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THE NATIONAL TEAM FOR
THE ACCELERATION OF POVERTY REDUCTION

Assessment of The Potential Effects of Policy Responses and Public Financial Management (PFM) Adjustment for The Continuation of Four Essential Public Health Services at The Primary Health Care Centre (PHC) Level during The Covid-19 Pandemic in Indonesia

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THE NATIONAL TEAM FOR THE ACCELERATION OF POVERTY REDUCTION (TNP2K)

Foreword

Since 2020, the Government of Indonesia has been adjusting its policy settings and refocusing and reallocating its budget to accelerate the COVID-19 pandemic response. These policy responses could impact on other essential health services, including maternal and child health (MCH), immunisation, nutrition, and family planning during the COVID-19 pandemic. This report aims to rapidly assess the effect of policy and financial adjustments of these four services, identify the obstacles, and recommend improvements to the delivery of health services during the pandemic.

The report consists of four chapters:

Chapter One: Introduction

This chapter presents background of the study, general and specific objectives, as well as the targeted outputs of this assessment.

Chapter Two: Framework and Methodology

Chapter 2 describes the theoretical framework, methodology, and implementation of the study. The theoretical framework is imperative for navigating the assessment process, by adopting three components of public financial management covering budget formulation, execution, and monitoring.

Chapter Three: Results and Discussion

In this chapter we present the findings from in-depth interviews and the secondary data collection process.

Chapter Four: Conclusions, Study Limitations, and Recommendations

The final chapter consists of the study conclusions, limitations, and recommendations for the relevant stakeholders to improve these essential public health services during future emergencies. These are specifically addressed to the Ministry of Health (MoH), Provincial Health Offices (PHOs), District Health Offices (DHOs), Primary Health Care Centres (PHCs), private midwifery practices, and academic researchers.

18 August 2021

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Executive Summary

COVID-19 has caused major disruption on health systems across the globe- threatening the continuation of essential health services delivery for the community as financial and other resources were absorbed for emergency responses. Previous disease outbreaks have led to additional morbidity and mortality due to the services delay as the indirect effect of resources reallocation and health systems shocks. Indonesia is no exception, as the PFM adjustments, policy frameworks, and containment measures have raised concerns on the potential effects of COVID-19 on essential public health programs in the country, including maternal and child health (MCH), immunisation, nutrition, and family planning (FP). This assessment aims to identify how the policy frameworks and PFM adjustments for Indonesia's COVID-19 pandemic response affect the delivery of these essential public health services.

Methods

We used a qualitative method to assess how the policy responses and PFM adjustments affect the continuation of essential public health services delivered at the PHC level. We conducted 28 focus group discussions (FGDs) with key informants from five Ministry of Health (MoH) units, eight District Health Offices (DHOs), 16 primary health care centres (PHCs), and 16 private midwifery practices (PMPs) in eight districts across four provinces in Indonesia.

Results

The untimely policy responses for preserving essential public health programs, and the disparity of PFM adjustment capacity at the district level has potentially hindered the implementation of essential public health services during the pandemic.

Despite these obstacles, we found that flexibility and authority for budget management across several PHCs with general public government agency (BLUD) status had made them respond more rapidly compared to other sampled sites. Aside from these identified challenges, we also found variations across districts regarding public health services' financing and services adjustment process.

Conclusions

Our study revealed alarming findings about the effect of the policy response and PFM adjustment of public health services, that caused a reduction in health services across the sampled sites. Several recommendations were proposed to improve the country's response in preserving these essential services during the current and/or future emergency.

Keywords: COVID-19, policy response, PFM, essential public health services, maternal and child health, immunisation, nutrition, family planning.

Abbreviations

APBD	*Anggaran Pendapatan Belanja Daerah* (District Budget)
APBN	*Anggaran Pendapatan Belanja Negara* (National Budget)
Bappeda	*Badan Perencanaan Pembangunan Daerah* (District Development Planning Agency)
BLUD	*Badan Layanan Umum Daerah* (Local-level General Service Agency)
BOK	*Bantuan Operasional Kesehatan* (Operational Assistance for Health)
BOKB	*Bantuan Operasional Keluarga Berencana* (Operational Assistance for Family Planning)
BPJS	*Badan Penyelenggara Jaminan Sosial* (Social Health Insurance Agency)
BPKAD	*Badan Pengelola Keuangan dan Aset Daerah* (District Financial and Asset Management Agency)
BTT	*Biaya Tak Terduga* (Contingency Fund)
DAK	*Dana Alokasi Khusus* (Special Funds Allocation)
DBHCHT	*Dana Bagi Hasil Cukai dan Hasil Tembakau* (Excise and Tobacco Profit-Sharing Funds)
DHO	District Health Office
DID	*Dana Insentif Daerah* (Regional Incentive Funds)
DPA	*Dokumen Pelaksanaan Anggaran* (Budget Implementation Document)
FGD	Focus Group Discussion
FP	Family Planning
JKN	*Jaminan Kesehatan Nasional* (National Health Insurance)
LMIC	Lower-middle-income
MCH	Maternal and Child Health
MoF	Minister/Ministry of Finance
MoH	Ministry of Health

MoHA	Ministry of Home Affairs
PCR	Polymerase Chain Reaction (Test)
PFM	Public Financial Management
PHC	Primary Health Care Centre
PHO	Provincial Health Office
PMP	Private Midwifery Practice
SHI	Social Health Insurance
TAPD	*Tim Anggaran Pemerintah Daerah* (District Government Budget Team)
VTM	Viral Transport Medium

CHAPTER ONE:

INTRODUCTION

1.1 Background

The COVID-19 pandemic has presented an unprecedented global health challenge that has caused health system shocks for many countries. As of 18 April 2021, it has infected more than 140.3 million people worldwide with a death toll of approximately 3,003,794 (WHO 2020). WHO has developed published guidelines to halt the disease transmission, yet several challenges still remain when the virus hits low- and middle-income countries (LMICs) such as Indonesia with limited capacity to prevent, detect, and respond novel pathogens (WHO 2018). The country has the highest number of npositive cases and deaths of COVID-19 in the Southeast Asia region.

Aside from the COVID-19 morbidity and mortality, there are potential indirect health consequences caused by the redirection of existing resources that have been heavily reallocated for the pandemic response. A recent study estimates that within six months of the declaration of a pandemic by WHO, it could cause 56,700 additional maternal deaths and 1,157,000 additional child deaths in 118 LMICs due to the disruption of health services delivery (Roberton et al. 2020). Health services have been disrupted in Indonesia. For example, the immunisation program has been affected in 84 per cent (4,469) of Primary Health Care Centres (PHCs) across 34 provinces since the pandemic hit the country (UNICEF 2020). While it remains unknown whether this disruption could lead to more fatal health consequences, the current finding is still alarming.

Indonesia's rapid responses through the implementation of massive public health measures and reallocating resources to COVID-19 is critical to minimising its impact.[1] This decision brings a potential trade-off as the budget cut for other public health programs is inevitable. Nevertheless, preventing indirect health effects due to the current disruption of other major public health programs is also pivotal (UNICEF 2020).

Given this situation, we conducted a study that focuses on identifying how the public financial management (PFM) response during the COVID-19 pandemic affects the delivery of MCH and FP services at the PHC level in Indonesia. This study provides evidence regarding the challenges and adjustments faced by the health workforce at the PHCs, local health officials at the district and city level, as well as policy makers at the Ministry of Health (MoH), and supports these key stakeholders to develop alternative strategies to minimise the disruption to these programs' delivery.

1.2 Objectives

This study aims to identify the challenges and adjustments that have been taken at the PHCs to deliver essential public health services delivery (covering maternal and child health, immunisation, nutrition, and family planning) during the COVID-19 pandemic in Indonesia, including:

a. Identify existing regulations or guidelines regarding the funding reprioritisation for the implementation of public health programs during the COVID-19 pandemic.
b. Identify how funding has been reprioritised and redetermined and funds refocused and reallocated.
c. Identify impact on budget reallocation towards the COVID-19 response, and its consequences on financing of essential public health services delivery.
d. Describe the potential implication of the PHCs' adjustments process, caused by budget reallocation and the large-scale social restriction policy during the COVID-19 period.
e. Identify the monitoring mechanism for the current budget spending.

[1] See Minister of Finance Decree No. 6/2020 and President Decree No. 9/2020.

1.3 Targeted Outputs

The research identified a number of targeted outputs from the study on the health financing response and impact during the COVID-19 pandemic in Indonesia:

a. Analysis on the budget formulation, execution, and monitoring process for the continuation of essential public health services delivery.
b. A cross-district analysis on the financing adjustment of the essential public health services delivery.
c. A cross-district analysis on the PHCs' adjustment practices and its implication on essential public health services delivery.

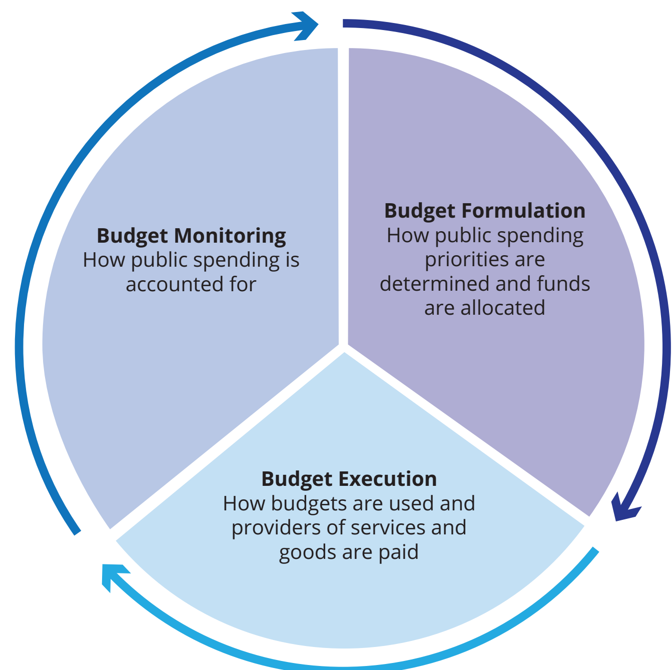
CHAPTER TWO:

FRAMEWORK AND METHODOLOGY

2.1 Theoretical Framework

We used the framework of PFM that consists of three stages: namely budget formulation, budget execution, and budget monitoring (Figure 2.1). In the stage of budget formulation, we identified the process of how the existing budget was refocused and reallocated for the COVID-19 response while, at the same time, preserving a certain level of funding to ensure the continuation of essential public health services. In the budget execution stage, we identified the process of budget disbursement and certain obstacles that might occur. For the monitoring stage, we analysed how the government monitored the budget's disbursement for delivering the services in accordance with fiscal regulations and guidelines (Cashin et al. 2017).

Figure 2.1: Public Financial Management Framework

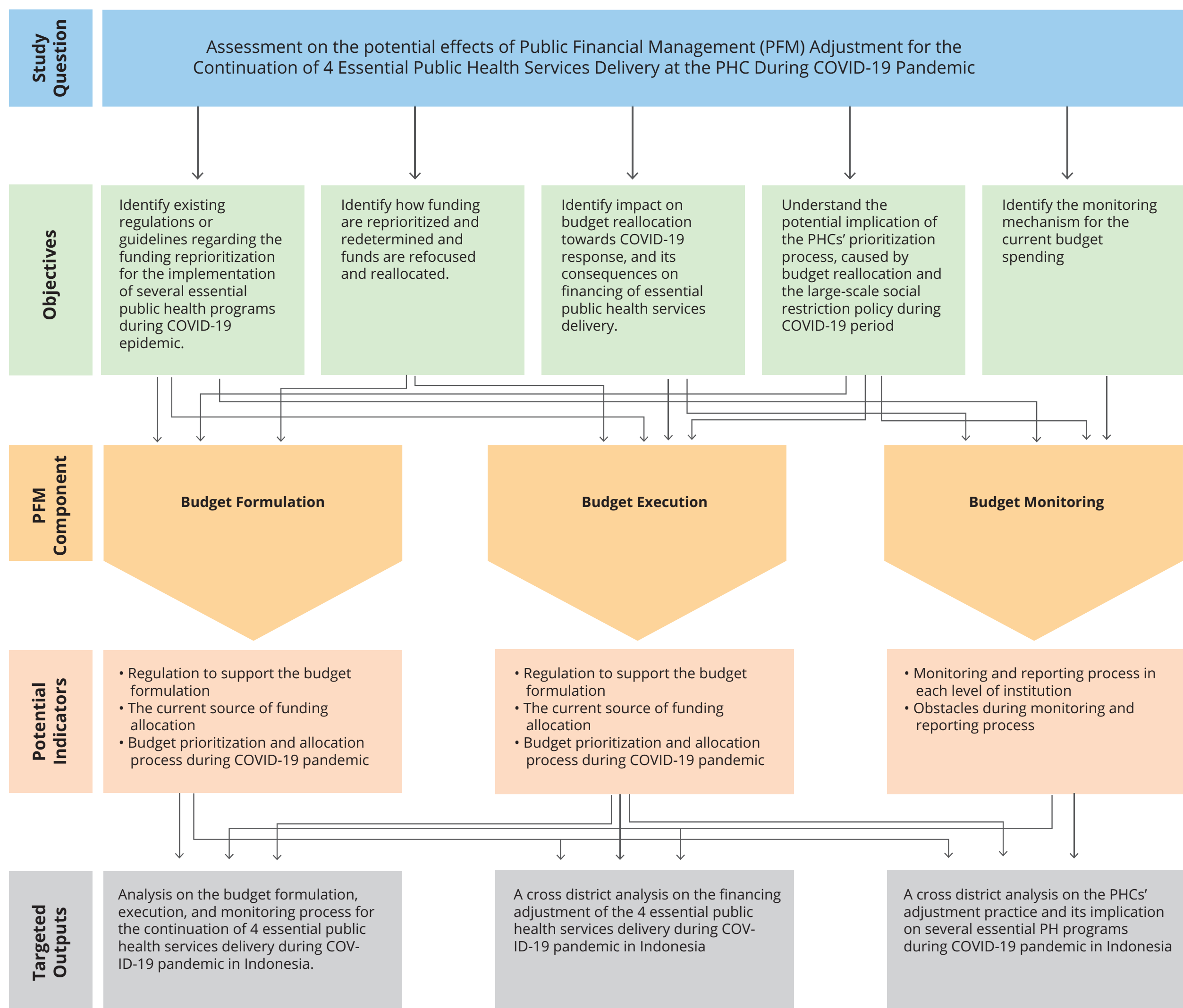


Source: (Cashin et al. 2017).

2.2 Methodology

This study employed a modified PFM framework to analysis its mechanism during the COVID-19 pandemic that might affect the continuation of essential public health services delivery at the PHC level in Indonesia. These programs are currently part of the national priorities of the Government of Indonesia (Ministry of National Development Planning 2019). We used qualitative methods through 28 focus group discussions (FGDs) with additional secondary data collection on services utilisation and budget reallocation/refocusing for the programs. Figure 2.2 below shows several indicators that we applied for the analysis.

Figure 2.2: Activity Framework



Source: Adopted from Cashin et al. 2017 with adjustment.

2.3 Study Implementation

We conducted 28 FGDs with representatives from four relevant units in the MoH, eight District Health Offices (DHOs), 16 PHCs, and 16 private midwifery practices (PMPs) in eight selected districts of four provinces that were severely affected by COVID-19 (Appendix One). The selected study sites were:

a. Jakarta Province: East Jakarta and South Jakarta City (Government of Jakarta Province, 2020).
b. West Java Province: Depok and Bandung City (Government of West Java Province, 2020).
c. East Java: Surabaya City and Sidoarjo Regency (Government of East Java Province, 2020).
d. South Sulawesi: Makassar City and Bone Regency (Government of South Sulawesi Province, 2020).

CHAPTER THREE:

RESULTS AND DISCUSSION

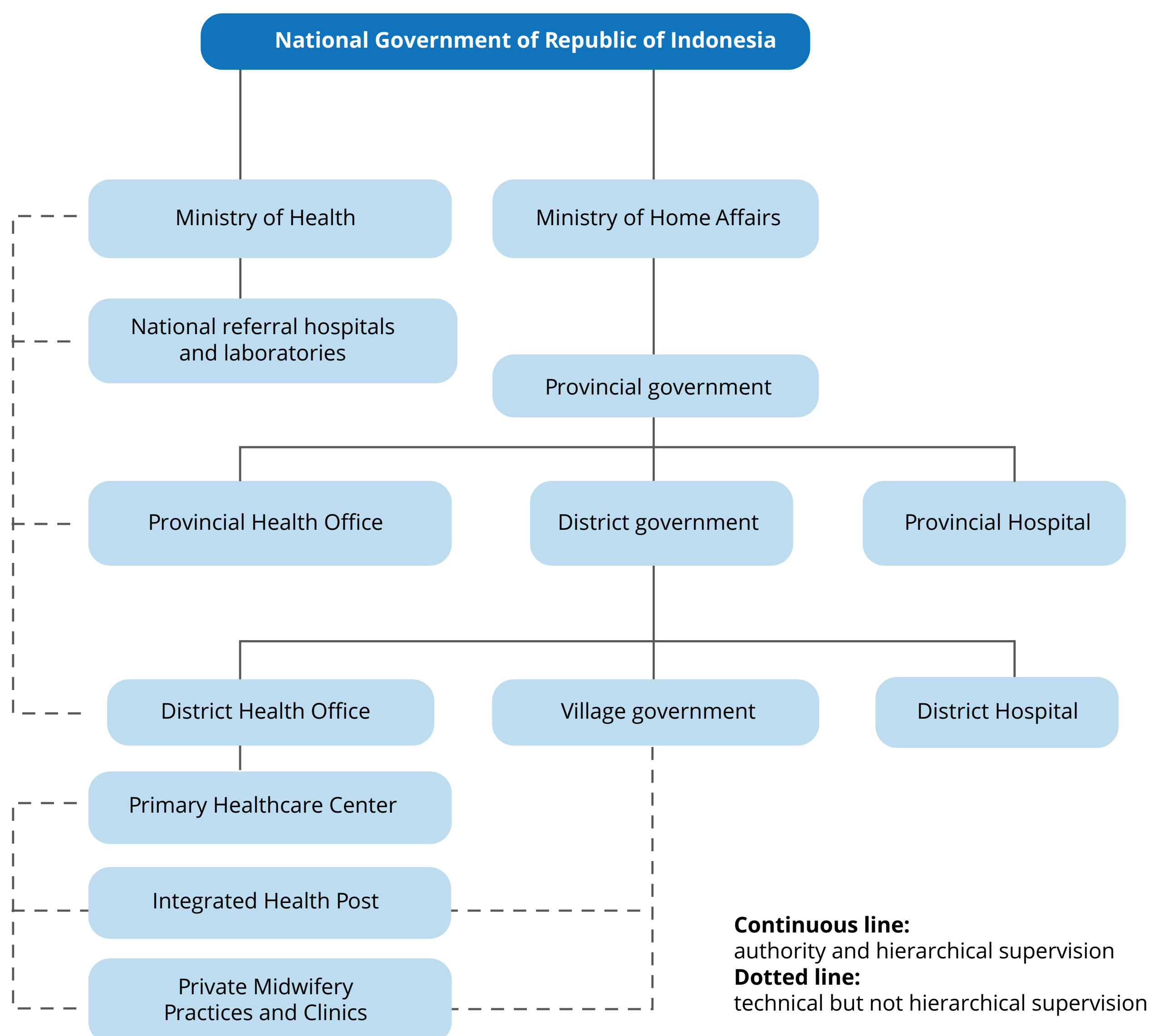
3.1 ___ Overview of Indonesia's Health Systems and Financing for Essential Public Health Services

Indonesia is a lower- and middle-income country which has had a decentralised system of governance since 1999. Due to this reform, the central government, including the Ministry of Health (MoH), has retained responsibilities for regulation, technical guidance, and supervision while devolving responsibility for service delivery to subnational governments through various disease-specific (vertical) programs. There are also several ministries involved in the health sector, usually on certain inter-sectoral programs that require coordination and collaboration among the relevant institutions.

The responsibility for planning and service delivery have been transferred to the provincial health offices (PHOs) and district health offices (DHOs) under the leadership of subnational governments, which are under the Ministry of Home Affairs (MoHA). MoHA, with technical advice from the MoH on health issues, decides the minimum standard of service that should be delivered, while the PHOs and DHOs are the technical agencies that deliver the service which is funded by the regional budget (*Anggaran Pendapatan Belanja Daerah:* APBD). In the village

government as the smallest administrative unit, the PHC with its supporting networks of integrated health posts, clinics, and PMPs serve the community at the front line (Mahendradhata et al. 2017) (Figure 3.1).

Figure 3.1: The Indonesia Health System Governance



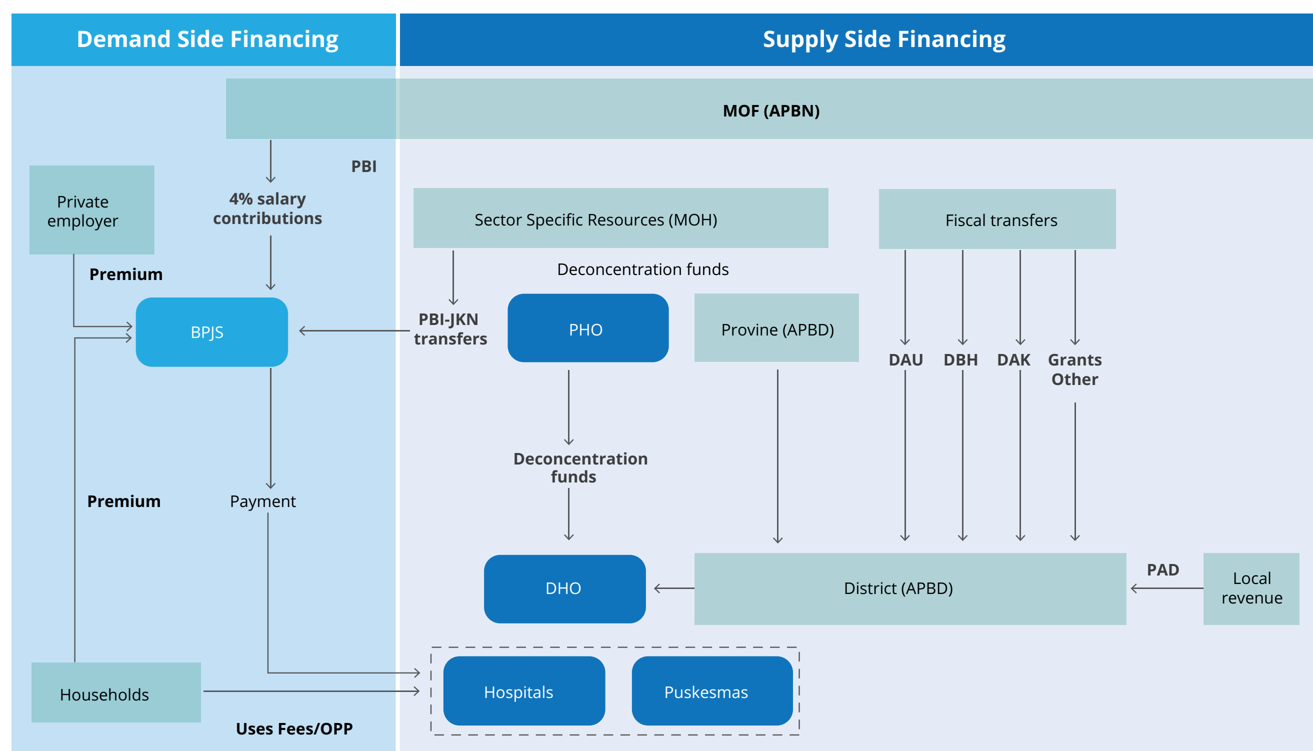
Source: Law No. 36/2009 on Health; Law No. 44/ 2009 on Hospitals; and Subnational Government Law No. 23/2014.

At the central level, approximately 5 per cent of the national budget (*Anggaran Pendapatan Belanja Negara:* APBN) is earmarked for the health sector. This budget is used to support health programs at the MoH, National Population and Family Planning Board, Food and Drug Agency, and several relevant ministries/ government institutions (Ministry for National Development Planning 2019). This earmarked budget is also allocated for the Social Health Insurance (SHI) (*Penerima Bantuan Iuran Jaminan Kesehatan Nasional: PBI JKN*) subsidy which is paid to the Indonesian Social Health Insurance Agency (*Badan Penyelenggara Jaminan Sosial Kesehatan: BPJS Kesehatan*).

A portion of the earmarked 5 per cent APBN is transferred to subnational governments to strengthen health care facilities, implement vertical disease control programs, and support the implementation of certain health programs. The transferred funds are in the form of deconcentration funds, physical special allocation funds (*Dana Alokasi Khusus Fisik: DAK Fisik*), and non-physical special allocation funds (*Dana Alokasi Khusus Non-fisik: DAK Non-fisik*) in the form of health operational assistance (*Bantuan Operasional Kesehatan: BOK*) (Mahendradhata 2017). There is an additional DAK specifically for family planning operational assistance (*Bantuan Operasional Keluarga Berencana*: BOKB). This budget covers the costs for FP counselling centres, the distribution of contraceptive devices, activity implementation at FP villages, operational budget for cadres and FP field workers, as well as health promotion activities related to FP (Head of FP Board Decree No. 1/2019).

In addition to the earmarked national budget allocation, 10 per cent of the APBD is allocated to health and managed by MoHA. This budget is allocated to support the health programs and its operational components at PHOs/DHOs and PHCs (Ministry for National Development Planning 2019). A certain amount of their budget is also received by the PHC in the form of JKN capitation funds sent by BPJS *Kesehatan*. This budget is used to pay for health care services and its supporting operational activities at the PHC level (Minister of Health Regulation No. 21/2016). A summary of the health financing flow for essential public health programs is seen in Figure 3.2.

Figure 3.2: Health Financing Flow for Essential Public Health Programs



Source: Modified from World Bank 2020.

3.2 Overview of COVID-19 Key Policy Responses in Indonesia

The COVID-19 key policy responses at the beginning of the pandemic were mainly focused on pandemic mitigation rather than strategies to preserve essential public health services. When COVID-19 was reported in Wuhan early in 2020, the Government of Indonesia had actually planned several strategies, evidenced by the issuance of pandemic preparedness technical guidelines during January – February 2020. After the first case reported on 2 March 2020, further fiscal and technical policy frameworks were developed, however, the technical guidance for essential public health services adjustment was issued at the end of April – May 2020, approximately two months after the disease hit the country (Figure 3.3). Local governments had also been waiting for direction from the central level, regardless of the current decentralisation system that should ideally have provided them the authority to take their own decisions in preserving essential services in their areas.

Figure 3.3: Timeline of Key Policy Responses (January – June 2020)

Source: Author's analysis, 2020.

3.3 Budget Formulation, Execution, and Monitoring Process During COVID-19 Pandemic

This section explains the fiscal regulatory frameworks, as well as the budget formulation, execution, and monitoring process to ensure the continuation of essential public health services delivery during the COVID-19 pandemic.

3.3.1 Fiscal regulatory frameworks

The Central Government of Indonesia has issued 15 regulations and technical guidelines on budget refocusing and reallocation, as well as to follow-up and accelerate the implementation of fiscal policy actions for COVID-19 responses. At the central level, all ministries or agencies were asked to adjust their national budget sourced from *rupiah murni* [2] revenues to support the COVID-19 response based on the Minister of Finance (MoF) Circular Letter No. S-302/MK.02/2020 on 15 April 2020. Moreover, local governments were given the authority to refocus and reallocate their usage of the APBD and were funded with transfers to the regions based on several regulations.

The budget was adjusted for expenditure items that were hampered by the COVID-19 pandemic and were considered of low priority. These included official travel expenditures, meeting package payments and honorariums, other goods expenditures, non-operational expenditures, and capital expenditures for development activities/projects. The regulations that gave effect to these adjustments are listed in Appendix Two. The fiscal regulatory framework allocated approximately Rp 87.55 trillion for a COVID-19 response package to purchase medical equipment such as Personal Protective Equipment (PPE), test kits, reagents, and ventilators, strengthen hospital infrastructure for treating COVID-19 patients, and to provide incentives for health workers, and SHI subsidies for informal sector workers (Ministry of Finance 2020).

[2] *Rupiah murni* (pure rupiah) refers to all government revenues, net of project financing derived from foreign and/or domestic loans.

3.3.2 Budget formulation process at the central level

Budget formulation at the Ministry of Health

In response to regulations related to the acceleration of COVID-19 responses, MoH conducted a budget efficiency analysis and shifted funds between organisational units, functions, and/or between programs. The budget efficiency saving in 2020 was around Rp 2.9 trillion in accordance with the Minister of Finance Letter No. S-302/MK.02/2020 dated 15 April 2020. A total of Rp 212 billion from this efficiency savings was allocated to support COVID-19 mitigation, such as through the procurement of PPE, epidemiological investigations, support for the implementation of activities at the Port Health Office, provision of isolation rooms, and procurement of ventilators.

The MoH seeks to keep the available budget sufficient to fund basic priority activities, including ensuring the continuation of MCH and FP programs, yet potential challenges occur. The remaining budget is estimated to be sufficient to fund employee expenditure and office operational expenditure, while budget support for mobilisation activities namely supervision, advocacy, outreach, dispatch of health workers, and training must undergo refocusing and reallocation. This condition has the potential to not only hamper the sustainability of the implementation of priority programs in the field, but also poses challenges in meeting those program's performance indicators according to the set targets.

Budget formulation at the Family Health Directorate

The budget at the Family Health Directorate underwent refocusing reaching more than 50 per cent of the total budget**.** As a result, the activity budget for the MCH program under the directorate is more focused on the procurement of MCH books. Implementation of guidelines and policy socialisation activities, training, or capacity building for health workers, monitoring and evaluation of program implementation in the regions must be held virtually because of the reallocation of deconcentrated funds. Donor-based funding support is still very reliable for the implementation of the MCH program, namely from USAID, UNICEF, WHO, UNFPA, and others. Donor-sourced funding is directed to support the implementation of activities at the service level, for example to increase the knowledge of PHCs in providing services, as well as compiling and socialising the MCH program service manuals during the pandemic to health facilities.

Budget formulation at the Surveillance and Health Quarantine Directorate related to immunisation services

Prior to the pandemic, approximately 80 per cent of the Ministry of Health's immunisation program budget was allocated to procuring vaccines while the balance of 20 per cent supported operational activities. The majority of funding comes from "*rupiah murni*". There are also donor funding contributions for the immunisation program from UNICEF, WHO, and GAVI in the form of technical assistance for immunisation program managers, procurement and logistics management of immunisations, and procurement of new vaccines.

Challenges remain due to the refocusing and reallocation process that has affected the operational activities of this program. The MoH has been trying to ensure that the vaccine procurement budget, especially for the procurement of a complete basic immunisation vaccine, is not affected by the refocusing and reallocation process. Nevertheless, the routine budget for the immunisation program for operational activities and program mobilisation is only about 4-5 per cent of the total budget because it has had to be refocused. As a result, activities related to the expansion of the new vaccine introduction campaign have yet to be carried out, and training activities for immunisation implementers and program monitoring and evaluation must also be held virtually.

Budget formulation at the National Population and Family Planning Board

According to the FP Circulation Letter No. 9/2020, the BOKB allocation was reduced from Rp 1,967,367,255,000 to Rp 1,888,673,255,000. The budget components that were affected consist of the operational budget at FP villages and budget support for information, education, and communication (IEC) (Table 3.1).

Table 3.1: Reallocation of FP Operational Budget/BOKB

No.	Program	Targeted Beneficiaries	Number of Targets	Initial Budget	Reallocated Budget	Budget Modification
1	FP Counselling Centres	Counselling centres	5,517	603,820,540,000	603,820,540,000	
2	Distribution of Contraceptive Devices	Health care facilities	18,001	43,404,876,000	43,404,876,000	
3	FP villages operational activities	Sub-district	7,144	676,710,851,000	598,079,230,000	78,631,621,000
	Stunting control at FP villages	Village	2,580	56,104,570,000	56,104,570,000	
4	FP community programs by cadres	Village	83,065	498,390,000,000	498,390,000,000	
5	Management support	District FP office	507	52,727,640,000	52,727,640,000	
6	FP Information, Education, and Communication (IEC)	Sub-district	7,144	36,208,778,000	36,146,399,000	62,379,000
Total Budget (Rp)				**1,967,367,255,000**	**1,888,673,255,000**	**78,694,000,000**

Source: Head of FP Circulation Letter No. 9/2020.

The budget reallocation on FP villages operational and IEC activities might disrupt those programs, particularly their ability to lift the numbers of new FP acceptors, ensure the compliance of existing FP acceptors, and reduce the unmet need for FP services among the village community. The National Population and Family Planning Board had sought to ensure that the contraceptive devices distribution budget was not affected by the reallocation process. Nevertheless, as the budget for operational activities is being cut, it is imperative to anticipate its effect on meeting the performance indicators at the FP villages.

3.3.3 Budget formulation process at the DHOs and PHCs level

This section discusses the budget formulation process at the DHO and PHC level that covers central transfer funds (*DAK fisik and non-fisik/BOK*), and APBD. In addition, we will explain the flexibility of those PHCs with the status of a local-level general services agency *(Badan Layanan Umum Daerah:* BLUD) to formulate their budget independently.

Central transfer funds (DAK fisik and non-fisik (BOK and BOKB))

The DHOs could refocus and reallocate the *DAK fisik and non-fisik (BOK and BOKB)* through the MoF online applications. MoF and MoH have provided guidance to local governments to submit changes to the special allocation fund's activity plan for the health sector through the online applications by adding a menu of COVID-19 prevention and/or treatment activities.

Local government budget (APBD)

As a part of their COVID-19 response, district governments should declare a health emergency in their administrative area. This would be the prerequisite to refocus and reallocate their local government budget (APBD) and other legal sources to be used as COVID-19 contingency funds (*Biaya Tak Terduga:* BTT) (Ministry of Home Affairs 2020). The operational costs in the local budget that have been refocused and reallocated include business trip spending, meeting activities that invite a lot of people (socialisation, workshops, technical guidance, training, FGDs), and rationalisation in the type of capital expenditure, namely spending on procurement of vehicles and office equipment, building renovations, and other infrastructure development that can be postponed until the next fiscal year.

The DHOs submitted the refocused and reallocated local budget to the District Government Budget Team (*Tim Anggaran Pemerintah Daerah*: TAPD). The team consists of the District Secretary as chair of the team, as well as representatives from the District Financial and Asset Management Agency (*Badan Pengelola Keuangan dan Aset Daerah*: BPKAD), the District Development Planning Agency (*Badan Perencanaan Pembangunan Daerah*: Bappeda), and the other institutions according to local management needs. The role of the TAPD is to verify and approve the revised local government budget submitted by the DHO and other district offices.

As per June 2020, the refocusing and reallocation process has been carried out in every sample district. This includes once in four districts (East Jakarta, South Jakarta, Surabaya City, Bone Regency), twice in one district (Makassar City), four times in two districts (Depok City and Sidoarjo Regency), and five times in one district (Bandung City). With the exception of Surabaya, all districts changed the budget during the refocusing process.

Constraint in conducting the budget refocusing and reallocation process at the district level

Our study found that the sampled districts faced difficulty with the refocusing and reallocation process. Prior to the pandemic, the PFM capacity of districts' officials had been a constraint that hindered the quality of health spending to achieve the targeted goals (World Bank 2020). This existing challenge was exacerbated during the pandemic as they faced difficulty doing multiple budget revisions for different funding types-consisting of the DAK and APBD-with its specific rules. Although the budgets were rapidly revised, the disbursement could take longer than one day which was not aligned with the guidance of the central government (Minister of Home Affairs Regulation No. 20/2020).

As an alternative, several districts utilised other budget sources for their COVID-19 response. The Surabaya DHO used their 2019 budget after determining that the remaining budget was sufficient to meet the needs of the DHO and PHCs during the first three months of the pandemic. The Sidoarjo DHO received a grant from the province to provide rapid tests which were prioritised for third trimester pregnant women. Funding support for handling COVID-19 at the Depok DHO was quite varied. Depok DHO used the Excise and Tobacco Profit-Sharing Funds (*Dana Bagi Hasil Cukai dan Hasil Tembakau*: DBHCHT) to support the implementation of the Polymerase Chain Reaction (PCR) test. In addition, there were Regional Incentive Funds (*Dana Insentif Daerah*: DID) and governor's assistance for the procurement of rapid tests and Viral Transport Medium (VTM). The DHO also procured disinfecting chambers by reallocating DAK *fisik* allocations for the procurement of a sanitarian kit.

The study found that the percentage change in the district budget resulting from the revision process varied across districts. Table 3.2 below summarises the result of the budget refocusing and reallocation (sourced from BOK, APBD, and other budget channels) process at the DHO level for each program, while Table 3.3 presents information regarding the result of the BOKB reallocation for the FP program. We found a significant decline above 50 per cent on several programs, such as FP in East and South Jakarta, MCH and nutrition in Bandung, and immunisation in Sidoarjo.

Table 3.2: Outcome of Budget Refocusing and Reallocation at DHO Level

Districts/Cities	Maternal and Child Health		Budget Modification
	Pre	Post	
East Jakarta	277,820,000	192,240,000	-30.8%
South Jakarta	277,820,000	192,240,000	-30.8%
Bandung	595,050,350	163,377,000	-72.5%
Depok	1,174,667,500	670,073,900	-43.0%
Surabaya	34,268,460,192	34,268,460,192	-
Sidoarjo	1,654,995,200	1,196,876,400	-27.7%
Makassar	1,178,863,000	1,060,413,000	-10.0%
Bone	1,748,826,000	1,743,536,000	-0.3%

Districts/Cities	Immunisation		Budget Modification
	Pre	Post	
East Jakarta	25,200,000	25,200,000	-
South Jakarta	25,200,000	25,200,000	-
Bandung	432,100,000	289,320,000	-33.0%
Depok	617,372,000	355,088,000	-42.5%
Surabaya	802,969,349	802,969,349	-
Sidoarjo	600,418,800	1,011,925,600	+68.5%
Makassar	Not reported	Not reported	Not reported
Bone	16,000,000	10,000,000	-37.5%

Districts/Cities	Nutrition		Budget Modification
	Pre	Post	
East Jakarta	11,900,000	11,900,000	-
South Jakarta	11,900,000	11,900,000	-
Bandung	218,745,030	47,870,000	-78.1%
Depok	1,263,225,300	997,115,800	-21.1%
Surabaya	5,354,356,869	5,354,356,869	-
Sidoarjo	3,634,927,600	5,192,735,608	+42.9%
Makassar	4,149,396,256	4,149,396,256	-
Bone	35,240,000	21,740,000	-38.3%

Districts/Cities	Family Planning		Budget Modification
	Pre	Post	
East Jakarta	6,276,236,278	2,992,788,543	-52.3%
South Jakarta	6,276,236,278	2,992,788,543	-52.3%
Bandung	Not reported	Not reported	Not reported
Depok	Not reported	Not reported	Not reported
Surabaya	4,989,600	4,989,600	-
Sidoarjo	Not reported	Not reported	Not reported
Makassar	Not reported	Not reported	Not reported
Bone	2,710,000	2,710,000	-

Source: Author's analysis, 2020.

Table 3.3: Outcome of BOKB Refocusing and Reallocation for FP Program at District FP Office

Districts/Cities	Family Planning		Budget Modification
	Pre	Post	
East Jakarta	Not allocated	Not allocated	-
South Jakarta	Not allocated	Not allocated	-
Bandung	4,299,214,000	4,212,364,000	-2%
Depok	2,850,353,000	2,818,508,000	-1.1%
Surabaya	4,051,322,000	3,961,732,000	-2.2%
Sidoarjo	4,244,872,000	4,192,852,000	
Makassar	2,990,400,000	2,619,360,000	
Bone	8,182,774,000	8,104,204,000	-1%

Source: Minister of Finance Regulation No. 35/2020 and Head of National Population and Family Planning Board Regulation No. 11/2019.

The flexibility of BLUD PHCs to conduct budget formulation

With the exception of the PHCs in Surabaya and Bone District, all other PHCs in this study had the financial management status of a BLUD. The status gives the PHCs the authority and flexibility to manage and spend their revenue consisting of services, grants, collaboration income with other parties, the SHI capitation funds, local government budget (APBD), central transfer funds (BOK), and other legal revenue sources. Prior to the pandemic, the PHCs stated that the BLUD's revenue was prioritised for operational expenditure (payment for electricity, telephone, water, and internet) and supported the implementation of curative care or other health services conducted within the PHCs' building. During the pandemic, all PHCs stated that this revenue was also used to support COVID-19 responses.

PHCs with the BLUD status could revise the Budget Implementation Document (*Dokumen Pelaksanaan Anggaran*: DPA) independently. This would lead to a faster budget execution process for their COVID-19 response and allow them to maintain essential health services. The opposite situation was found with non-BLUD PHCs as they had to proceed with the budget revision and then wait for approval from the district team.

As was the case with the results at district level, 16 PHCs had varied outcomes from the budget refocusing and reallocation process. Table 3.4 and 3.5 below summarise the result (sourced from multiple funds except the BOKB) at the PHCs level for each program. The BOKB itself was not channelled to the PHC. A significant decline above 50 per cent was found at several PHCs, such as South Jakarta PHCs (covering four programs), and a Depok PHC (covering immunisation). Regarding immunisation, PHCs in South Jakarta and Depok deleted the allocation as they were relying from APBD at the DHO level.

Table 3.4: Outcome of Budget Refocusing and Reallocation from Multiple Sources of Funding for MCH and Immunisation at PHC Level

Maternal and Child Health						
Districts/ Cities	PHC 1		Budget Modification	PHC 2		Budget Modification
	Pre	Post		Pre	Post	
East Jakarta	48,135,000	48,135,000	-	309,070,000	238,770,000	-22.7%
South Jakarta	89,675,000	25,575,000	-71.5%	78,314,730	78,314,730	-
Bandung	72,000,000	72,000,000	-	25,650,000.00	25,650,000.00	-
Depok	6,825,000	4,146,000	-39.3%	225,045,000	207,045,000	-8.0%
Surabaya	Still on process as per June 2020					
Sidoarjo	115,645,000	114,480,000	-1.0%	211,590,000	196,590,000	-7.1%
Makassar	176,454,000	147,045,000	-16.7%	Not reported	Not reported	Not reported
Bone	34,320,000	29,400,000	-14.3%	63,520,000	55,240,000	-13.0%

Immunisation						
Districts/ Cities	PHC 1		Budget Modification	PHC 2		Budget Modification
	Pre	Post		Pre	Post	
East Jakarta	48,667,400	48,667,400	-	2,820,000	2,820,000	-
South Jakarta	1,080,000	-	-100%	23,799,000	23,799,000	-
Bandung	-	-	-	8,305,000	8,305,000	-
Depok	3,150,000	-	-100%	37,617,000	37,617,000	-

Immunisation						
Districts/ Cities	PHC 1		Budget Modification	PHC 2		Budget Modification
	Pre	Post		Pre	Post	
Surabaya	Still on process as per June 2020					
Sidoarjo	14,990,000	14,990,000	-	32,460,000	32,460,000	-
Makassar	28,110,000	23,425,000	-16.7%	Not reported	Not reported	Not reported
Bone	29,520,000	24,600,000	-16.7%	17,400,000	14,360,000	-17.5%

Source: Author's analysis, 2020.

Table 3.5: Outcome of Budget Refocusing and Reallocation from Multiple Sources of Funding for Nutrition and Family Planning at PHC Level

Nutrition						
Districts/ Cities	PHC 1		Budget Modification	PHC 2		Budget Modification
	Pre	Post		Pre	Post	
East Jakarta	48,135,000	48,135,000	-	309,070,000	238,770,000	-22.7%
South Jakarta	89,675,000	25,575,000	-71.5%	78,314,730	78,314,730	-
Bandung	72,000,000	72,000,000	-	25,650,000.00	25,650,000.00	-
Depok	6,825,000	4,146,000	-39.3%	225,045,000	207,045,000	-8.0%
Surabaya	Still on process as per June 2020					
Sidoarjo	109,460,000	109,460,000	-	40,825,000	40,825,000	-
Makassar	600,000	500,000	-16.7%	Not reported	Not reported	Not reported
Bone	6,060,000	6,060,000	-	1,840,000	1,840,000	-

Family Planning						
Districts/ Cities	PHC 1		Budget Modification	PHC 2		Budget Modification
	Pre	Post		Pre	Post	
East Jakarta	7,500,000	7,500,000	-	-	-	-
South Jakarta	12,009,000	2,850,000	-76.3%	109,028,000	109,028,000	-
Bandung	500,000	500,000	-	-	-	-
Depok	1,260,000	1,260,000	-	-	-	-
Surabaya	Still on process as per June 2020					
Sidoarjo	7,840,000	7,840,000	-	17,345,000	17,345,000	-
Makassar	-	-	-	Not reported	Not reported	Not reported
Bone	1,800,000	1,800,000	-	-	-	-

Source: Author's analysis, 2020.

Budget execution and services adjustment

The budget change, diversion of staff to meet the COVID-19 response, and lack of technical guidelines for essential services delivery at the beginning of the pandemic led to significant adjustments at the PHC level. Our sampled sites reported that several PHCs staff responsible for the provision of MCH services were mobilised to help the surveillance team conduct COVID-19 disease detection and contact tracing. To reduce the burden on staff at PHCs, most facilities limited the number of patients' visits per day, and prioritised treatment for emergency cases. Other activities were conducted by health cadres and private midwives. Some of the adjustments to services are listed in Table 3.6.

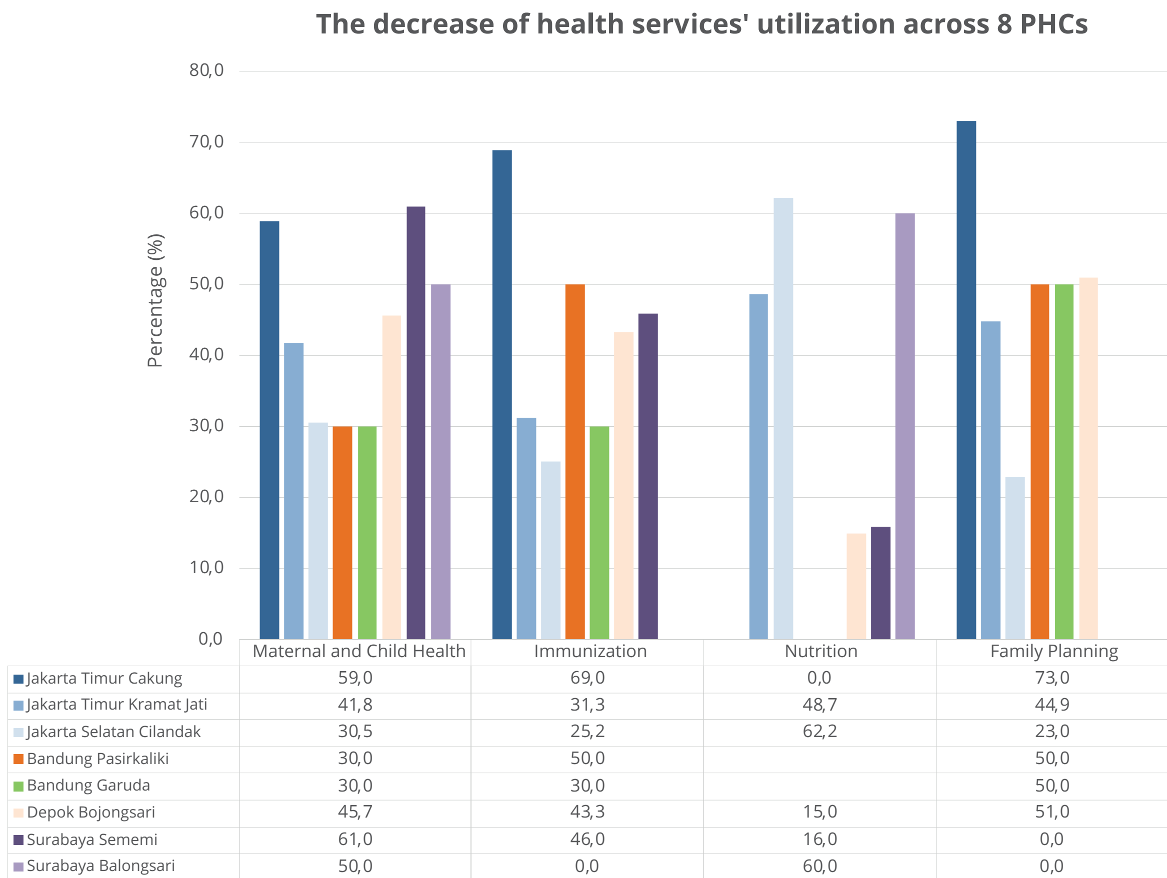
Table 3.6: Services Adjustment at the PHCs Level

Public Health Services	General Finding
Maternal and child health	a. Prioritising antenatal care and treatment for emergency maternal cases. b. Most consultation conducted through virtual platform such as phone call or instant messaging application.
Immunisation	a. Immunisation services at integrated health post and schools had been postponed, and diverted to: b. Immunisation at the PHCs; c. Home visit; or d. No immunisation at all.
Nutrition	a. The distribution of food supplement for pregnant women and malnourished children conducted by the cadres. b. Across our sampled sites, the distribution of Fe tablet for female teenagers was postponed.
Family Planning	a. Short-term contraceptive methods (pill, injection, condom) had been recommended compared to the long-acting methods (IUD, implant). b. Cadres, private midwives, and FP counsellors help in distributing the contraceptive devices to FP acceptors. c. FP services for injection, IUD, and implant was implemented using scheduling system to prevent patients' crowding at the facilities.

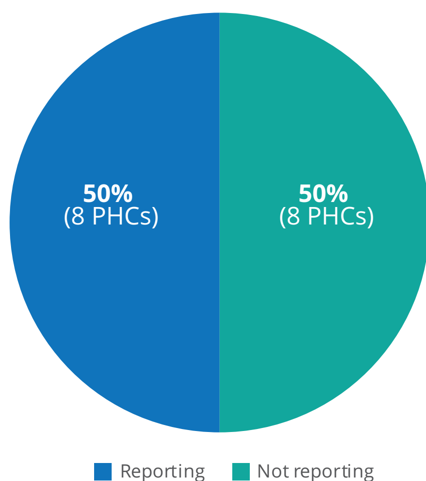
Source: Author's analysis, 2020.

These adjustments led to reduction in services at our sampled sites. Among 16 PHCs that were involved in our study, only eight provided data regarding the change in service utilisation pre-COVID and during the pandemic. A contraction in health services for these four essential public health programs was consistently found at these eight PHCs (Figure 3.4).

Figure 3.4: Change in Health Service Utilisation Across Eight PHCs



	Maternal and Child Health	Immunization	Nutrition	Family Planning
Jakarta Timur Cakung	59,0	69,0	0,0	73,0
Jakarta Timur Kramat Jati	41,8	31,3	48,7	44,9
Jakarta Selatan Cilandak	30,5	25,2	62,2	23,0
Bandung Pasirkaliki	30,0	50,0		50,0
Bandung Garuda	30,0	30,0		50,0
Depok Bojongsari	45,7	43,3	15,0	51,0
Surabaya Sememi	61,0	46,0	16,0	0,0
Surabaya Balongsari	50,0	0,0	60,0	0,0



Source: Author's analysis, 2020.

Another issue that was found during this study was a lack of support for PMPs in delivering midwifery services. Although they are acknowledged as a part of the PHC's service network (Ministry of Health Regulation No. 75/2014 on PHCs), there was no financial support for PPE procurement given to these providers and relied on donations from professional associations, NGOs, and the private sector instead. Most of them also used their personal savings for procuring the PPEs and continuing services. In addition, only two out of 16 PMPs received direct monitoring from the midwife coordinator at PHCs, while

two PMPs were not monitored at all either directly or virtually. Despite limited supervision, they were still obligated to report the services delivery regularly to the PHCs. Many also noted that they did not receive the distribution of rapid test kits from the PHCs or information about suspected COVID-19 patients nearby. The rapid test kits and updated information of COVID-19 transmission in their area was critical for the patients triage process and preventing midwives from contracting COVID-19.

This lack of support led to financial difficulty and services reduction across the PMPs. Fourteen PMPs admitted that their income had decreased due to the reduction in services utilisation, as well as PPE expenses that they purchased independently. A PMP in Depok even closed the practice temporarily as the owner did not want to bear the risk of a COVID-19 cluster emerging in her clinic due to limited PPE. Some of the services adjustments found across the PMPs by this study are presented in Table 3.7.

Table 3.7: Services Adjustment at the PMPs Level

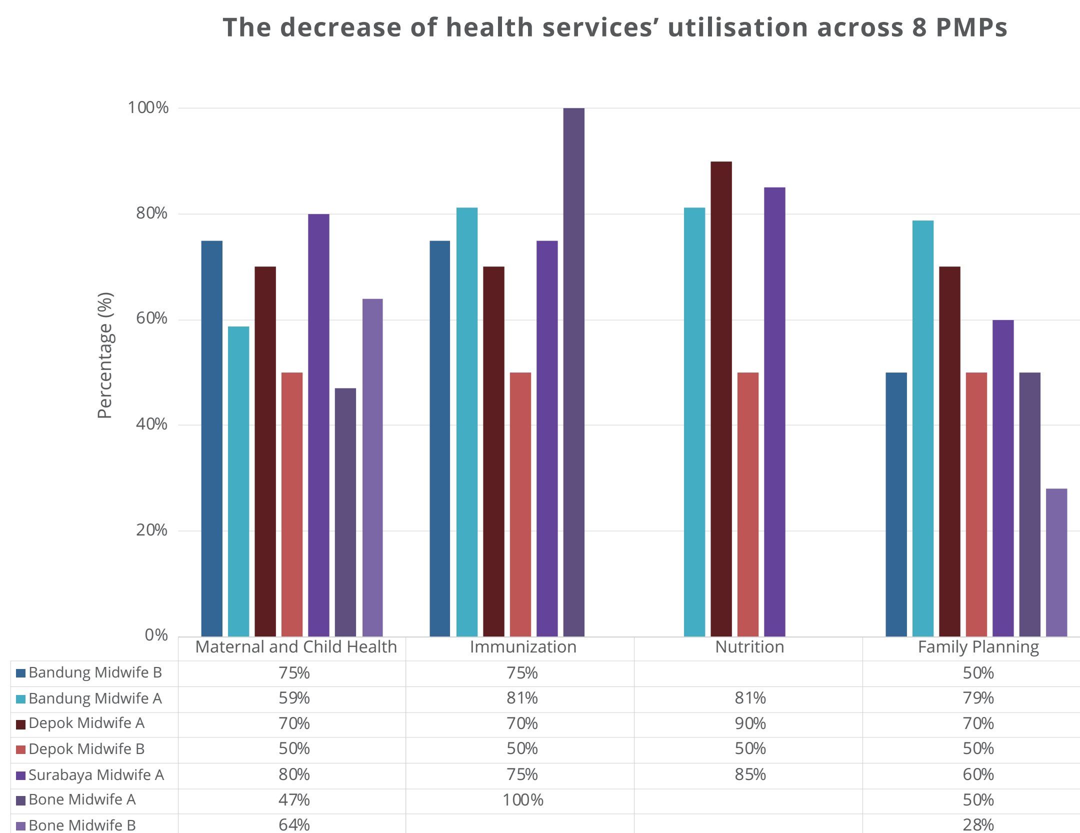
Public Health Services	General Finding
Maternal and child health	a. Antenatal care services were provided through an instant messaging application, unless there was an emergency need. b. Birth services were only carried out for pregnant women with no symptoms of COVID-19. Suspected COVID-19 patients will be immediately referred to the PHCs or hospital. The unavailability of rapid test kits might, however, lead to an asymptomatic patient being undetected and posing a risk to the midwives.
Immunisation	a. Immunisation conducted by initial agreement or home visit. b. Most PMPs only provided immunisation covering BCG and HB0 among all other types of immunisation services. c. PMPs admitted that many clients postponed the services due to fear of COVID-19.
Nutrition	a. Two PMPs in Bone and Bandung reported not conducting child development monitoring services. b. Other PMPs admitted that the growth and development assessment were implemented during patients' check-up or immunisation services.

Public Health Services	General Finding
Family Planning	a. The service was carried out by appointment, especially for IUD and implant methods. b. One PMP in Bandung and one in Depok only provide injection and pills methods. c. FP counselling was carried out through an instant messaging application.

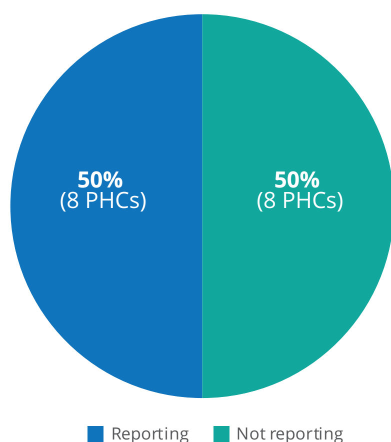
Source: Author's analysis, 2020.

The pandemic actually provided an opportunity to expand PMP services due to the diversion of patients who usually visit PHCs and hospitals, and yet service reductions were found across the sampled sites. Midwives noted that many patients were afraid to visit their clinics due to the COVID-19 pandemic. Of the 16 PMPs that were involved in our study, only eight provided data regarding the change in service utilisation pre-COVID and during the pandemic. The decrease of health services for four programs was consistently found at these eight PMPs (Figure 3.5).

Figure 3.5: Change in Health Services Utilisation Across Eight PMPs



	Maternal and Child Health	Immunization	Nutrition	Family Planning
Bandung Midwife B	75%	75%		50%
Bandung Midwife A	59%	81%	81%	79%
Depok Midwife A	70%	70%	90%	70%
Depok Midwife B	50%	50%	50%	50%
Surabaya Midwife A	80%	75%	85%	60%
Bone Midwife A	47%	100%		50%
Bone Midwife B	64%			28%



Source: Author's analysis, 2020.

Budget and program monitoring process

Budget monitoring

Lack of budget monitoring had been a systemic constraint for evaluating the quality of health spending prior to, and during, the COVID-19 pandemic. Prior to the pandemic, fragmentation of the PFM system had become a concern as it is difficult to assess budget efficiency. There were significant differences between the proposed health budget compared to the actual allocation during 2014-16, which indicates challenges and adjustments in the budget planning and execution process.

In addition, the budget and targeted performance are reviewed by separated institutions. The MoF is responsible for reviewing the financial aspects, whereas the MoH and local government have the role of reviewing performance. There is also a lack of integrated data to track the appropriateness and efficiency of budget spending (World Bank 2020).

During the pandemic, a COVID-19 budget dashboard at the central and local level is imperative to ensure transparency and accountability of the budget revision process. This would: (i) keep the budget changes on track; (ii) ensure the process remains aligned with the targeted pandemic response; (iii) provide real-time data for any necessary improvements; and (iv) ensure other essential health services do not suffer further due to insufficient funding.

The availability of this platform would also allow the public, including academia and NGOs, to monitor the budget spending performance. It will facilitate them to contribute suggestions for improvement to the government (Ministry of National Development Planning 2020).

Furthermore, when the COVID-19 pandemic is declared over, the government should consider the importance of establishing an effective budget tracking mechanism to ensure the accountability, appropriateness, and efficiency of health spending across different administrative levels (World Bank 2020; Barroy et al. 2020).

Program monitoring

Our study provided information regarding the services reduction during the second quarter of 2020 across the sampled sites Similar results have been reported from other studies conducted in different areas in Indonesia (Saputri et al. 2020; Ministry of Health and UNICEF 2020a). This situation might hinder the accomplishment of targeted health indicators in the national medium-term development plan 2020 – 2024.

Real-time program monitoring through an integrated health information system is critical for monitoring the progress of essential public health services delivery during the pandemic. During the pandemic, PHCs as the front-line provider received support from cadres and private midwives to monitor patients' health status through online messaging platforms. The reporting accuracy should be maintained to ensure data reliability. The collected data should be utilised to develop a strategy for: (i) problem identification in a timely manner (Kruk 2008); (ii) preserving the continuation of these essential services; and (iii) catching up on progressing the service indicators in the national medium-term development plan 2020-2024. The MoH state that they are starting to build the one integrated health data system among entities and programs to reduce fragmentation in reporting mechanism.

CHAPTER FOUR:

CONCLUSIONS, STUDY LIMITATIONS, AND RECOMMENDATIONS

4.1 Conclusions

Untimely policy responses to preserve essential public health services have affected the implementation of four essential public health programs during the first three months of the pandemic. In addition, there was lack of leadership from local government to take decisions in preserving these essential services because they were awaiting direction from central government. We found various changes in the implementation of essential public health programs in different districts across Indonesia. Although PHCs and PMPs in our study demonstrated their effort to maintain essential public health programs, there were inevitable disruptions to the delivery of services.

Furthermore, this pandemic has shown how essential is PFM capacity at the local level, as well as flexibility and authority for budget management. When district governments struggled to conduct multiple budget revision with different rules, both PHCs with BLUD or non-BLUD status also faced challenges in revising their own.

Those with a BLUD status, however, had more freedom to execute their budget (from various sources, including government transfers and capitation) and have, therefore, been coping better during this crisis.

In mitigating any public health emergency, preserving essential services should be prioritised to prevent unintended consequences on these programs. A rapid coordinated response across levels in the areas of policy and budget formulation, program adjustment and budget execution, as well as monitoring led by the central government, is pivotal to mitigate adverse impacts on these services. Improving the PFM capacity of local staff could lead to better health spending and contribute to achieving targeted budget performance. Moreover, strengthening budget and program monitoring would provide a learning platform to ensure the room for continuous necessary improvement.

4.2 ____ Study Limitations

Our study has several limitations as follows:

a. This study was conducted in only six districts in three Java provinces, and two districts in South Sulawesi province. Given the time constraint, we could not expand the study sites to other regions and, therefore, the findings of this study are not necessarily representative of conditions throughout Indonesia.
b. The results from this study have not yet identified the impact of the COVID-19 pandemic on the accomplishment of several national medium-term development targets 2020–2024 for MCH, immunisation, nutrition, and family planning. A further assessment by the end of the pandemic might be needed to provide evidence and consideration of whether the medium-term targets should be recalibrated.
c. This study acts as a rapid assessment, in which more robust research assessing the pandemic disruption on each of the health system's subcomponents is warranted.
d. This study only covered four essential public health programs, and other assessments on the effects of the COVID-19 pandemic on communicable and noncommunicable diseases and mental health services is needed.

4.3 Recommendations

We put forward recommendations not only to lessen the adverse impact of this pandemic but also to improve the implementation of essential public health programs for the upcoming years.

Recommendations for MoH, PHOs, and DHOs

a. Strengthen emergency preparedness and response to manage future pandemics and other emergencies across units and between levels. The strategy should also prioritise preserving essential public health services in the time of emergency.

b. Ensure coordinated response for policy and budget formulation, program adjustment and budget execution, and monitoring processes led by the central government, with active support from the local government.

c. Establish an effective budget planning and budget tracking platform to ensure the accountability, appropriateness, and efficiency of health spending across different administrative levels. This platform is particularly pivotal at the local level.

d. Provide capacity building for local government in planning, budgeting, and execution. This is imperative for an emergency response and to ensure an adaptive PFM in the future.

e. Provide support for PHCs to accelerate their transformation to BLUD status.

f. Provide sufficient resources such as supplies of PPEs, and medical diagnostic kits. This equipment should be provided to both PHCs and PMPs to establish standard precautions and continuation of essential public health program service delivery.

g. Integrate the currently fragmented health information system to rapidly detect any services disruption, track current progress, and to provide reliable evidence for the decision-making process and feedback for monitoring and evaluation.

Recommendations for PHCs and PMPs

a. Regularly map and monitor all target populations related to the four essential public health programs during the COVID-19 pandemic and conduct outreach services to these target population if possible.
b. Ensure that regular consultation continues with a good quality in online settings.
c. Continue to record and document the routine programs that have already transformed into online mechanisms such as antenatal care consultations.
d. Ensure support for PMPs including on PPE fulfilment, technical supervision, and work closely with PMPs to achieve the program target coverage.
e. Develop innovative approaches to ensure health service delivery is accessed by the community and increase health promotion activities, particularly during emergencies such as a pandemic.
f. Provide adequate protection, technical support, and incentives for cadres. These PHC staff have been burdened with additional task during this pandemic.

Recommendations for research units at government institutions, researchers at development agencies, and academia

a. Conduct assessment regarding the impact of COVID-19 pandemic on the accomplishment of several national medium-term development targets 2020–2024 for MCH, immunisation, nutrition, and family planning, to provide evidence and consideration for whether the medium-term targets should be recalibrated.
b. Conduct assessments on the effects of the COVID-19 pandemic on communicable and noncommunicable diseases, and mental health services.
c. Conduct an assessment on the pandemic's disruption of each health system subcomponent and develop policy responses to improve the health system.

APPENDIX ONE: SCHEDULE OF FOCUS GROUP DISCUSSIONS

Date	Central/Local Level	Institution	Informants
9 June 2020	Bandung City, West Java Province	District Health Office (DHO)	Resource person: DHO's Secretary Informants: a. Head of Surveillance and Immunisation b. Head of Data and Information c. Head of Family Health and Nutrition d. Surveillance and Immunisation Staff
10 June 2020	Makassar City, South Sulawesi Province	DHO	Informants: a. Head of Public Health b. Head of Family Health and Nutrition c. Head of Planning and Budgeting
		Bara Baraya PHC	Informants: a. Head of PHC b. PIC of Maternal and Child Health c. PIC of Family Planning
		Jongaya PHC	Informants: a. Head of PHC b. Nurse c. PIC for Nutrition
	Bone District, South Sulawesi Province	DHO	Resource person: Head of DHO Informants: a. Head of Disease Prevention and Control b. Head of Public Health c. Head of Health Services d. Head of Planning
	Depok City, West Java Province	DHO	Informants: a. Head of Family Health and Nutrition b. Head of Planning, Evaluation, and Reporting c. Head of Primary Health Care
11 June 2020	Central level	Directorate for Surveillance and Health Quarantine, Ministry of Health	Informants: a. Head of Immunisation b. Head of Emerging Infectious Diseases
	Bone District, South Sulawesi Province	Ajangale PHC	Informants: a. Head of PHC b. Midwife Coordinator c. PIC of General Affairs d. PIC of Curative Care
		Kading PHC	Informants: a. Head of PHC b. PIC of Public Health c. PIC of General Affairs d. PIC of Curative Care

Date	Central/Local Level	Institution	Informants
12 June 2020	Depok City, West Java Province	Cimanggis PHC	Informants: a. Head of PHC b. PIC of Curative Care c. PIC of Maternal and Child Health
		Bojongsari PHC	Informants: a. Head of PHC b. PIC of Maternal and Child Health
		Private Midwifery Practice 1	Midwife 1 (Depok)
		Private Midwifery Practice 2	Midwife 2 (Depok)
	Bandung City, West Java Province	Pasir Kaliki PHC	Informants: a. Head of PHC b. PIC of General Affairs c. PIC of Public Health
		Garuda PHC	Informants: a. Head of PHC b. PIC of General Affairs c. PIC of Maternal and Child Health
		Private Midwifery Practice 1	Midwife 1 (Bandung)
		Private Midwifery Practice 2	Midwife 2 (Bandung)
	Makassar City, South Sulawesi Province	Private Midwifery Practice 1	Midwife 1 (Makassar)
		Private Midwifery Practice 2	Midwife 2 (Makassar)
	Bone District, South Sulawesi Province	Private Midwifery Practice 1	Midwife 1 (Bone)
		Private Midwifery Practice 2	Midwife 2 (Bone)
15 June 2020	Central level	Directorate for Primary Health Care, Ministry of Health	Resource person: Director for Primary Health Care Informants: a. Staff member 1 b. Staff member 2
	Sidoarjo District, East Java Province	DHO	Resource person: Head of DHO Informants: a. DHO's Secretary b. Head of Public Health c. Head of Family Health and Nutrition

Date	Central/Local Level	Institution	Informants
16 June 2020	South Jakarta City, Jakarta Province	Cilandak PHC	Informants: a. PIC of Curative Care b. PIC of Public Health c. PIC of Maternal Health d. PIC of Birth Delivery e. PIC of Child Health
		Pancoran PHC	Informants: a. Head of PHC b. PIC of Public Health c. PIC of Maternal Health d. PIC of Nutrition e. PIC of Immunisation
	East Jakarta City, Jakarta Province	Private Midwifery Practice 1	Midwife 1 (East Jakarta)
		Private Midwifery Practice 2	Midwife 2 (East Jakarta)
	Surabaya City, East Java Province	DHO	Resource person: DHO's Secretary Informants: a. Head of Health Services b. Head of Public Health c. Head of Family Health and Nutrition d. Head of Planning, Information, and Public Relations
		Sememi PHC	Informant: Head of PHC
		Balongsari PHC	Informant: Head of PHC
17 June 2020	Sidoarjo District, East Java Province	Wonoayu PHC	Informants: a. Head of PHC b. PIC of Public Health c. PIC of General Public Agency d. PIC of Maternal and Child Health
		Taman PHC	Informants: a. Head of PHC b. PIC of Public Health c. PIC of Maternal and Child Health d. Midwife Coordinator
		Private Midwifery Practice 1	Midwife 1 (Sidoarjo)
		Private Midwifery Practice 2	Midwife 2 (Sidoarjo)
18 June 2020	Central level	Directorate for Family Health, Ministry of Health	Resource person: Director for Family Health Informant: Head of Child Health

Date	Central/Local Level	Institution	Informants
19 June 2020	Central level	Bureau for Planning and Budgeting, Ministry of Health	Resource person: Head of Bureau Informants: a. Head of National Budget 3 b. Sub-head of National Budget 1
		Directorate for Public Health Nutrition, Ministry of Health	Informants: a. Sub-head of Malnutrition Control b. Sub-head of Nutrition Surveillance c. PIC of Malnutrition Control
	Surabaya City, East Java Province	Private Midwifery Practice 1	Midwife 1 (Surabaya)
		Private Midwifery Practice 2	Midwife 2 (Surabaya)
	Jakarta Province	Province Health Office	Informants: a. Head of Family Health b. Staff member 1 of Family Health c. Staff member 2 of Family Health d. Staff of Planning and Budgeting e. Head of Data and Information
	East Jakarta City, Jakarta Province	Sub Health Office, East Jakarta	Informants: a. Head of Public Health b. PIC of Child Health c. Staff of Public Health
	South Jakarta City, Jakarta Province	Sub Health Office, South Jakarta	Informants: a. Head of Public Health b. PIC of Infection Prevention and Control c. Staff of Infection Prevention and Control
		Private Midwifery Practice 1	Midwife 1 (South Jakarta)
		Private Midwifery Practice 2	Midwife 2 (South Jakarta)
22 June 2020	East Jakarta City, Jakarta Province	Cakung PHC	Informants: a. Head of PHC b. PIC of Public Health c. PIC of Curative Care d. PIC of Network e. Midwife Coordinator
		Kramat Jati PHC	Informants: a. Head of PHC b. Midwife Coordinator c. PIC of General Affairs d. PIC of Public Health e. PIC of Nutrition

Source: Author's analysis, 2020.

APPENDIX TWO: IMPLEMENTING REGULATIONS FOR REALLOCATION OF BUDGET FUNDS

1. Presidential Instruction No. 4/2020 on Refocusing Activities, Budget Reallocation, and Goods and Services Procurement in the Framework of Accelerating the Handling of Coronavirus Disease 2019 (COVID-19).

2. Government Regulation in Lieu of Law (*Perppu*) No. 1/2020 on Fiscal Policy and Financial System Stability for COVID-19 Pandemic and/or Other Potential Threats.

3. President Regulation No. 54/2020 on Revision of Posture and Details of the State Budget.

4. Ministry of Finance Decree No. 6/KM.7/2020 on the Distribution of Special Allocation Funds for Health and Health Operational Assistance Funds for the Prevention and Mitigation of COVID-19.

5. Minister of Home Affairs Regulation No. 20/2020 on the Acceleration of COVID-19 Mitigation by Local Governments.

6. Minister of Finance Regulation No. 19/PMK.07/2020 on the Distribution and Utilisation of Revenue Sharing Funds (*Dana Bagi Hasil: DBH*), General Allocation Funds (*Dana Alokasi Umum: DAU*) and Regional Incentive Funds (*Dana Insentif Daerah: DID*) for Coronavirus Disease 2019 (COVID-19) Mitigation.

7. Minister of Finance Letter No. 302/2020 on Steps for Ministries/Institutions' Budget Revision.

8. Minister of Finance Regulation No. 38/2020 on Implementation of The States' Fiscal Policy for Rapid Responses towards COVID-19 or Other Potential Threats to the National Economy and/or the Stability of Financial System.

9. Minister of Finance Regulation No. 39/2020 on Steps for Budget Revision of Fiscal Year 2020.

10. Minister of Home Affairs and Minister of Finance Mutual Decrees No. 119/2813/SJ and 177/ KMK.07/2020 on the Acceleration of Local Government Budget in 2020 for Safeguarding the Purchasing Power of the Community and the National Economy for COVID-19 Mitigaton.

11. Ministry of Health Decree No. HK.01.07/MENKES/215/2020 on the Utilisation of Special Allocation Funds for Health in Budget Year 2020 for the Prevention and Mitigation of COVID-19.

12. Minister of Health Statement Letter No. HK.02.01/ MENKES/ 215/2020 on the Utilisation of Special Allocation Funds for Health in Budget Year 2020 for the Prevention and Mitigation of COVID-19.

13. Director General for Budget Regulation No. 3/2020 on Technical Guidance for Budget Revision of Fiscal Year 2020.

14. Secretary General Letter No. PR.04.02/I/1380/2020 on the Ministry of Health Proposal for Budget Revision for Fiscal Year 2020.

15. Head of FP Circulation Letter No. 9/2020 on the Revision of Family Planning Operational Budget for Fiscal Year 2020.

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