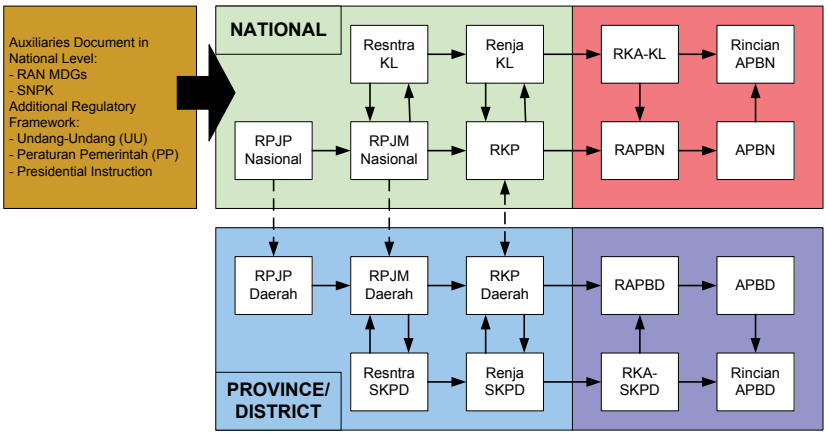
Commitment of the government can be found from the direction contained in national development planning system document. National development planning system document is the main reference for other planning documents. There are three frameworks that explain how the government's commitment specified in strategic document i.e. mandatory document, auxiliary documents and other related regulatory framework. The mandatory document is divided into two levels, the national level and province/municipal level and it is hierarchical and refers to each other. The auxiliary documents are documents to accelerate the achievement of target and the affirmative regulatory framework is a document to strengthen and explain target more detail. All documents are mutually reinforcing and complementary. It is also expected that the existing policy and regulatory frameworks provide minimum

3 Indonesia government's output commitments are:
to ensure all deliveries will be performed by skilled birth attendants by 2015;
to ensure approximately 1.5 million deliveries by poor women will be fully funded by the government; and
to increase funding support by USD 556 million in 2011 to support professional health personel.

4 Indonesia government's outcome commitment is to reduce the maternal mortality ratio (MMR) from 228 to 102 in 2015

requirement to ensure the availability of resources for maternal health. The planning document is also used for government to allocate budget to address maternal health issue. The framework of national development planning system is described in the chart below.

Figure 1.
Indonesia Development Planning System



Catatan :

- RAN MDGs (*Rencana Aksi Nasional – MDGs*) : National Action Plan on MDGs
- SNPK (*Strategi Nasional Penanggulangan Kemiskinan*) : National Strategy on Poverty Alleviation
- UU (*Undang-Undang*) : Law
- PP (*Peraturan Pemerintah)* : Government Regulation INPRES *(Instruksi Presiden*) : Presidential Instruction
- RPJPN/D (*Rencana Pembangunan Jangka Panjang Nasional/Daerah*) : National/ Regional Long Term Development Plan
- RPJMN/D (*Rencana Pembangunan Jangka Menengah Nasional/Daerah*) : National/ Regional Medium Term Development Plan
- RKP (*Rencana Kerja Pemerintah*) : National Government Work Plan
- RKPD (*Rencana Kerja Pembangunan Daerah*) : Regional Development Work Plan
- Renstra-KL (*Rencana Strategis Kementerian dan Lembaga*) : Ministerial Strategic Plan
- Renstra-SKPD (*Rencana Strategis Satuan Kerja Perangkat Daerah*) : Regional Government Agency Strategic Plan
- Renja-KL (*Rencana Kerja Kementerian dan Lembaga*) : Ministerial Work Plan
- Renja-SKPD (*Rencana Kerja Satuan Kerja Perangkat Daerah*) : Regional Government Agency Work Plan
- RKA-KL (*Rencana Kerja dan Anggaran Kementerian danLembaga*) : Ministerial Work Plan Budget
- RKA-SKPD (*Rencana Kerja dan Anggaran Satuan Kerja Perangkat Daerah*) : Regional Government Agency Work Plan Budget
- RAPBN/D (*Rancangan Anggaran Pendapatan dan Belanja Negara/Daerah*) : National/Regional Revenue and Expenditure Budget Draft
- APBN/D (*Anggaran Pendapatan dan Belanja Negara/Daerah*) : National/Regional Revenue and Expenditure Budget
- *Rincian APBN/D* : Detailed National/Regional Revenue and Expenditure Budget

Assessment of policy to address maternal health issues uses is based on this planning system. The policy analysis framework is composed from all the types of strategic planning document. The policy analysis framework is described in the table below.

Table 2.
Criteria, Indicators, and Parameter for Maternal Health Policy Analysis

Criteria	Indicator	Rationale	Parameter	Score
1) Progressive achievement of the right to health	The government's commitment targets are explicitly stated in policy documents *(mandatory document)*	A target in each of the policy and planning document reflects the priority and direction of the government in improving maternal health	The extent of national government actions toward progressive achievement of the right to health can be assessed as:	
			Achieved if the targets are related to maternal health commitments are explicitly stated in EVERY planning documents (RPJP, RPJMN, RKP or RKA / RKL) AND the targets are quantifiable and indicates increasing trend from year to year over the planning period toward meeting the final targets.	5
			On-track if the targets related to maternal health commitments is explicitly stated in ANY of the available planning documents (RPJP, RPJM, RKP and RKA / RKL) AND the targets are sufficiently indicated	3
			Off-track if the targets related to maternal health commitments are not explicitly states in ANY planning documents.	1

Criteria	Indicator	Rationale	Parameter	Score
	The availability of government auxiliary document to support the achievement of maternal health commitment targets	The auxiliary planning documents may act as technical guidance, support, arguments that can be used to accelerate the achievement of targets in formal planning process	***Achieved*** if the government has produced comprehensive auxiliary documents that contains explicit and concrete strategies to accelerate the achievement of ALL targets related to maternal health commitments	5
			On-track if the government has produced necessary auxiliary documents that contains strategies to accelerate the achievement of SOME of the targets related to maternal health commitments	3
			Off-track if the government has not produced ANY auxiliary documents that contains strategies to accelerate the achievement of maternal health commitments	1
2) Full use of maximum available resources	The availability of regulatory framework that provides minimum requirements that needs to be fulfilled by the government in order to achieve commitment targets.	The legal provision of minimum requirements may ensure the availability of adequate resources for achieving maternal health commitment targets	The extent of national government actions to fully use maximum available resources for realizing the right to health can be assessed as:	
			Achieved if there are ANY regulations that explicitly states the minimum requirement that should be met by government agencies in order to achieve maternal health commitment targets. The minimum requirement should also accompanied by sanctions if the government agencies fail to meet the requirement.	5
			On-track if there are ANY regulations that explicitly states the minimum requirement that should be met by government agencies in order to achieve maternal health commitment targets	3
			Off-track if there are no regulation and informal direction that state the minimum requirement to support the achievement of maternal health commitments.	1

Source : Team Analysis, 2013.

2.3. Budget Analysis Framework

Budget analysis framework is used to assess the government budget allocation to fullfill commitments of maternal health. The budget analysis will look at the general maternal health commitment, particularly related to the efforts to reduce maternal mortality and those that are related to maternal health outputs commitments. There are two analysis frameworks of budget analysis i.e. general health sector budget analysis and maternal health program budget analysis.

2.1.3. General Health Budget Analysis

The criteria, indicator, rationale and parameter to assess the extent to which the national government is taking serious efforts in term of general health budget toward fulfilling maternal health commitments are summarized in the following table.

Table 3.
Criteria, Indicators, Parameters for General Health Budget Analysis

Criteria	Indicator	Rationale	Parameter	Score
Progressive achievement of the right to health	Inflation-adjusted spending trend of health sector from 2010 to 2012	The inflation adjusted spending provide more accurate indicator for spending value over time	*The extent of national government actions toward progressive achievement of the right to health can be assessed as:*	
			Achieved if the inflation-adjusted spending trend of health sector indicates ***increasing trend from year to year*** over time	5
			On-track if the **overall** inflation-adjusted spending trend of health sector **shows increasing trend** over time	3
			Off-track if the **overall** inflation-adjusted spending trend of health sector shows **decreasing trend** over time	1

Criteria	Indicator	Rationale	Parameter	Score
Full use of maximum available resources	Health sector spending to GDP ratio trend over time	GDP is a monetary measurement of country's productivity. The greater the GDP, the greater potential economic resources that can be potentially mobilized by the government for health programs	*The full use of maximum available resources can be indicated by the following two conditions:* • The average health sector spending to GDP ratio is greater or equal to the global/regional average • The overall health sector spending to GDP ratio shows increasing trend over time The extent of national government actions to fully use maximum available resources for realizing the right to health can be assessed as:	
			Achieved if both condition (1) and condition (2) are **met**	5
			On-track if one of the conditions is met (**condition (1) OR condition (2)**)	3
			Off-track if both condition (1) and condition (2) are **unmet**	1
	Comparison of health-sector-to-total-government-spending ratio with other sectors to total government spending ratio	Comparison among sector-to-total-government-spending ratio provides important information about government's relative priority of sectoral policies	*The full use of maximum available resources can be indicated by the following two conditions:* 1. the sector-to-total-government-spending ratio for health sector is within the top five of sector-to-total spending ratio 2. within the top five sector-to-total spending ratio, the health-sector-to-total spending ration is not exceeded by less important sectors The extent of national government actions to fully use maximum available resources for realizing the right to health can be assessed as:	
			Achieved if both condition (1) and condition (2) are **met**	5
			On-track if one of the conditions is met (**condition (1) OR condition (2)**)	3
			Off-track if both condition (1) and condition (2) are **unmet**	1

Source : Team Analysis, 2013

2.1.4. Maternal Health Program Budget Analysis

The criteria, indicator, rationale and parameter to assess the extent to which the national government is taking serious efforts in term of maternal health program and budget toward fulfilling maternal health commitments are summarized in the following table.

Table 4.
Criteria, Indicators, Parameters for Maternal Health Program and Budget Analysis

Criteria	Indicator	Rationale	Parameter	Score
Progressive achievement of the right to maternal health	The inflation-adjusted spending trend of maternal health programs over time	The inflation adjusted spending provide more accurate information of the spending value over time	The progressive achievement can be indicated by the following two conditions: • the inflation-adjusted spending trend of maternal health programs shows increasing trend from year to year over time • the inflation-adjusted spending trend of maternal health programs which match with evidence based interventions for maternal health indicates increasing trend from year to year over time The extent of national government actions toward progressive achievement of the right to maternal health can be assessed as:	
			• Achieved if both condition (1) and condition (2) are met	5
			• On-track if one of the conditions is met (condition (1) OR condition (2))	3
			• Off-track if both condition (1) and condition (2) are unmet	1

Criteria	Indicator	Rationale	Parameter	Score
Progressive achievement of the right to maternal health	The inflation-adjusted spending trend for maternal health that are transferred to regional governments (i.e DAK/ specific purpose grant, de-concentrated fund, co-administered tasks, and con-current function)	The amount of allocation that is being transferred to the regions indicates that the national government takes progressive actions to bear the financial burden to fulfill the commitments at the regions	The progressive achievement can be indicated by the following two conditions: • the inflation-adjusted spending trend for maternal health that are transferred to regional governments shows increasing overall trend over time • the proportion maternal health spending as regional transfer to total maternal health spending shows overall increasing trend over time The extent of national government actions toward progressive achievement of the right to maternal health can be assessed as:	
			• Achieved if both condition (1) and condition (2) are met	5
			• On-track if one of the conditions is met (condition (1) OR condition (2))	3
			• Off-track if both condition (1) and condition (2) are unmet	1
Progressive achievement of the right to maternal health	The inflation-adjusted spending trend of maternal health program targeting poor women	• The inflation adjusted spending provide more accurate information of the spending value over time • Maternal health program targeting poor women/family can be seen as government's affirmative actions to fulfill the non-discriminatory obligation by providing guarantee for the poor to access essential maternal health programs and services	The extent of national government actions toward progressive achievement of the right to maternal health can be assessed as:	
			• Achieved if the inflation-adjusted spending trend of health sector indicates increasing trend from year to year over time	5
			• On-track if the overall inflation-adjusted spending trend of health sector shows increasing trend over time	3
			• Off-track if the overall inflation-adjusted spending trend of health sector shows decreasing trend over time	1

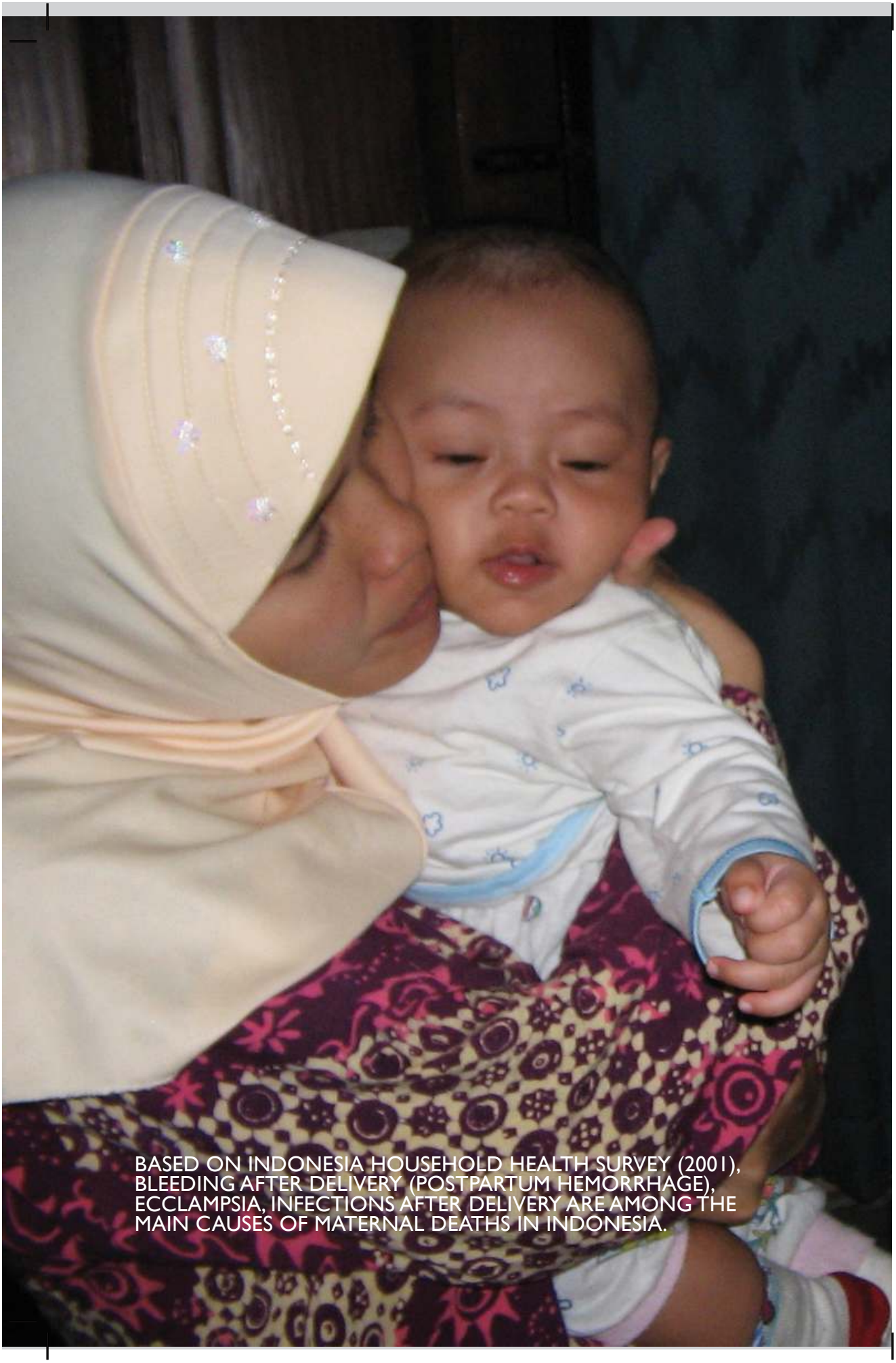
Criteria	Indicator	Rationale	Parameter	Score
Full use of maximum available resources	The extent to which that the resource available is effectively used and no resources are wasted	The available resource may not necessarily utilized effectively due to various factors. The budget that has been allocated should reflect the magnitude of the problems being address and may also be spent effectively and efficiently.	The full use of maximum available resources can be indicated by the following two conditions: • there is quantifiable measure whether the available resource for major maternal health programs has been spent effectively and efficiently • there is an observable indication whether the available major maternal health programs is allocated/ distributed proportionally based on the magnitude variations of maternal health problems being addressed. The extent of national government actions toward full use of maximum available resources to maternal health can be assessed as:	
			• Achieved, if both condition (1) and condition (2) are met	5
			• On-track, if one of the conditions is met (condition (1) OR condition (2))	3
			• Off-track if both condition (1) and condition (2) are unmet	1
Full use of maximum available resources	Comparison of maternal-health-programs-to-total-health-sector spending ratio with other health-programs-to-total health sector spending ratio	Comparison among program-to-total-sector-spending ratio provides important information about government's relative priority within the sector being studied.	The full use of maximum available resource for health spending by the following two conditions : • the programs-to-total-health-sector-spending ratio for maternal programs is within the top five of programs-to-total-health-sector spending ratio • within the top five programs-to-total-health-sector spending ratio, the maternal health-programs are not exceeded by less important health programs (e.g. may only benefit a portion of the population, or is not aligned with national top priorities) The extent of national government actions to fully use maximum available resources for realizing the right to health can be assessed as:	
			• Achieved if both condition (1) and condition (2) are met	5
			• On-track if one of the conditions is met(condition (1) OR condition (2))	3
			• Off-track if both condition (1) and condition (2) are unmet	1

Criteria	Indicator	Rationale	Parameter	Score
Full use of maximum available resources	Percentage of the maternal health programs that adopts evidence based interventions for maternal health	This indicator provides information about the extent to which the government uses any available resources for the interventions that have been proven to deliver outcomes in improving maternal health.	The full use of maximum available resource for health spending by the following two conditions : • at least 75% of the maternal health programs adopts evidence based interventions for maternal health • the average of maternal health programs that adopts evidence based interventions for maternal health accounts for at least 75% of the total spending for maternal health programs The extent of national government actions to fully use maximum available resources for realizing the right to health can be assessed as:	
			• Achieved if both condition (1) and condition (2) are met	5
			• On-track if one of the conditions is met (condition (1) OR condition (2))	3
			• Off-track if both condition (1) and condition (2) are unmet	1

THE NATIONAL GOVERNMENT EFFORTS TO PROGRESSIVELY REDUCE MATERNAL MORTALITY RATE, WHICH IS INDICATED BY ITS EXPLICIT DECLARATION TO THE GLOBAL COMMUNITY, SHOULD BE APPRECIATED AND SUPPORTED.

CHAPTER 3

INDONESIA MATERNAL HEALTH STATUS



BASED ON INDONESIA HOUSEHOLD HEALTH SURVEY (2001), BLEEDING AFTER DELIVERY (POSTPARTUM HEMORRHAGE), ECCLAMPSIA, INFECTIONS AFTER DELIVERY ARE AMONG THE MAIN CAUSES OF MATERNAL DEATHS IN INDONESIA.

Chapter 3.

INDONESIA MATERNAL HEALTH STATUS

3.1. Indonesia Maternal Health Status

Maternal health is a major development issue Indonesia. In fact, among other Indonesia Millennium Development Goals, the progress in maternal health targets is among those that are still lagged behind and need special attentions. Although, Indonesia's MMR has been gradually decreasing from 390 deaths per 100,000 live births in 1991 to 228 in 2007, it still remains high. Indonesia MMR is still considered as among the highest in South-east Asia region. According to UNESCAP[5], Indonesia's MMR is the fourth highest MMR (220/100.000 life birth) among South East Asia countries following Cambodia, Timor-Leste and Lao PDR. It is higher than the average of MMR in ASEAN and South-East Asia. Moreover, the number of maternal mortality in Indonesia was the highest among East Asia countries in the last 10 years.

The national government efforts to progressively reduce maternal mortality rate, which is indicated by its explicit declaration to the global community, should be appreciated and supported. However, the target of reducing MMR to 102 deaths per 100,000 live births by 2015 seems to be too ambitious. Using the past time series MMR data and projected to the year of 2015, the lowest possible of MMR is only 153. Even the national's MMR target as stated in National Medium Term Development Plan 2010-2014 (*Rencana Pembangunan Jangka Menengah/RPJMN 2010-2014*), which are more realistic, still seems to be out of reach.

5 UNESCAP Online Database (http://www.unescap.org/stat/data/statdb/DataExplorer.aspx), accessed in January, 11, 2013

Chart 1.
Maternal Mortality rate in Southeast Asia Region (1990-2010)

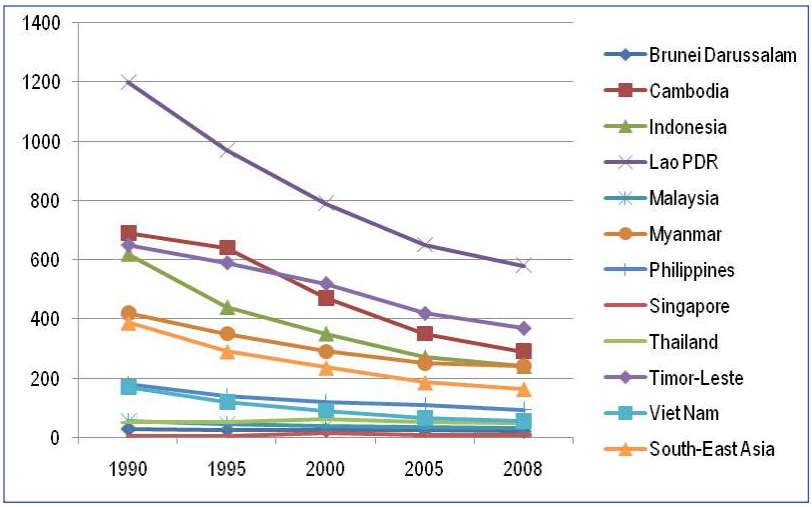
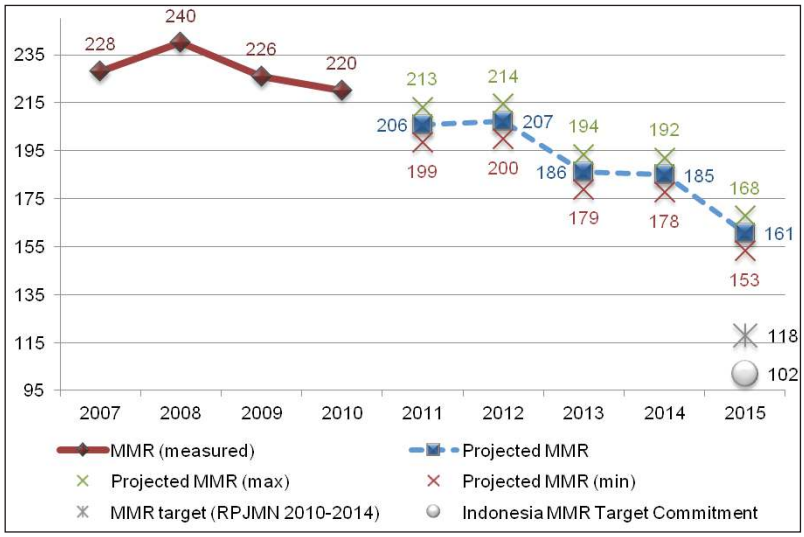


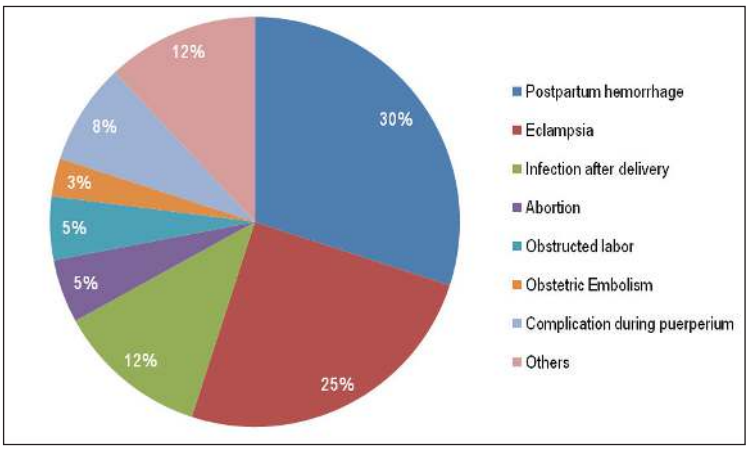
Chart 2.
Measured, Targets, and Projected Indonesia MMR



3.2. Major Causes of Maternal Mortality in Indonesia

Based on *Indonesia Household Health Survey* (2001), bleeding after delivery (*postpartum hemorrhage*), *ecclampsia*, infections after delivery are among the main causes of maternal deaths in Indonesia. These main causes can be minimized by ensuring that all birth deliveries are attended by skilled health worker, all pregnant women are receiving proper and quality antenatal care; and delivering women have access to emergency *obstetric care facilities in timely manner (UNICEF, 2004).* Antenatal care is expected to treat anemia during pregnancy, while skilled birth attendant may prevent or treat bleeding with correct treatments. *Therefore, the status of these intervention outputs is essential toward achieving target of reduced MMR.*

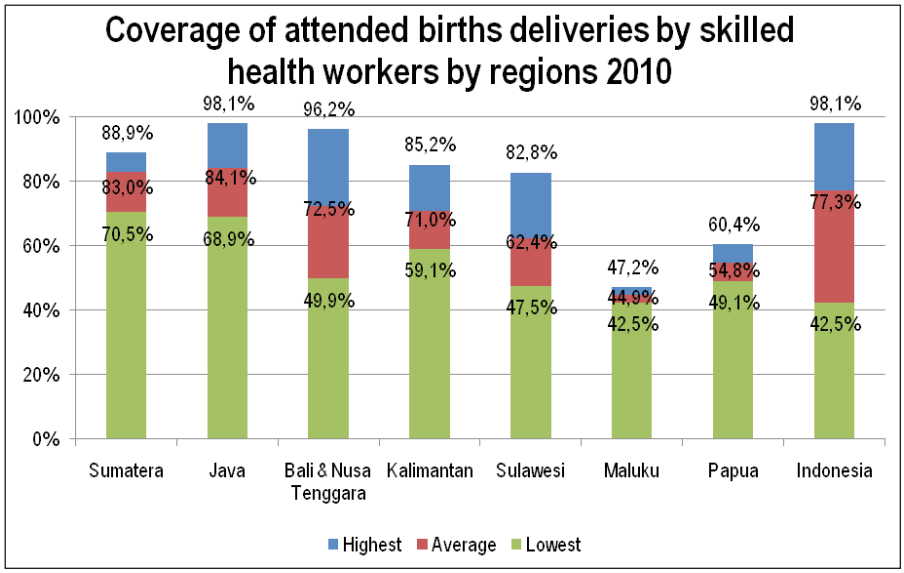
Chart 3.
Major Causes of Maternal Deaths in Indonesia



3.3. The Coverage of Attended Birth Deliveries by Skilled Health Worker

The progress in coverage of attended birth deliveries by skilled health workers is promising, with the increasing trend of coverage in national figure. Currently, 77.34 percent of births are assisted by a skilled health provider (SUSENAS 2009). This figure continues to increase, from 66.7 percent in 2002, and reached 82.3 percent in 2010 (interim data from RISKESDAS 2010).

Chart 4.
Coverage of Attended Births Deliveries by Skilled Health Workers by Regions in 2010



However, achieving 100% coverage of attended birth deliveries by skilled health worker may still be a big challenge. One main problem that prevents achieving this target is the regional disparity across regions in Indonesia. Chart 4 shows the regional variations of the percentage coverage of the attended births deliveries by skilled health worker. The three number of coverage in each bar of the chart represent the highest, the overall average, and the lowest coverage percentage of the region[6]. The highest coverage percentage is taken from the provincial coverage that has the highest percentage among

6 It should be noted that each region comprises a number of provinces. For example, the Java region comprises Banten, DKI Jakarta, Jawa Barat, Jawa Tengah, Yogyakarta, and Jawa Timur.

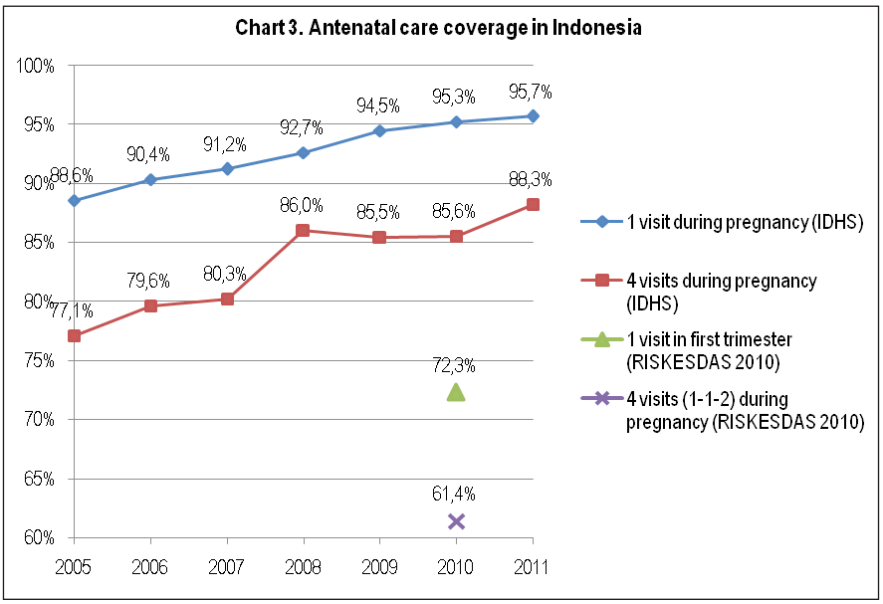
provinces in the region. The overall average is calculated by averaging all of the provincial coverage percentage of the region. The lowest coverage percentage is taken from the provincial coverage that has the lowest percentage among provinces in the region.

The highest coverage of attended births deliveries by skilled health workers is in Sumatera and Java regions, while the lowest coverage are found in Maluku (42.5%-47%) and Papua (49.1%-60%) regions. Improving the coverage of attended birth deliveries by skilled health workers is a big challenge due to limited availability of skilled health workers, access problems to health facility due to inadequate road and transportation infrastructure.

3.4. The Outreach And Quality of Antenatal Care

The outreach and quality of antenatal care also determines reduced risks during birth deliveries. According to RISKESDAS 2010, even though the antenatal care coverage has shown improvement, there were only 72.3% of pregnant women who checked their pregnancy during the first three months of pregnancy period, and there are only about 61.4% of pregnant women who undergo complete antenatal care as recommended by the government.

Chart 5.
Antenatal Care Coverage in Indonesia (2005-2011)



The study by Titaley et al. (2010) demonstrates that region and type of residence, socioeconomic condition and maternal education are among the factors associated with underutilization of antenatal care in Indonesia. Pregnant women from outer Java-Bali region, particularly from rural areas are more likely to underutilize antenatal services. This might be due to the problems of health services shortages and limited access in outer islands. Poor road conditions, long distance of health facilities locations, and poor transportation modes may have prevented pregnant women to access antenatal care. The study also shows that, the underutilization of antenatal care has strong association with socio-economic status of pregnant mother. Pregnant women from poor family are more likely to experience financial problems that prevent them from accessing antenatal care services. They are also more likely to have less education particularly related to maternal health because of their poor education level or exposure of mass media. The study by Agus and Huriuchi (2012) also confirms that the pregnant women's level of education and knowledge of pregnancy are among factors that are associated with the underutilization of antenatal care particularly in rural areas.

High coverage of pregnant women receiving complete antenatal care and high coverage of attended birth deliveries by skilled health worker are still no guarantee for reduced maternal deaths. Mothers who are experiencing complications during laboring process require proper emergency obstetric care. Therefore, the availability and access of emergency obstetric care (EmOC) are also essential in ensuring reduced maternal health. In Indonesia, the government has realized the importance of EmOC in reducing maternal mortality by building more health facilities equipped with basic emergency obstetric and neonatal care service (Pelayanan Obstetri Neonatal Emergensi Dasar/PONED) and comprehensive emergency obstetric care service (Pelayanan Obstetri Neonatal Emergensi Komprehensif/PONEK).

CHAPTER 4

ANALYSIS OF INDONESIA GOVERMENT'S COMMITMENTS ON MATERNAL HEALTH

THE LACK OF PROGRESS IN MATERNAL HEALTH TARGETS OF MDG HAD MOTIVATED THE LAUNCH OF THE GLOBAL STRATEGY FOR WOMEN'S AND CHILDREN'S HEALTH (GLOBAL STRATEGY) IN THE U.N. MDG SUMMIT IN SEPTEMBER 2010.

Chapter 4.

ANALYSIS OF INDONESIA GOVERMENT'S COMMITMENTS ON MATERNAL HEALTH

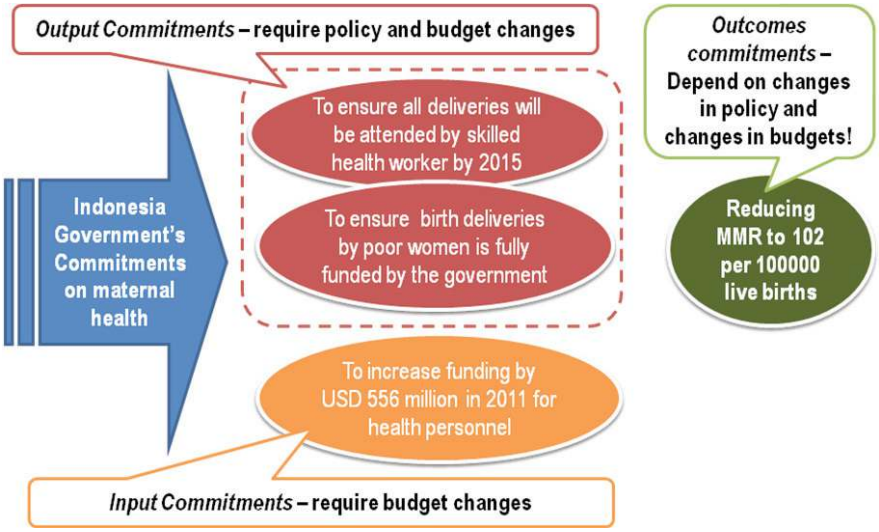
4.1. Analysis of Maternal Health Policy

Indonesia's commitment in maternal health is one of the objectives of MDGs. To achieving the MDGs is a reflection upon the state's commitment to its people's welfare while contributing to the welfare of the world community. In this respect, the MDGs have been a key reference in the National Long Term Development Plan (RPJPN) for 2005 - 2025, the National Medium Term Development Plans (RPJMN) for 2004-2009 and 2010-2014, Annual Government Work Plans (RKPs), and State Budget (APBN) documents. In addressing these commitments, however, Indonesia faces considerable global challenges. Free trade, rising oil prices followed by ever-increasing fuel oil subsidies, climate change and global warming and their multiplier effect on ever-increasing food prices – they all color the social and economic dynamics of Indonesia's national development.

Indonesia's achievements in its development of welfare have been widely recognized on a global scale. Indonesia has been invited by industrialized countries to join the Organization for Economic Cooperation and Development (OECD) and the group of enhanced engagement countries. Through the international engagement with industrialized countries, Indonesia has been part of the G-20 Forum, a group of 20 countries which together count for 85 percent of the world's gross domestic product (GDP). Indonesia's role in global policymaking has become very important. The lack of progress in maternal health targets of MDG had motivated the launch of the Global Strategy for Women's and Children's Health (Global Strategy) in the U.N. MDG Summit in

September 2010. Through the Global Strategy's "Every Woman, Every Child" Initiative, 49 heads of state of the world's poorest countries have pledged to intensify their efforts to improve women's and children's health. Indonesia, as one of the high burden countries, had also joined the initiative and had pledged the commitments to accelerate the achievement of maternal health targets in 2015.

Figure 2.
Framework to Achieve Country's Commitments In Maternal Health



The Government of Indonesia's commitments in maternal health comprises commitments in maternal health outcome, output, and input. In term of maternal health outcome commitment, the government has committed to reduce maternal mortality ration to 102 deaths per 100,000 live births by 2015. In term of maternal health output commitment, the government pledged its commitments to ensure that all birth deliveries will be performed by skilled birth attendants by 2015 and to ensure that 1.5 million deliveries by poor women will be fully funded by the government. In term of maternal health input commitment, the government had committed to increase funding support by USD 556 million in 2011 to support professional health personnel.

The achievement of these commitments requires great efforts and concrete actions from government institution. In order to ensure that the output commitment can be achieved require policy and budget changes. The policy changes are required to establish a normative framework that assigns liability to government institutions to provide services of performing birth deliveries attended by skilled birth attended for all deliveries. It also provides the entitlement for delivering mother from poor family to receive financial support from the government to cover costs associated with birth deliveries. The budget allocation is the immediate consequence of these policy changes in order to ensure that government's actions to achieve these output targets are adequately funded through government budgeting. The input commitment is more straightforward as it states explicitly the amount of allocated budget for supporting health personnel. This implies the requirement for the government to allocate USD 556 million in 2011 for supporting health personnel. However, the government needs to elaborate the specific purposes of this committed budget allocation.

Although, these policy and budget changes are expected to contribute to reduced maternal mortality ratio, it will not necessarily result on achieved outcome commitment, which is reduced MMR to 102 maternal deaths per 100,000 live births. One major challenge is the decentralization context and geographical variation in Indonesia that makes interregional disparity in development persist, including in maternal health. Therefore special attention is also needed to overcome problems that are caused by decentralization and vast geographical variations across regions.

Coordinated actions between national-regional governments to address maternal health problems are still an issue since the implementation of regional autonomy. Indonesia has embarked toward a massive decentralization system since 2000 following the collapse of New Order regime in 1998. The decentralization framework has undergone a series of revisions (Budlender and Satriyo, 2008). The first decentralization law in post-New Order regime was Law No. 22/1999 on Regional Autonomy, which was in place in 2000. In 2004, the government revised the law with Law the 32/2004 as a response to impacts caused by the preceding law. Nevertheless, under this decentralized system, government responsibilities, including maternal health sector are shared among national, provincial, and district level government

The extent to which the national government's actions to fulfill its commitments on maternal health can be assessed first from its national policy framework

related to maternal health. It is the initial stepping stone for the government to ensure that its commitments will be materialized into specific budget allocation to deliver concrete programs and projects for maternal health. Said differently, the expected higher budget allocation for maternal health can only be ensured if the specific strategies, policies, and targets are explicitly stated in the existing formal regulatory and development policy framework. By using the two key human rights principles as the main criteria, the progressive achievement of the right to maternal health and the full use of maximum available resources, the extent to which the existing formal regulatory and development policy framework can be assessed

4.1.1. Analysis of National Government's Policy Analysis toward Progressive Achievement of the Right to Maternal Health

The extent to which National government's policy is aligned with the progressive achievement criteria can be assessed from how do maternal health's targets are: 1) explicitly stated in the existing regulatory and development policy framework; and 2) supported by additional and auxiliary documents. The explicit statement of maternal health commitments in the existing regulatory and development policy framework will ensure that the government is held accountable to deliver the stated targets, by allocating adequate funding for maternal health in national budget. The second indicator means that because the maternal health targets are the top priority of the government as well as country's promise to the global commitment, it requires progressive actions to mainstream stakeholder attentions and mobilize resources to deliver maternal health commitments. These auxiliary policy or planning documents are expected to provide technical guidance, arguments, or other needed materials to support the needs for actions to mainstream maternal health commitment targets.

The government's commitments on maternal health are relatively very concrete by explicitly stating the quantitative targets from each commitment. This is because those commitments were actually taken from the National Medium Term Development Plan (*Rencana Pembangunan Jangka Menegah Nasional/RPJMN*) 2009-2014, and Government Work Plan (*Rencana Kerja Anggaran/RKA-KL*) 2010 document. This planning document is a policy document that guides the focus, and direction of national development within the 5 year period timeframe. It highlights the focus policy areas, strategies, proposed programs and objective indicators that can be used as the point of reference in monitoring the policy performance.

The key policy interventions related to maternal health in RPJMN 2009-2014 comprise six key interventions. The first is improving reproductive and maternal health service. This key intervention area involves expanding the coverage and support for skilled/professional birth attendants; providing support for antenatal and post-natal care. The second key intervention area is improving health care nursing and midwifery services that involve efforts to enhance quality of midwifery services in public hospital; and improving basic maternal health care services in primary health care (PUSKESMAS). The third key intervention area is technical task implementation and health care management support that aims to provide support for the expansion of village health service center and improving maternal health facility in primary health care (PUSKESMAS). The fourth and fifth key intervention areas are expanding the establishment of health care equipped with Basic and Essential Obstetric & Neo-natal Care (PONED) in PUSKESMAS and Comprehensive Emergency Obstetric Care (PONEK) in public hospital. The last key intervention area is the establishment of social and health insurance for pregnant women and for women who are giving birth. Table 1 summarizes national government targets related to maternal health.

Table 5.
Achievement Indicators for Maternal Health

Indicator of Achievement	Targets					Proposed Budget Ceiling (US$ million)
	2010	2011	2012	2013	2014	
Priority maternal health program that are stated in RPJMN 2009-2014						
Percentage of attended deliveries by skilled health workers;	84%	86%	88%	89%	90%	230.95
Percentage of pregnant women receiving at least 1 visit antenatal care						
Percentage of pregnant women receiving at least 4 visit antenatal care	84%	86%	90%	93%	95%	
Percentage of delivering mother receiving postnatal care						

Indicator of Achievement	Targets					Proposed Budget Ceiling (US$ million)
	2010	2011	2012	2013	2014	
Priority maternal health program that are stated in RPJMN 2009-2014						
Number of primary health care facilities (PUSKESMAS) performing midwifery services as standard and guidelines	70	354	496	644	792	420.53
Number of hospital that performing nursing and midwifery services as standard and guidelines;	220	220	240	260	280	
Number of village health center (POSKESDES) that is in operation	7.000	7.200			7.800	(N/A)
Percentage of the availability of nutrition and maternal and children health in primary health care (PUSKESMAS)						(N/A)
Percentage of primary health care that has BemOC (PONED) services capability	60%	70%			100%	131.79
Percentage of distrit public hospital that perform CemOC (PONEK) services	80%	85%			100%	45.79
Priority maternal health programs other than those that are stated in RPJMN 2009-2014						
Number of health care facilities that have performed services for JAMPERSAL scheme						
Number of very poor families receiving condition cash transfer assistance from Family Welfare Program (PKH)	816.000	1.116.000			1.170.000	945.79

Source: BAPPENAS (2009)

The analysis of policy documents reveals that the targets related to maternal health commitments are stated in the policy documents, particularly in the National Medium Term Development Plan (*Rencana Pembangunan Jangka Menegah Nasional/RPJMN*) 2009-2014, and Government Work Plan (*Rencana Kerja Anggaran/RKA-KL*) 2010 document. The targets are also quantifiable although there are also annual targets are missing from a number of years or from certain program. Therefore, it can be stated that in term of how

the existing regulatory and development policy framework adopts the commitments, governments is ***on-track*** toward progressive realization of the maternal health commitments.

In order to progressively realize the maternal health related targets, the governments is expected to take progressive actions to mainstream stakeholder attentions and mobilize resources to deliver maternal health commitments by issuing auxiliary planning documents that act as technical guidance, arguments, or other needed materials to support the needs for actions to mainstream maternal health commitment targets. In order to accelerate the achievement of MDGs target, the government has launched a number of actions. First, the national government has instructed to integrate MDGs targets into National Medium Term Development Plan, by issuing the President Regulation (Peraturan Presiden/Perpres) No. 5/2010, which have taken effect since January 20th, 2010. The government, through the National Development Planning Agency/BAPPENAS, introduced MDGs Road Map in April 21st 2010, a policy document outlining strategies to mainstream and accelerate the achievement of MDGs targets[7]. BAPPENAS also published the Guideline for Regional Action Plan on MDGs and Financial Support in 2011. This document is a guideline for regional governments to formulate and produce its action plans to accelerate the achievement of MDGs targets.

The analysis of auxiliary policy/planning documents reveals that there are a number of documents and regulations have been produced that aim to accelerate the achievement of MDGs targets in the form of National Road-map toward MDGs targets as well as the guideline Guide-line for Regional Action Plan on MDGs and Financial Support. Although these documents do not specifically address the maternal health targets, the documents also contain maternal health targets as these targets also belong to MDGs. Therefore, it can be stated that in term of the availability of the auxiliary planning and policy document toward accelerating the achievement of MDGs targets, the government is ***on-track*** toward progressive realization of the maternal health commitments.

7 https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&ved=0CC8QFjAA&url=http%3A%2F%2Fwww.bappenas.go.id%2Fget-file-server%2Fnode%2F10299%2F&ei=P5WtUcXGJcuJrAeNz4DQDA&usg=AFQjCNFbiE-zpRRCAEpP0BeZTsPCE9ulgQ&sig2=d_OgIbkPwsSxydJsU-ZBMg&bvm=bv.47244034,d.bmk

4.1.2. Analysis of National Government's Policy Analysis toward Full Use of Maximum Available Resources to maternal health rights

The extent to which National government's policy is aligned with the full use of maximum available resources criteria can be assessed from the existence of regulatory frameworks that provide minimum requirement for the government to allocate available resources for achieving maternal health targets. The explicit statement of the minimum requirement to allocate resources for maternal health commitments will ensure the availability of resources regardless any internal or external factors that may regress progress in maternal health that have been made so far.

The national government introduced Presidential Instruction (Inpres) 3/2010 on Equitable Development Programming (*Program Pembangunan Berkeadilan*). One of the mandates denoted within the Inpres is that all ministries/ agencies, governors, and district heads/mayors are required to take the steps that are necessary in accordance with each respective duties, functions, and competences to ensure the implementation of equitable development programs, which includes the achievement of the Millennium Development Goals (MDGs). Furthermore it also states that:

> *"... to encourage sub-national regions to prepare programs and activities and to **allocate budgets** in accordance to local development work plans (RKPDs), local government unit work plans (SKPDs), and local government unit work plans and budgets by making reference to the MDGs work plans of each respective province in order to accelerate achievement of MDGs objectives, targets, and indicators."*

The Presidential Instruction also provides direction in order to strengthen financial support for accelerated achievement of the MDGs by:

- Formulating a policy framework of funding for accelerated achievement of the MDGs through public-private partnerships (PPP) in order to encourage the private sector to form partnerships with the Government in an effort to accelerate achievement of the MDGs;
- Formulating harmonization guidelines for the implementation of corporate social responsibilities (CSRs) in order to create synergies between CSR activities and programs and activities designed to accelerate achievement of the MDGs, which include efforts to achieve synergy with (i) CSR and

MDGs objectives, (ii) community groups targeting, (iii) CSR and MDGs localities; and (iv) CSR and MDGs performance indicators.

In order to encourage regional governments' participation to achieve MDGs targets by mainstreaming MDGs targets and programs into local actions, the Presidential Instruction mandates the national government to formulate guidelines for the granting of incentives to sub-national regions to support accelerated achievement of the MDGs. The guidance should include identifying, implementing, and monitoring the granting of local incentives which have demonstrated satisfactory performances in achieving the MDGs.

The analysis of the existing regulatory framework that outline the provision of minimum requirement toward the mobilization of resources reveals that there is a regulation document in the form of Presidential Instruction No. 3/2010 on Equitable Development Programming (*Program Pembangunan Berkeadilan*) that contains minimum requirement for the government institution to mobilize resources for the accelerated achievement of MDGs targets. Although Presidential Instruction is relatively weak in Indonesia regulatory system, which means that there is no strong obligation for other national government institutions or regional government to follow up the provisions, it gives a sense of political will from the national government to push forward other institutions, both at national and regional level toward accelerated achievement of MDGs targets. Therefore, it can be stated that in term of the availability of regulation document in providing minimum requirement toward accelerating the achievement of MDGs targets, the government is ***on-track*** toward the full use of maximum available resources for the realization of maternal health commitments.

4.1.3. Overall Policy Assessment of Policy toward Fulfilling Government Commitments on Maternal Health

Based on the preceding analysis of the existing policy and planning framework, it reveals that the national government's policy related to maternal health commitment is ***on-track*** in term of explicitly adopt the maternal health commitments into the existing policy and planning documents, and in term of producing auxiliary planning and policy documents toward accelerated achievements of MDGs targets, including maternal health. The government is also ***on-track*** in term of mobilizing available resources for maternal health commitments by issuing regulation that provide minimum requirements toward resource mobilization. Therefore, the overall assessment of maternal health related policy and plans can be summarized in the following table.

Table 6.
Summary of Policy Analysis related to Maternal Health Commitments

Criteria	Indicator	Status	Level Commitment	Score
Progressive achievement of the right to health	Target of the government's commitment explicit in the policy documents *(mandatory document)*	Commitment to achievement in improving maternal health is listed in RPJMN	***On track***	3
	Target of the government's commitment explicit in the auxiliary planning documents	Although there is no auxiliary document specifically for maternal health, at the national level, BAPPENAS has produced National Action Plan on MDG.	***On-track***	3
Full use of maximum available resources	There is an affirmative regulatory framework	The government commitment of maternal health in affirmative policy document stated in Inpres 3/2010)	***On-Track***	3
Total Score/Maximum Score				**9/15*)**
Overall Status				**On-Track**

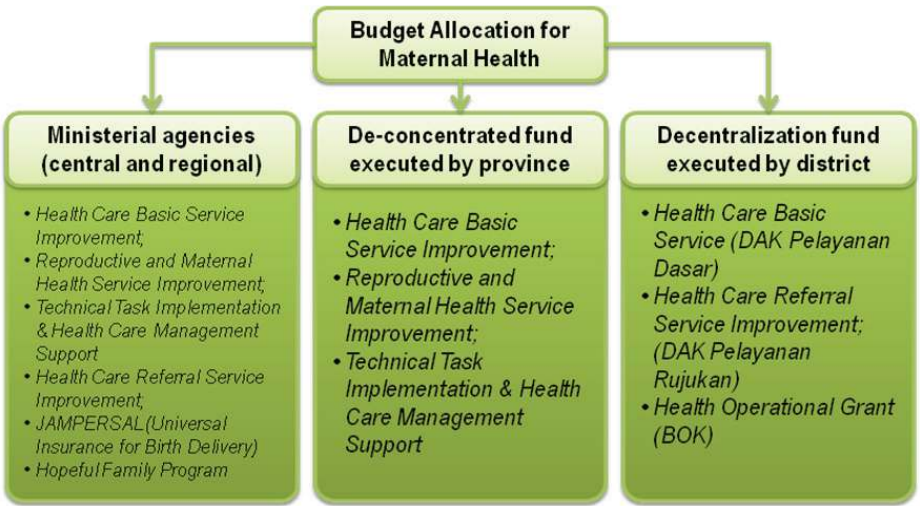
*) Minimum value: 3, maximum value, 15. Off-track value interval is > 3 and < 7; On-track value range interval is > 7 and < 11; and achieved value range interval is > 11 and < 15

4.2. Analysis of General Health Budget

The analysis of general health budget is also important analysis of national government actions toward fulfilling commitments in maternal health. The analysis aims at understanding the extent to which the national government is committed to mobilize adequate resources for health sector that would be used also for maternal health programs. If the government could not demonstrate that it has taken serious efforts in mobilizing resources for health sector, there would be a possibility that maternal health program would receive resources that is less than needed.

Budget allocation for maternal health is channeled out through three financing schemes: ministerial budget, de-concentrated fund, and decentralization fund. The ministerial budget are budget allocation that are executed by ministerial agencies at the national level as well as at the regions to perform government task in health sectors, which are assigned as national government responsibility. De-concentrated fund is financial resources being transferred

Figure 3. Channels Of Maternal Health Budget Expenditure

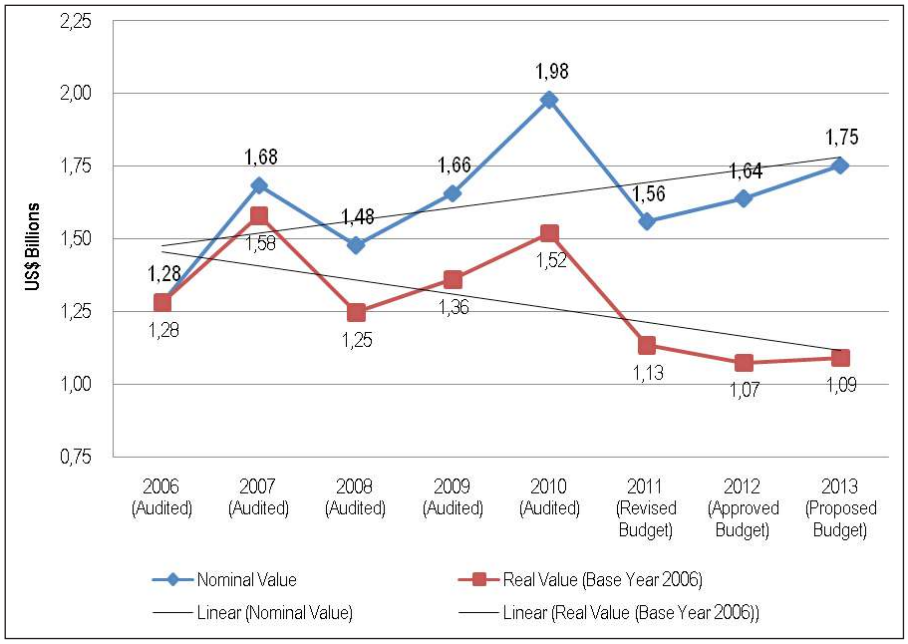


to regional government agencies, and executed by the regional government (province) in order to perform government tasks in health sector of the national government. Decentralization fund is financial resources being transferred to regional government agencies (province and district) in order to support province and district government in performing government task in health sector, which have been assigned as provincial and district governments' responsibility, but are also of the interests of the national government.

4.2.1. Analysis of National Government's General Health Budget toward Progressive Achievement of the Right to Maternal Health

Budget allocation is essential for determining how changes in policy will materialize into expected health outputs and outcomes. Therefore it is important for the government to allocate adequate amount of money in order to ensure that the actions required for achieving policy targets and objectives are carried as should be. The assessment of government actions toward progressive achievement of right to maternal health is based on the analysis of the government spending trend adjusted by inflation rate. The analysis of inflation-adjusted spending value provides better information compared to spending value in nominal term.

Chart 6.
National Health Budget Trend in Nominal and Real Value (US$)

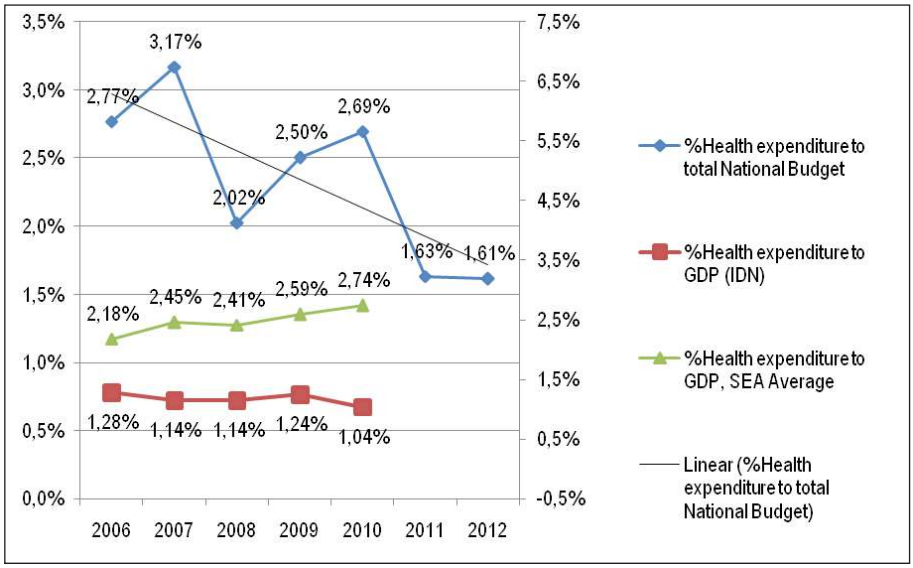


Government's commitment in health, particularly in maternal health, can be assessed by looking at the trend of budget allocation for health in general. During period from 2006 to 2013, the overall trend of national budget allocation for health sector is increasing in nominal term. However, despite the increasing trend of the nominal value, the real value is actually decreasing. This means that the national budget allocation for health sector has not been keeping up with the inflation rate. Said differently, the national government buys less goods and services for health sector in recent years compared to 2006. The highest national budget allocation for health sector was in 2010, which was accounted for US$ 1.98 billion. This means that the national government is off-track in its efforts to fulfill commitments in maternal health as indicated that it failed to maintain the increasing trend of health budget allocation in term of real value.

4.2.2. Analysis of National Government's General Health Budget toward Full-Use of Maximum Available resource for the realization of the Right to Maternal Health

The extent to which the government actions are fully using of maximum available resource for the realization of the right to maternal health can be assessed in term of health sector spending to GDP ratio trend over time and comparison of health-sector-to-total-government-spending ratio with other sectors to total government spending ratio. The former reflects to what extent does the national government is able to mobilize nation's potential available economic resource. As the GDP is a monetary measurement of country's productivity, the greater the GDP means the greater potential economic resources that can be potentially mobilized by the government for health programs. The latter indicator provides important information about government's relative priority of sectoral policies.

Chart 7.
Share of Health Expenditure to Total National Budget and GDP



From Chart 7, it can be inferred that the national government has not been effectively utilizing the available economic resources for health. The share of health expenditure to total national budget decreased from 2.8% in 2006 to just 1.6% in 2012. Moreover, the overall trend of health expenditure to GDP ratio is decreasing with the average ratio below the average of South-East Asia countries. The average of health expenditure to GDP ratio in 2006 to 2010 is 1.168% which was below Southeast Asian countries average of 2.474%. These figures indicate that the government has not been able to mobilize potential economic resources for health sector. Moreover, there is an indication that the health sector spending allocation was underutilized. In the 2008-2011 periods, there was an average of 8% of health budget allocation which was not disbursed. Furthermore, in 2013 budget planning, there is an indication that the national government has not been making serious efforts to fulfill its commitments in health sector because the allocated health budget is far below of the amount proposed by the ministry of Health in its budget document proposal (RKA/KL). This means that the national government failed to tap the opportunities to mobilize potential economic resources yielded by the positive national and regional economic growth toward realization of rights in health in general.

The following table 7 shows that the health sector has not been among the national top development priorities. Health spending was ranked at 7th position among the national government priorities in 2010 and shifted down to 8^{th} position in 2011 and 2012. Although in nominal term, the health budget spending is increasing, its increasing rate is somewhat insignificant if it is compared to other sector such as general services, education, and even defense. This indicates that health sector, even though it is very important, has not been yet become the top development priority. Therefore, in term of the health to total government spending ratio, the government is off-track as it fails to ensure health sector as the national top development priorities.

Table 7.
Amount, Share, and Rank of National Budget Expenditure by Functions (2010-2012)

Expenditure by Functions	2010			2011			2012		
	$	%	Rank	$	%	Rank	$	%	Rank
General Services	11,602,748,771	15.2%	2	11,879,936,597	13.5%	2	14,144,491,343	13.9%	2
Defense	1,571,161,293	2.9%	5	4,991,441,305	5.7%	5	7,674,986,597	7.6%	5
Public Order & Safety	6,037,771,137	2.1%	8	2,322,801,940	2.6%	7	3,169,401,985	3.1%	6
Economic	830,445,095	7.9%	4	10,710,960,972	12.2%	3	10,799,419,423	10.6%	4
Environment	2,200,697,351	1.1%	9	1,165,216,536	1.3%	9	1,205,416,704	1.2%	9
Housing & Public Facilities	1,894,929,465	2.9%	6	2,483,613,721	2.8%	6	2,787,039,805	2.7%	7
Health	**149,059,587**	**2.5%**	**7**	**1,436,777,894**	**1.6%**	**8**	**1,638,370,956**	**1.6%**	**8**
Tourism & Culture	96,113,232	0.2%	11	305,408,009	0.3%	11	258,315,524	0.3%	12
Religion	8,851,209,318	0.1%	12	147,086,056	0.2%	12	378,315,554	0.4%	11
Education	363,858,630	11.6%	3	9,629,790,150	10.9%	4	10,868,640,471	10.7%	3
Social Protection	40,536,194,581	0.5%	10	482,683,739	0.5%	10	587,135,241	0.6%	10
State Treasury	76,341,369,569	53.1%	1	42,505,142,746	48.3%	1	48,067,125,494	47.3%	1
Total	**150,475,558,030**	**100.0%**		**88,060,859,666**	**100.0%**		**101,578,659,095**	**100.0%**	

4.2.3. Overall Policy Assessment of National Government's General Health Budget toward Fulfilling Government Commitments on Maternal Health

Based on the preceding analysis of the national general health budget spending, it reveals that the national government fails to ensure the progressive achievement to the realization of right to maternal health. The government is ***off-track*** in term of ensuring that annual budget allocation in real value is increasing that will allow government to provide better health care services to its public. The national government also failed to fully use the maximum available resources. The government is ***off-track*** in term of tapping the potential economic development as indicated by the relatively low health spending to GDP ratio compared to the regional average. The government is ***off-track*** in term of ensuring health sector as the top national development priorities. The overall assessment of general health budget can be summarized in the following table.

Table 8.
Summary of National Government's General Health Budget Analysis

Criteria	Indicator	Status	Level Commitment	Score
Progressive achievement of the right to health	Inflation-adjusted spending trend of health sector from 2010 to 2012	Overall inflation-adjusted spending trend of health sector shows decreasing trend over time	***Off track***	1
Full use of maximum available resources	Health sector spending to GDP ratio trend over time	Overall health sector spending to GDP ratio is decreasing from 2.77% in 2006 to just 1.61% in 2012	***Off-track***	1
	Comparison of health-sector-to-total-government-spending ratio with other sectors to total government spending ratio	In nominal term, the health budget spending is increasing, but its increasing rate is somewhat insignificant if it is compared to other sector such as general services, education, and even defense. This indicates that health sector, even though it is very important, has not been yet become the top development priority	***Off track***	1
Total Score/Maximum Score				**0/15*)**
Overall Status				**Off-Track**

*) Minimum value: 3, maximum value, 15. Off-track value interval is > 3 and < 7; On-track value range interval is > 7 and < 11; and achieved value range interval is > 11 and < 15

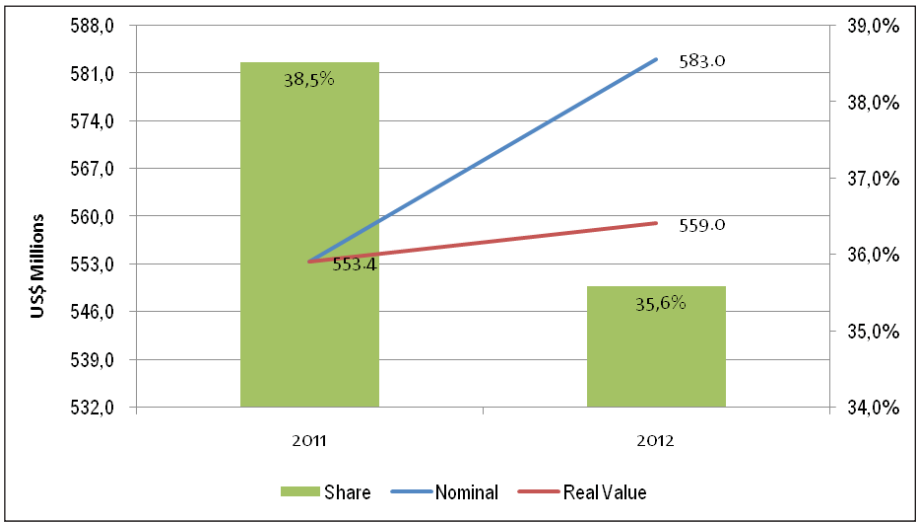
4.3. Maternal Health Program and Budget Analysis

The analysis of maternal health program and budget is also important analysis of national government actions toward fulfilling commitments in maternal health as it will give the information about the extent to which the government has been effective in using available financial resource to deliver maternal health program as the government's efforts to fulfill commitments in maternal health.

4.3.1. Analysis of Maternal Health Program and Budget toward Progressive Achievement of the Right to Maternal Health

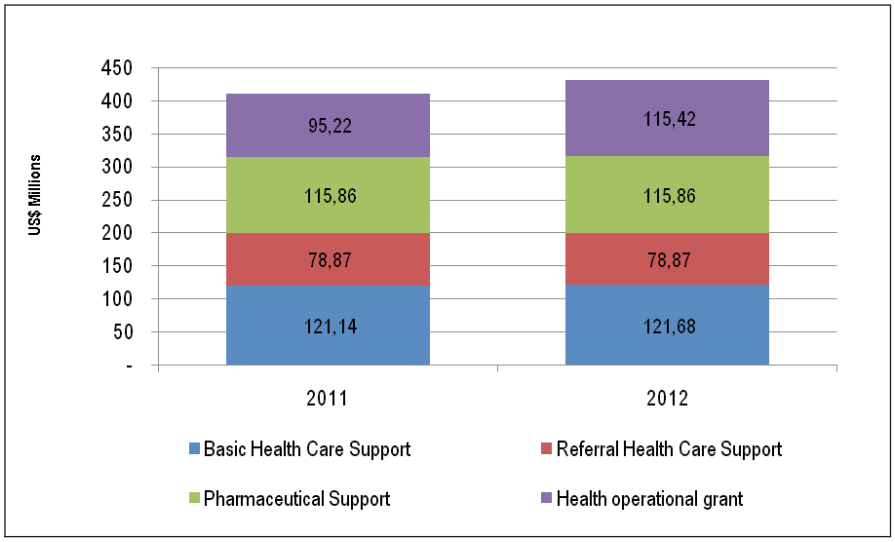
Since the commitments on maternal health were pledged by the government, the maternal health budget allocation has been increasing in term of both nominal and real value. The nominal of maternal health budget grew from US$ 553.4 millions in 2011 to US$ 583.05 millions in 2012. However, the share of maternal health programs in the total health budget was somewhat decreasing from 38.5% in 2011 to 35.6% in 2012. This indicates that the government is ***on-track*** in ensuring progress in maternal health budget allocation, but the fact that share of maternal health decreased may regress the efforts to fully realize the progressive achievement in fulfilling maternal health commitments.

Chart 8. Trend and Share of Maternal Health Budget in Nominal and Real Value (2011-2012)



Decentralization fund is also important in ensuring the progressive achievement toward fulfilling maternal health commitments as it will extend the efforts to the regional government. As previously discussed, the decentralization arrangement has devolve substantial government functions to regional government (provincial and district level), including maternal health. In fact, district governments have become the frontline for service delivery in maternal health. Key basic maternal services are delivered by PUSKESMAS, which has been under district government responsibility. Therefore decentralization fund has become important financing scheme in provincial and district level government to ensure that the commitment on maternal health targets is mainstreamed in local government programs.

Chart 9. Regional Transfer Scheme in Health Sector



In general, there are three types of decentralization fund in Indonesia decentralization framework. The first is *Dana Bagi Hasil/DBH* which is revenue sharing fund. Provincial and district government receive money from the central government as shares of tax revenue and natural resource exploitation collected by the central government to the originating governments. The second type of decentralization fund is *Dana Alokasi Umum/DAU* (general allocation fund), which can be described as block grant from the central

government to province and district level government in order to perform provincial and district level governments tasks and responsibilities in providing basic services to its people. The usage of DBH and DAU is at the regional governments discretion based on their development priorities. The third type is *Dana Alokasi Khusus*, which is basically a specific purpose grant. This type of decentralization fund is actually a kind of central government transfer to regional government, by which its usage are limited by pre-determined purposes. Among the three type of decentralization fund, DAK is important financing instrument that allow mainstreaming national agenda into local actions.

In the period of 2011-2012, the amount of central government transfer to regional government in health sectors has been increasing. Regional transfer comprises specific purpose grant for basic health care support (DAK Kesehatan – Pelayanan Kesehatan Dasar); specific purpose grant for referral health care support (DAK Kesehatan – Pelayanan Kesehatan Rujukan); specific purpose grant for Pharmaceutical support (DAK – Kefarmasian); and health operational grant (Bantuan Operational Kesehatan/BOK). These transfer funds are also important in achieving maternal health targets. In principle, DAK Kesehatan aims for providing financial support for activities in health sector that belongs to regional government responsibilities whilst aligned to health development priorities at national level (Kementerian Kesehatan, 2012). DAK Kesehatan is expected to improve health service distribution, coverage, and quality particularly at primary health facility (PUSKESMAS) and village health care center (POSKESDES), public hospital, and ensuring the availability of drug supplies.

In regard of maternal health programs, each of these transfer funds is designed to contribute achieving maternal health targets. DAK Kesehatan for basic health care service is prioritized for improving primary health care (PUSKESMAS) facility to be able to perform intervention for normal birth delivery. It can be used to upgrade PUSKESMAS with basic emergency obstetric care (PONED) services and facilities. DAK Kesehatan for referral health care can be used to ensure the availability of CemOC (PONEK) facilities, infrastructure, and equipment in public hospitals. All in all, transfer grant in the form of specific purpose grant is important for infrastructure and facility provisions for maternal health related services.

These all indicate that the government has demonstrated to take serious actions to increase more transfer fund to provincial and district level government. These will encourage provincial and district level government to take part in national efforts to fulfill maternal health commitments. The government is **on track** toward progressive achievement of maternal health commitments by ensuring that the regional (provincial and district) governments have the financial resources needed to take part in addressing maternal health problem.

Another aspect of maternal health budget that need to be analyzed is whether the available financial resources for maternal health is also substantially allocated to target specifically poor women/mother. The increasing trend of maternal health allocation in National budget indicates a positive development of government efforts to accelerate the achievement of maternal health target. An in-depth look on maternal health budget data reveals that the increase of maternal health programs are due to the introduction of new scheme, the universal birth delivery insurance (Jaminan Persalinan Universal/ JAMPERSAL), which add to the existing conditional cash transfer program for poor family (*Program Keluarga Harapan/PKH*); health operation grant (*Bantuan Operasional Kesehatan/BOK*) which was also introduced in 2011; and medical equipment procurement. Some of these schemes may be attributed to government efforts in accelerating the achievement of maternal health targets as set out in RPJMN 2009-2014 document, which correspond with government commitments in maternal health to the global community as pledged in the UN Summit on MDGs 2010.

JAMPERSAL is a new scheme, which was introduced by the Ministry of Health. It aims to provide financial supports to pregnant women and delivering mother in order to reduce risks of delivering births. It is a government action to respond to the access problem caused by financial difficulties experienced by pregnant women, which prevent them to access maternal health services. All pregnant women who are seeking maternal health care services in public health care service facilities (primary health care and state midwifes services) are eligible to receive benefits from this scheme. Services that are being covered by JAMPERSAL include antenatal care (maximum of 4 visits); normal birth delivery attended by skilled birth attendant, postnatal and neonatal care services, interventions for obstructed labor and pre-referral care for newborn with complication; and post-abortion care, and basic emergency obstetric care services.

Chart 10.
Share of Maternal Health Budget by Components (2011-2013)

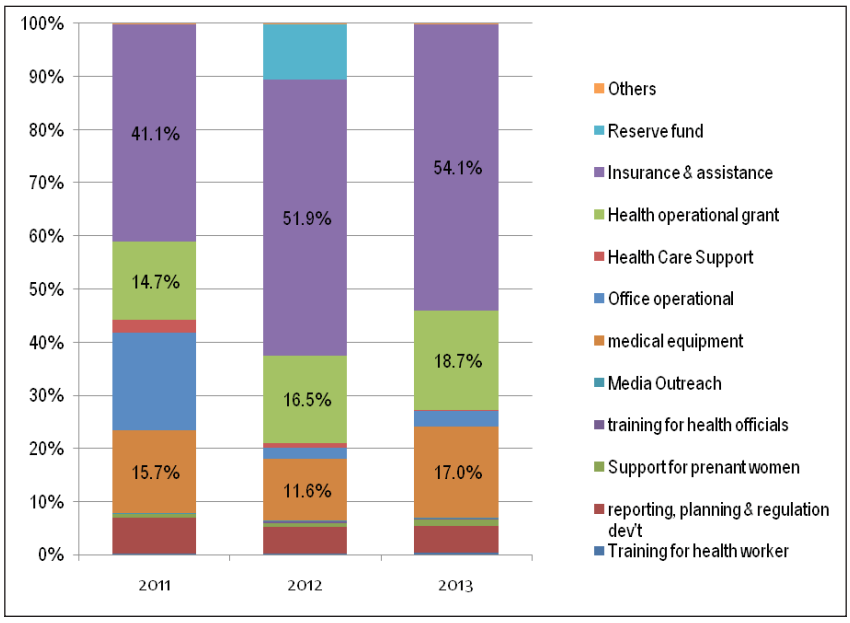
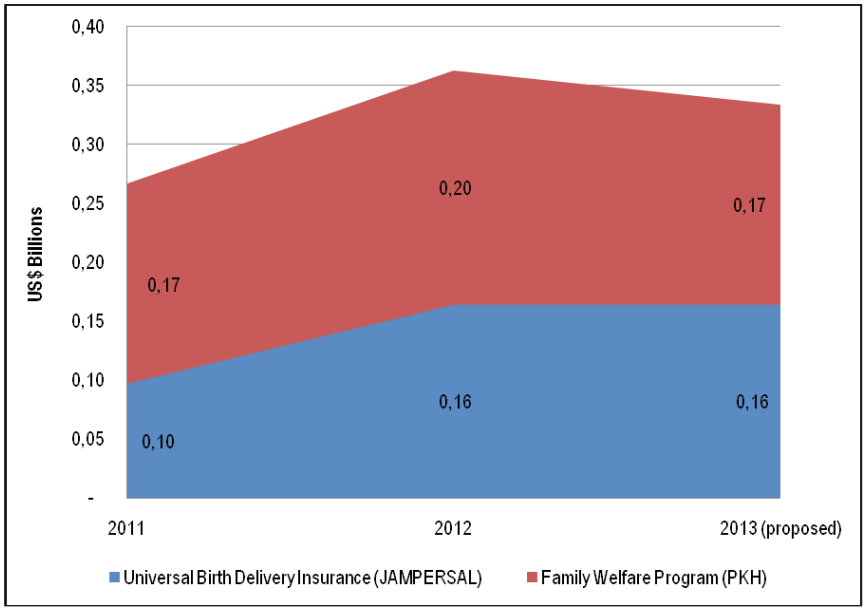


Chart 11.
Trend of Budget Allocation for JAMPERSAL and PKH2011-2013



Program Keluarga Harapan/PKH (Family Welfare Program) is a conditional cash transfer program for very poor families to promote maternal health quality and children education among poor families. It was introduced and managed by the Ministry of Social Welfare and has been running since 2006. It is a targeted scheme which means that those who are eligible are mother and children from very poor family based on verified beneficiary data from Indonesia Statistics Agency (*Badan Pusat Statistik*). The scheme provides cash grant to very poor family with certain conditions. Some of the conditions are that all pregnant women from poor family are required (mandatory) to visit primary health care facility to receive a package of antenatal care for their pregnancy.

Bantuan Operational Kesehatan/BOK (Health Operational Grant) is grant given by national government to primary health care facilities (PUSKESMAS) in order to provide financial support that can be used for improving the quality of health care services in PUSKESMAS including maternal health services. The main objective of BOK is to ensure increased access and equal public health services distribution through health promotion and prevention activities of primary health care facility (PUSKESMAS) in order to achieve minimum service standard targets in health sector and MDGs targets by 2015 (Kementerian Kesehatan, 2011). Among activities that are supported by BOK include transportation supports for PUSKESMAS health workers performing ante-natal care, birth delivery, post-natal care, and *post-puerpurium* visits.

This maternal health budget figures indicate that the government is currently focusing on achieving target of reduced maternal health ratio by providing insurance scheme for birth deliveries. By introducing this scheme the government expects that more pregnant women are more willing to access antenatal care services in primary health facilities and more willing to deliver births attended by skilled health workers. It is also evident that in the period of 2011-2012, the amount of budget allocated for JAMPERSAL is increasing. The budget allocation for JAMPERSAL is rising from US$ 0.1 billion in 2011 to US$0.16 billion in 2012. The proposed amount for 2013 may at least be equal to the allocated amount in the previous year.

The analysis of maternal health budget reveal that the government has demonstrated to take serious actions in reducing maternal mortality by specifically allocating substantial funds to ensure affordable and safe birth deliveries, particularly for poor women from poor family as indicated by the JAMPERSAL scheme and PKH. There is also an increasing trend of budget

allocation nominal for JAMPERSAL and PKH in 2011-2012 period. In this sense, the government is ***on-track*** in ensuring progressive achievement toward maternal health commitments to reduce maternal mortality.

4.3.2. Analysis of Maternal Health Program and Budget toward Full-Use of Maximum Available resource for the realization of the Right to Maternal Health

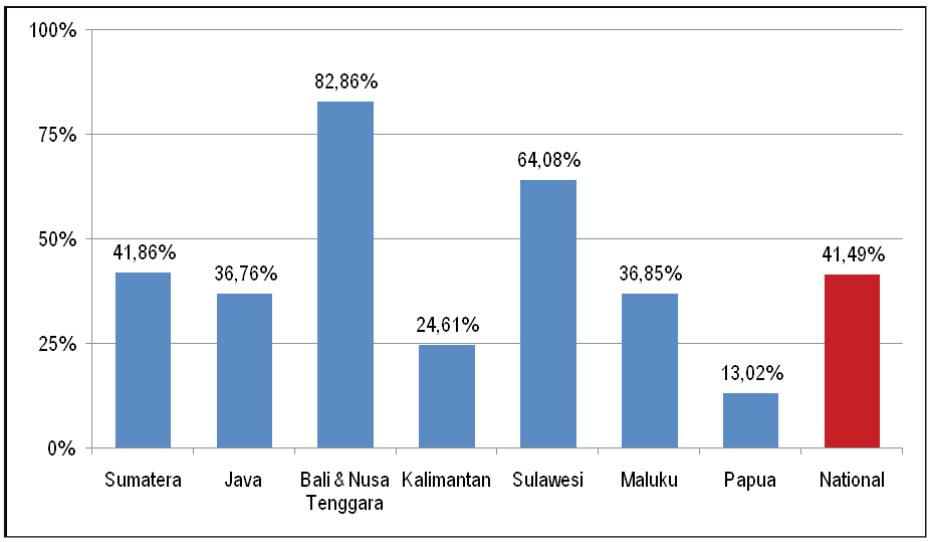
The analysis of maternal health program and budget toward full use of maximum available resources aims at assessing to what extent the national government has been effective to utilize available resources for achieving maternal health commitments. The analysis will be focused on how the major maternal program (JAMPERSAL and decentralization funds) was delivered as well as to look at the overall maternal health programs.

The first aspect to look at is how the major scheme in maternal health i.e JAMPERSAL, performed. Despite substantial amount of financial resources has been allocated for JAMPERSAL scheme, the actual spending of this scheme is relatively low. The level of actual spending of JAMPERSAL in 2011 is 41.5% nationally. There is also great geographical variation of JAMPERSAL spending level across regions. The highest spending level of JAMPERSAL is the Bali and Nusa Tenggara region which spent 82.86% of the allocated money. The lowest is Papua region which only spent 13.02% from the allocated quota. The problem of under spending of JAMPERSAL scheme may be because this scheme was relatively new, of which most of the eligible beneficiaries was not aware about the scheme.

Other scheme that is also important to analyze is the decentralization funds to regional governments (provincial and district). Despite its importance in providing financial resource to regional government that can be used for facility and infrastructure development in maternal health, the allocation of transfer grant does not necessarily align with the prevailing maternal health problems at regions. Chart 11 shows a correlation test between the average amount of central government transfer for basic health care services to regions and the number of unattended deliveries by skilled worker. The logic behind this test is that if the government is assumed to be effective in allocating funds to regions, therefore, regions with bigger problem, as indicated by number of unattended skilled health worker, would receive more funds. The unattended birth delivery indicator signals problems of accessibility of maternal health care

services due to various factors such as poor road infrastructures, geographical difficulties, uneven health care workers distribution, and other factors. The correlation test of these two variables result insignificant r coefficient value, which indicate a very weak correlation (r= 0.044722). It can be inferred that the allocation of transfers may not correspond effectively the magnitude of maternal health problems that are encountered by the regions. In term of full use of maximum available resources criteria, the central government fails to effectively use the resources to address maternal health problems in the regions.

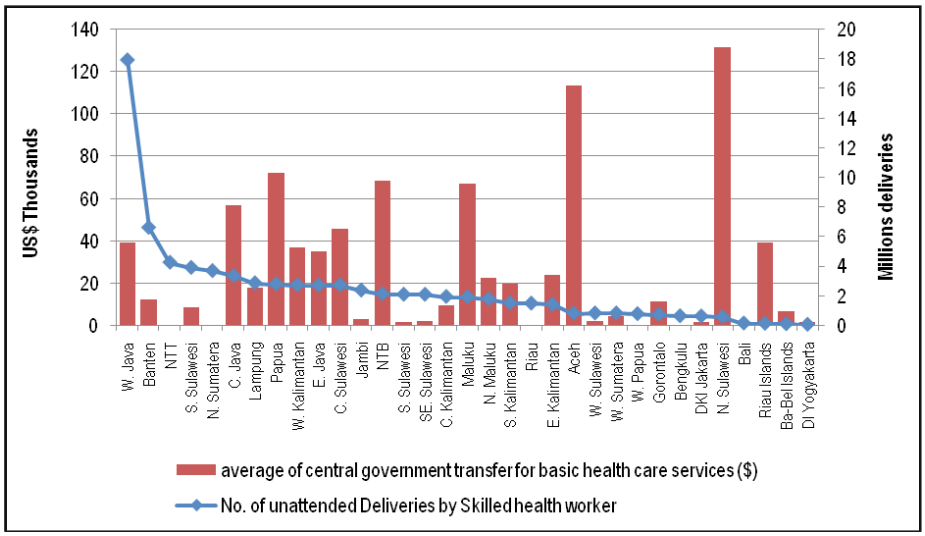
Chart 12.
Actual Spending of JAMPERSAL Scheme 2011



Based on this assessment, the government fails to full use maximum available resource that had been allocated for maternal health programs to progressively fulfill commitments in maternal health. The JAMPERSAL fund was substantially underspent, indicating that more serious efforts are needed to ensure that the objective of the scheme can be met. The distribution of transfer from national grants has not reflected that the scheme was distributed affectively to address the varied magnitude of maternal health problems in the regions. In these regards, the government is ***off-track*** to fully use maximum available resources toward the realization of commitments in maternal health.

Another aspect of assessment is to assess the share of maternal health programs. The bigger share of maternal health programs compared to non-maternal health programs may indicated the seriousness of national government in its efforts to accelerate the achievement of commitments in maternal health. The chart 8 shows that the share of maternal health programs is quite substantial. In 2011, the share of maternal health program to total health budget allocation was 38.5%. It slightly decreased to 35.6% in 2012. However, the overall share of maternal health program in 2011 and 2012 was more than one-third of the total health budget. In this regard, the government is ***on-track*** to fully use maximum available resources to achieve maternal health commitments by maintaining the share of maternal health programs budget more than one-third of the total health budget in the 2011-2012.

Chart 13.
The Average Amount of Allocation for Basic Health Care Services and Number of Unattended Deliveries by Skilled Health Worker 2011-2012



The last aspect that needs to be analyzed is whether the interventions being adopted in maternal health program correspond to the recommended evidence-based interventions for maternal health. The evidence based interventions are a set of interventions that have been proven to address maternal health problems through systematic research and experiments. By adopting the evidence based interventions, it is expected that the resources

will be effectively used and no resources will be wasted because the adopted interventions have been proven to work. As discussed in the previous chapter, the main causes of maternal mortality in Indonesia include bleeding after delivery (*postpartum hemorrhage*), *eclampsia* , and infections after delivery. These main causes can be reduced by ensuring that all birth deliveries are attended by skilled health worker, all pregnant women are receiving proper and quality antenatal care; and delivering women have access to emergency *obstetric care facilities in timely manner (UNICEF, 2004).* Antenatal care is expected to treat anemia during pregnancy, while skilled birth attendant may prevent or treat bleeding with correct treatments.

As previously discussed, there are three major maternal health related programs, which are *Jaminan Persalinan Universal/JAMPERSAL* (Universal Birth Delivery Insurance), *Program Keluarga Harapan/PKH* (Family Welfare Program), and *Bantuan Operational Kesehatan/BOK* (Health Operational Grant). JAMPERSAL aims to provide financial supports to pregnant women and delivering mother in order to reduce risks of delivering births. It is a government action to respond to the access problem caused by financial difficulties experienced by pregnant women, which prevent them to access maternal health services. Through this scheme, it is expected that mother will have access to quality antenatal care so that any births related complications can be detected as early as possible allowing proper treatments to reduce fatal risks. *Program Keluarga Harapan/PKH* (Family Welfare Program) is a conditional cash transfer program for very poor families to promote maternal health quality and children education among poor families. Some of the conditions are that all pregnant women from poor family are required (mandatory) to visit primary health care facility to receive a package of antenatal care for their pregnancy. *Bantuan Operational Kesehatan/BOK* (Health Operational Grant) is grant given by national government to primary health care facilities (PUSKESMAS) in order to provide financial support that can be used for improving the quality of health care services in PUSKESMAS including maternal health services. Among activities that are supported by BOK include transportation supports for PUSKESMAS health workers performing ante-natal care, birth delivery, post-natal care, and *post-puerpurium* visits.

Based on this assessment, the national government has been taking serious efforts to adopt interventions in maternal health programs that correspond with the evidence based interventions to reduce maternal mortality in Indonesia. The choice of interventions has reflected the prevailing problems that cause high mortality rate in Indonesia, that are any health conditions which may

lead to fatal risks during birth deliveries due to poor access to quality health care services performing ante-natal care, birth delivery, post-natal care, and other essential services. In this regards, the government is ***On-track*** to fully use of maximum available resources toward the realization of commitments in maternal health. However, it has not yet reached the ***achieved*** status as there is no information on other required interventions to address maternal health problems that are related to prevailing cultural and social factors. It is also unclear whether the transferred grants to regional governments will be used in accordance to evidence based intervention principles.

4.3.3. Overall Maternal Health Program and Budget Analysis

The overall maternal health program and budget analysis toward fulfilling maternal health commitments can be summarized in the following table 9. In the criteria of progressive achievement of the right to maternal health, the government is ***on-track*** in ensuring progress in maternal health budget allocation, but the fact that share of maternal health decreased may regress the efforts to fully realize the progressive achievement in fulfilling maternal health commitments. The government is found **on track** toward progressive achievement of maternal health commitments by ensuring that the regional (provincial and district) governments have the financial resources needed to take part in addressing maternal health problem. The analysis of maternal health budget also reveals that the government is ***on-track*** in ensuring progressive achievement toward maternal health commitments to reduce maternal mortality by demonstrating its serious actions in reducing maternal mortality by specifically allocating substantial funds to ensure affordable and safe birth deliveries, particularly for poor women from poor family as indicated by the JAMPERSAL scheme and PKH.

In the criteria of full use of maximum available resource for the realization of maternal health commitments, the government is found ***off-track*** as it fails to ensure that resources available for delivering maternal health programs and schemes as it is indicated by the significant underutilization of JAMPERSAL and the extent to which the amount transferred to regions is corresponding proportionally with the magnitude of maternal health problem in the regions. The government is also found ***on-track*** by ensuring that the allocation for maternal health program has substantial share from total health budget. The government is also seen as on-track as it has adopts programs and interventions that correspond with the prevailing maternal health problems in general.

Table 9.
Summary of Maternal Health Program and Budget Analysis

Criteria		Indicator	Status	Level Commitment	Score
Maternal Health Program and Budget Analysis	Progressive achievement of the right to maternal health	The inflation-adjusted spending trend of maternal health programs over time	Overall inflation-adjusted spending trend of maternal health programs over time was increasing but the share of maternal health program was decreasing	***Between On-track and Off-track***	2
		The inflation-adjusted spending trend for maternal health that are transferred to regional governments (i.e DAK/specific purpose grant, de-concentrated fund, co-administered tasks, and con-current function)	The nominal spending trend for maternal health that are transferred to regional governments shows increasing overall trend over time	***On-track***	**3**
		The inflation-adjusted spending trend of maternal health program targeting poor women	Overall spending trend of maternal health program targeting poor women (JAMPERSAL, BOK, PKH) is increasing	***On-track***	**3**
	Full use of maximum available resources	The extent to which that the resource available is effectively used and no resources are wasted	The JAMPERSAL fund was substantially underspent, indicating that more serious efforts are needed to ensure that the objective of the scheme can be met. The distribution of transfer from national grants has not reflected that the scheme was distributed affectively to address the varied magnitude of maternal health problems in the regions.	***Off-track***	**1**

Criteria		Indicator	Status	Level Commitment	Score
Maternal Health Program and Budget Analysis		Comparison of maternal-health-programs-to-total-health-sector spending ratio with other health-programs-to-total health sector spending ratio	The programs-to-total-health-sector-spending ratio for maternal programs is within the top five of programs-to-total-health-sector spending ratio	***On track***	**3**
		Percentage of the maternal health programs that adopts evidence based interventions for maternal health	The choice of interventions has reflected the prevailing problems that cause high mortality rate in Indonesia, that are any health conditions which may lead to fatal risks during birth deliveries due to poor access to quality health care services performing ante-natal care, birth delivery, post-natal care, and other essential services	***On-track***	**3**
Total Score/Maximum Score					**15/30*)**
Overall Status					**On Track**

*) Minimum value is 6 and maximum value is 30. Off-track value interval is > 6 and < 14; On-track value range interval is > 14 and < 22; and achieved value range interval is > 22 and < 30

4.4. The Overall Assessment of Government's Actions toward Realization of Maternal Health Commitments

In the previous sections, a detailed assessment of the policy and budget allocation has yield important findings.

Table 10.
Un-weighted Overall Assessment of Government's actions toward Realization of Maternal Health Commitments

Scope of Assessment	Status	Score
Policy Analysis related to Maternal Health Commitments	On-Track	(9/15)*(1/3) = 0.2
National Government's General Health Budget Analysis	Off-Track	(0/15)*(1/3) = 0.0
Maternal Health Program and Budget Analysis	On- Track	(15/30)*(1/3) = 0.17
Overall Assessment of Government's Actions toward Realization of Maternal Health Commitments	On-Track	0.2+0.0+0.17 = 0.37 *)

*) Minimum value is 0 and maximum value is 1. Off-track value interval is > 0 and < 0.33; On-track value range interval is > 0.33 and < 0.67; and achieved value range interval is > 0.67 and < 1

From the summary table, it can be concluded that the national government has done a very good job in ensuring that the Indonesia's commitments in maternal health are adopted in the existing regulatory and planning framework. Another finding is that, the government has been working very well to ensure that the available resource in health budget can be effectively used for maternal health program. However, the area that the government poorly performed is in ensuring that the health sector will have a substantial amount of resources that can be used for maternal health programs. The poor efforts from the government may results in limited resources. The government fails to effectively mobilized resources for health sector, let alone the maternal health issues.

The summary table assumes that each of analysis area has similar weight. This may not be accurate representation of the actual reality on how the government is thriving to fulfill its commitment in maternal health. Based on this thinking, it can be proposed a different approach in making the overall assessment of government's actions toward realization of maternal health commitments. This can be performed by assigning weight for each of analysis areas. The weighing scenario can be elaborated as follow.

Table 11.
Weight Assignment Rationale

Scope of Assessment	Weight	Rationale
Policy Analysis related to Maternal Health Commitments	30%	The adoption of maternal health targets into existing policy and planning documents is important to ensure that maternal health issues is still in the policy agenda of the policy maker. It also gives formal foundations for the government to generate and to spend public financial resources. However, its importance may be undermined by the existing realities that the policy or planning may not be materialized into budget allocations.
National Government's General Health Budget Analysis	40%	It is very important steps as it determine the extent to which the government can mobilize resources for maternal health. The bigger amount of health budget, there will be a good chance that maternal health program will receive more funds.
Maternal Health Program and Budget Analysis	30%	In this aspect, the focus of government actions is effectiveness and efficiency of health sector resource utilization.

Based on the preceding discussion, the result of assessment of the policy and budget allocation can be revised as follow.

Table 12.
Weighted Overall Assessment of Government's actions toward Realization of Maternal Health Commitments

Scope of Assessment	Status	Weighted-Score
Policy Analysis related to Maternal Health Commitments	On-Track	(9/15)*30% = 0.18
National Government's General Health Budget Analysis	Off-Track	(0/15)*40% = 0.0
Maternal Health Program and Budget Analysis	On-Track	(15/30)*30% = 0.15
Overall Assessment of Government's Actions toward Realization of Maternal Health Commitments	Off-Track	0.18+0.0+0.15=0.33 *)

*) Minimum value is 0 and maximum value is 1. Off-track value interval is > 0 and < 0.33; On-track value range interval is > 0.33 and < 0.67; and achieved value range interval is > 0.67 and < 1

By assigning proper weight for the corresponding score, the overall assessment of government's actions toward realization of maternal health commitments yields a different result that is *off-track*.In this regard, it can be concluded that the government actions are off-track in achieving the realization of commitment in maternal health due to poor efforts in generating and mobilizing required resources for health sector. The **government is off-track in its efforts to maintain the increasing trend of health budget allocation in term of real value. The government also failed to tap the opportunities to mobilize potential economic resources yielded by the positive national and regional economic growth toward realization of rights in health in general. T**he government also failed to ensure health sector as the national top development priorities.

CHAPTER 5

CONCLUSION

THE PERSISTING GEOGRAPHICAL DISPARITY OF ATTENDED BIRTHS BY SKILLED HEALTH WORKER, ANTENATAL CARE AND POST-NATAL CARE COVERAGE ACROSS REGIONS MAY UNDERMINE EFFORTS TOWARD REDUCED MMR ARE AMONG THE FEW PROBLEMS THAT MAY HINDER THE FURTHER PROGRESSES IN MATERNAL HEALTH.

Chapter 5.
CONCLUSION

This section discusses key findings from the research and outlines a number of recommendations in order to accelerate the realization of Indonesian Government's commitment toward maternal health targets by 2015. Overall, there has been progress toward achieving maternal health targets, however, great efforts are still needed to achieve maternal health target by 2015.

5.1. Key Findings

In term of maternal health status, the Indonesian Government has made some progresses toward the achievement of maternal health commitments. The overall trend of MMR has been declining over the decades. However, the targets made by the Indonesian Government are somewhat too ambitious and is highly unlikely to be achieved in the remaining time period. The target of 102 maternal deaths per 100,000 live births is unlikely to be achieved by 2015. The persisting geographical disparity of attended births by skilled health worker, antenatal care and post-natal care coverage across regions may undermine efforts toward reduced MMR are among the few problems that may hinder the further progresses in maternal health. In order to respond these problems proper policy measures and adequate budget allocation are very important.

The analysis of government commitment toward the realization of maternal health targets shows a mixed result. In term or policy measures aiming at accelerated efforts toward the realization of maternal health targets, the national government is indicated as in the right track (on-track). There have been a number of important policies that can be exploited to better address maternal health problems. The existence of these policies may serve as the basis for greater budget allocation for maternal health. However, such presumption does not necessarily materialize in reality.

The analysis on general health budget indicates that the government somewhat poorly performs in its efforts to generate and mobilize required resources for health sector. The **government is off-track in its efforts to maintain the increasing trend of health budget allocation in term of real value. The government also failed to tap the opportunities to mobilize potential economic resources yielded by the positive national and regional economic growth toward realization of rights in health in general. T**he government also failed to ensure health sector as the national top development priorities. The implication from this situation is that the available resources for maternal health is continuously limited.

However, despite the limited available resources for maternal health, the government agencies whose responsibilities are delivering maternal health services have done relatively well in ensuring effectiveness and efficiency of health sector resource utilization. For example, the government has increased the amount of resources being transferred to regional government that may encourage the regional government to take more proactive actions toward maternal health problems in their respective localities. The government has also allocated substantial amount of financial resources being targeted to poor women. These are among the few examples that indicate the positive progress of national government's actions toward the realization of maternal health targets.

5.2. Recommendations

Based on these findings, there are a number of recommendations that can be proposed:

For the conclusion, Manu has the same suggestions that she had before:

- Following a good policy and to accelerate progressively achievement of MDG targets on maternal and child health, it is important for the Government of Indonesia to increase the budget allocation and spending on maternal health according to the policy that has been made by the government.
- For the CSOs who work on maternal health advocacy, it is important to think aboutbig picture of policy and budget and follow through until the policy and budget implementation stages. It would be helpful to use clear criteria/indicator/parameter in doing evidence based advocacy.

APPENDIX

INDONESIA CONTEXT AND INDONESIA FISCAL DECENTRALIZATION FRAMEWORK

THE DECENTRALIZATION REFORM THAT ALSO HAS RESULTED ON THE INCREASING AVAILABILITY OF FINANCIAL RESOURCE TO DISTRICT GOVERNMENTS THROUGH DECENTRALIZATION FUND TRANSFER FROM CENTRAL TO LOCAL GOVERNMENT DOES NOT NECESSARILY AFFECT ON THE INCREASED FUND FOR HEALTH SECTOR.

Appendix 1.
Indonesia Context

A. Indonesia in Brief

The Republic of Indonesia is located between6 degrees north and 11 degrees south latitude, and from 95 to 141 degrees east longitude. It is an archipelagic country of approximately 17,000 islands which lies between Asia and Australia. It is also bounded by the South China Sea in the north, the Pacific Ocean in the north and east, and the Indian Ocean in the south and west. It spreads on a vast area of seawater, by which the land areas is 1,904,569 km2, which is accounted for 20% of the total territory area.

Indonesia is administratively divided into provinces which are divided into Kabupaten (districts) and Kota (municipalities). Since 2001, the number of provinces was expanded from 26 to 33. Altogether, there are 370 districts and 96 municipalities in Indonesia. The next lower administrative units are Kecamatan (sub-districts) and villages. In 2010, there are 6,131 sub-districts and 73,405 villages in Indonesia. The entire village is classified into Kelurahan, for villages that have a more urban character or Desa, for those that still maintain their rural characters.

APPENDIX 1

According to the latest 2010 Population census, the population of Indonesia is 237,5 millions, which makes Indonesia as one of most populous countries in the world after People's Republic of China, India, and the United States of America. It is estimated that approximately 42% of Indonesian population live in urban areas. However, this huge number of population is not evenly distributed geographically across the country. Java Island, which covers only 7 percent of the total area of Indonesia, is inhabited by 59 percent of the country's population, making the population density of Java (951 persons per square kilometer) higher than that of other islands. Within provinces in Java, the population density ranges from 12,700 persons per square kilometer in DKI Jakarta to 726 persons per square kilometer in East Java.

B. Decentralization in Indonesia

Since 1999, Indonesia has been undergoing decentralization from a centralistic system during Soeharto presidency. The Law 22/1999 was a milestone of the decentralization process. The Indonesia decentralization, which has been acclaimed as one the most ambitious decentralization system in the world, has transferred almost all central government functions and authorities to regional government except five absolute government authorities in foreign policy, defense and security, finance, law, and religious affairs.

The law 22/1999 was revised by the Law 32/2004 during the era of Megawati Presidency. The revision was aimed as the correction of the former law that has created coordination bottle-neck in development process. The district level government was considered too strong compared to the provincial government which was in turn created inter-district and district-province conflicts. In the Law 32/2004, the provincial governments have been slightly strengthened and act as the extended arms and implementers of the national government's programs. However, the principal nature of Indonesia decentralization is still remain that the district level governments still act as the frontline of public service delivery.

C. Indonesia Health System

Health system delivery is also affected by the decentralization process in Indonesia. Since the inception of decentralization law in 1999, the district level governments were transferred approximately 70% of central civil servants and most of the responsibility for public services and facilities. The reform also

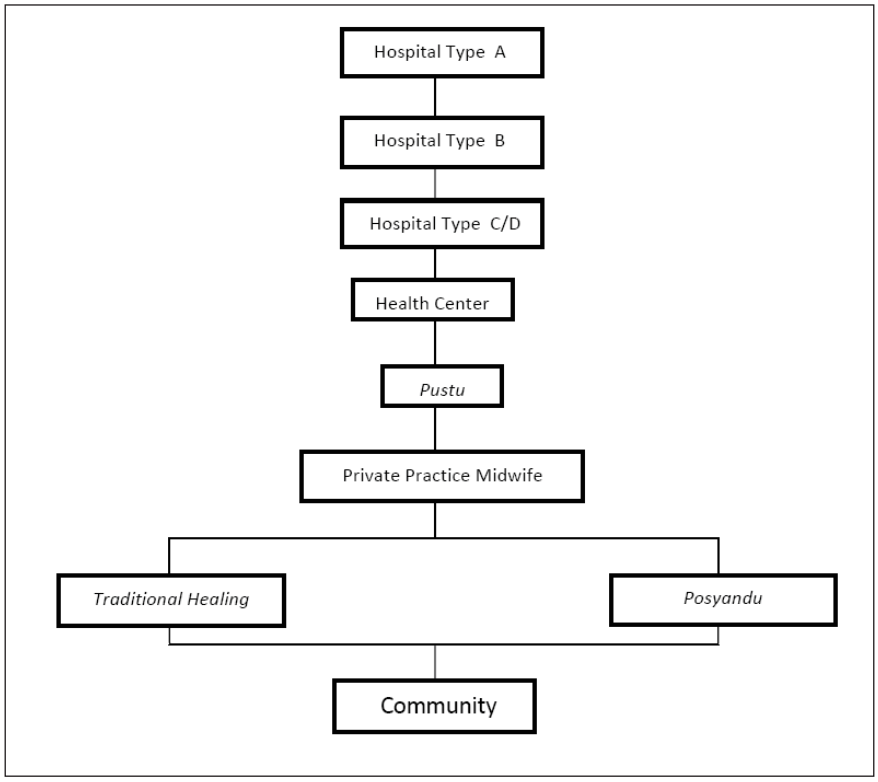
devolved substantial funds to local governments. However these transfers were not accompanied by transfers of capacity to perform new responsibilities. This eventually results on stagnant development in many areas of development, including health sector.

The decentralization reform that also has resulted on the increasing availability of financial resource to district governments through decentralization fund transfer from central to local government does not necessarily affect on the increased fund for health sector. Interestingly, the health sector in district level was experiencing financial shortages. The health sector must compete with other sector to receive budget allocation from the General Allocation Fund (DAU) and Local Own Revenue (PAD). In many regions, health sector receive relatively lower budget allocation areas. Shortages in health sector funding also occurred in areas with high fiscal capacity, which would be in a position to adequately finance the provision of health services to the population. This situation may undermine the progress in health indicators of the last decades. This leads to the increasing trend of central government funding on health sector directly from the Ministry of Health, which implies the increasing reliance of district government on central government funding.

At the national level, the Indonesia health system is structured in six major programmatic areas, which comprises Maternal and Children Health; Health Care Financing; Human Resources; Pharmaceuticals, Supplies, and Health Equipment; Management and Health Information, and Community Empowerment. At local level, BAPPEDA (the planning agency at the local level) has the responsibility to coordinate the local policy development, development planning and budgeting. The Dinas Kesehatan (District Health Office) have the responsibilities of the health related program and projects, and to develop technical standard. The provincial health office has the responsibilities to coordinate program and projects in health sectors among the districts, and to be in charge of inter-districts health issues. Through the de-concentrated tasks, the provincial health office also implemented national health policy and programs in its jurisdiction.

As a response of varied outcome of health sector performance among districts government as mentioned earlier, The Ministry of Health has developed the Minimum Service Standard in health sector. The standard is developed to provide concrete indicators that will be used to measure district health office and local governments performance in health sectors.

APPENDIX 1



The delivery of health care in Indonesia is organized in hierarchical health care system. The first level is the health care delivery system in the community, which involves Pusat Kesehatan Masyarakat/Puskesmas (community health center); Pos Pelayanan Terpadu/Posyandu (integrated village health post); Pos Bersalin Desa/Polindes (village maternity post); and bidan desa (village midwife). Puskesmas is run by the government as the extension of District health office providing basic health service in sub-districts areas. In order to serve remote villages that may beyond the Puskesmas outreach, Puskesmas Pembantu/Pustu (auxiliary community health center) may be established under the supervision of Puskemas. Polindes is run by nurses and midwife who are deployed by the government and assisted by village health cadres.

Posyandu is the the backbone of community participation in health services. Posyandu was originally introduced as a component of national program to provide basic nutrition and growth monitoring services at the community level. Posyandu is run entirely by volunteers who were trained as health cadres. It was one of the most successful examples of large scale nutrition

projects in Indonesia, which was successfully providing nutrition services to 10 million children by 1984. The basic roles of Pusyandu was later expanded in the mid 1980s to include community activities related to the family planning program as well as the provision of basic medical services such immunisation and diarrhoeal disease control with the support of health workers.

Secondary health services are provided by district hospitals, so called type C and D, which are served by at least four specialists. Referral from a primary health care provider is required to access hospital services, except in case of emergency. Tertiary health services are delivered by provincial hospitals (type B and C).

The public health facilities were formerly financed by the central government. However, after the decentralization, the disitricts government failed to allocate adequate funding to provide essential health services. The health facility operator than rely on user charges fees as the source of income to deliver its services. However, the reliance on user charges has led to increasing financial barriers for the poor. It has also created perverse incentives for facilities not to deliver public health interventions, including preventative care, which are less profitable than curative interventions. This situation that trigger off the central government to introduce national program such as Askeskin, which was later on transformed to Jamkesmas, to provide support for poor people to access health care services.

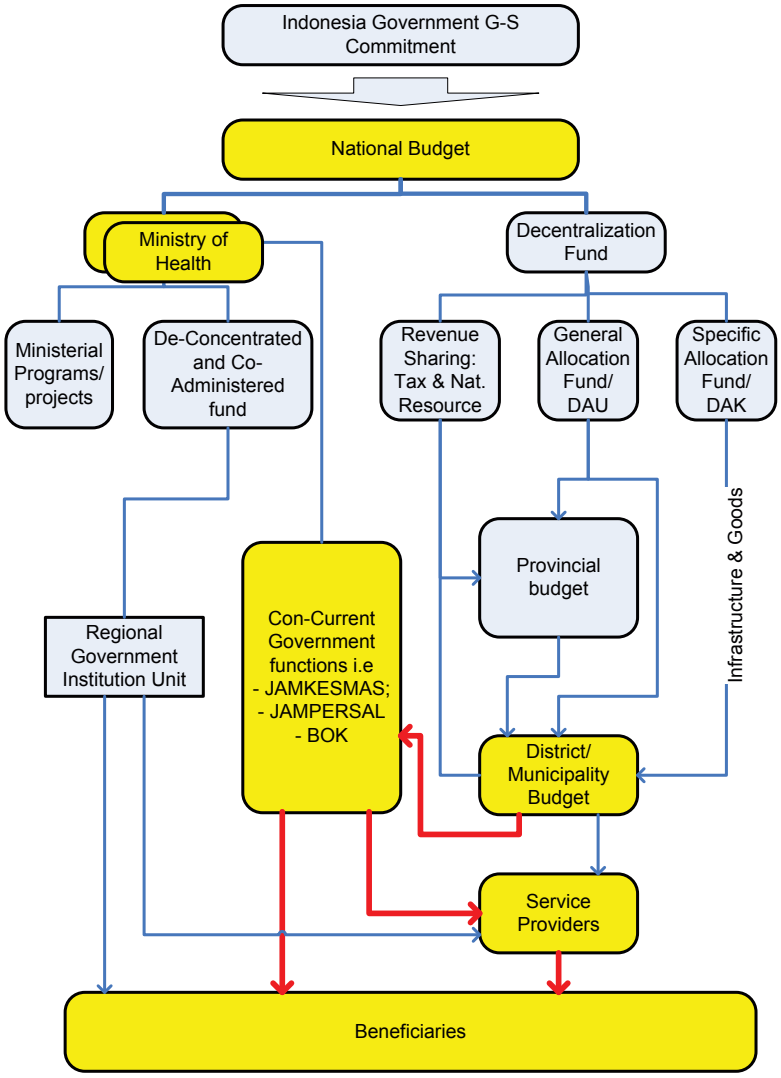
APPENDIX 1

D. Indonesia Health Status

Health Indicator	Year	Status
Life expectancy at birth, annual estimates (years)	2005	69.7
Life expectancy at birth female (years)	2007	72.4
Life expectancy at birth , male (years)	2007	68.4
Fertility rate, total (births per woman)	1970-75	5.5
	2000-05	2.4
	2007	2.6
Physicians (per 100,000 people)	2000-04	13
Contraceptive prevalence rate (% of married woman aged 15-49)	1997-2005	57
	2007	61.4
Infant mortality rate (per 1,000 live births)	1970	142
	2007	34
Infant mortality rate, poorest 20% (per 1,000 live births)		56
infant mortality rate, richest 20% (per 1,000 live births)		26
Under-five mortality rate (per 1,000 live births)	1970	172
	2007	44
Under-five mortality rate, poorest 20% (per 1,000 live births)		77
Under-five mortality rate, richest 20% (per 1,000 live births)		32
Maternal mortality ratio (per 1,000 live births)	1986	450
	1995	334
	2007	228
Births attended by skilled health personnel (%)	1997-2005	72
	2007	73
Births attended by skilled health personnel, poorest 20% (%)		43.8
Births attended by skilled health personnel, richest 20% (%)		95.4
HIV prevalence	2005	0.1
	2009	0.2

Appendix 2.

Indonesia Fiscal Decentralization Framework



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