The Strategic Purchasing for Primary Health Care (SP4PHC) project aims to improve how governments purchase primary health care (PHC) services, with a focus on family planning (FP) and maternal, newborn, and child health (MNCH). The project is supported by the Bill & Melinda Gates Foundation and implemented by ThinkWell and partners in five countries: Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda. In Indonesia, SP4PHC is helping to improve how the government and the national health insurance scheme, Jaminan Kesehatan Nasional (JKN), engages and incentivizes the full range of health providers to increase access to quality FP and MNCH services.

This brief summarizes findings from a study that the ThinkWell Indonesia team conducted with the Vice President’s Office of the Government of Indonesia (GoI) on how the GoI rapidly responded to the coronavirus disease 2019 (COVID-19) virus while trying to maintain access to essential health services. Drawing from interviews with key stakeholders at the national, district, and provider levels, as well as quantitative analysis of budget and utilization data, this study focuses on the upstream processes of budget revision, reallocation, and technical guidance provided by the government to PHC facilities. It highlights how health financing challenges faced at different levels of the system had a ripple effect for providers on the frontline and offers policy recommendations on improving the COVID-19 response and for future crises.

COVID-19 ENTERS INDONESIA

In March 2020, the COVID-19 virus entered the shores of Indonesia and the GoI needed to immediately respond. Within a few weeks, the cumulative confirmed cases had exponentially grown to the tens of thousands. To respond to the growing crisis, the government quickly adopted a large-scale social distancing policy (PSBB) and a series of containment measures in early April (Ministry of Finance Indonesia 2020a; President of the Republic of Indonesia 2020b; Ministry of Home Affairs Indonesia 2020a). They also instituted major revisions to the 2020 national budget, exemplified by an IDR 677.2 trillion (US $47.76 billion) increase in spending towards the pandemic. As seen in Table 1 below, about IDR 87.55 trillion (US $6.14 billion) of this budget was dedicated to the health sector, including for the purchase of medical equipment (e.g., test kits, ventilators, personal protective equipment – PPE) and earmarked funds for the districts and facilities to respond to the impending increase in COVID-19 patients.

While the government scrambled to increase the prevention and treatment services for COVID-19 patients, there was less focus on how essential health services (EHS) like FP, MNCH, immunization, and nutrition services would be maintained. The influx of COVID-19 cases not only placed additional pressure on the Indonesian health system and its providers, but it also reduced the demand for routine essential services due to the population’s fear of contracting the virus when visiting crowded health facilities. Due to the focus on COVID-19, the GoI was not able to provide immediate technical guidance nor budget revisions on these essential services until a few months into the crisis. While the omission was understandable given the pressures COVID-19 presented, this left district health officials and health facility managers on their own to figure out how to balance testing, isolation, and treatment of COVID-19 patients with the maintenance...
of essential services. Even when technical and budget guidance was provided for essential services, district health officials often lacked the capacity to rapidly revise their budgets and facilities did not receive the resources they needed (Pan et al. 2021).

Table 1. Breakdown of Indonesia’s revised 2020 budget.

<table>
<thead>
<tr>
<th>Category</th>
<th>Budget Allocation</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Health sector    | IDR 87.55 trillion (US $6.14 billion) | - The purchase of medical equipment such as PPE, test kit, reagent, ventilators  
                          - Strengthening hospital infrastructures for COVID-19 responses  
                          - Incentives for health workers including doctors and nurses  
                          - JKN subsidy for informal workers |
| Economic Recovery|                   |                                                                             |
| Demand side      | IDR 205.2 trillion (US $14.40 billion) | - Social protection  
                          - Housing incentives |
| Supply side      | IDR 1.3 trillion (US $91.20 million)   | - Tax incentives  
                          - Funding assistance for corporate  
                          - Funding support for small and medium enterprises Funding support for line ministries and subnational govt |

Source: (Ministry of Finance Indonesia 2020a)

METHODOLOGY

The purpose of this brief is to provide an overview of the steps the GoI took to maintain essential services during the COVID-19 outbreak, especially from a budget perspective, and the challenges faced during implementation. It summarizes the findings of a joint study between ThinkWell Indonesia and the Vice President’s Office of the GoI that was conducted from April to August 2020. The larger, more detailed report from this study will be published in late 2021. The study focused on four essential services that are national priorities: 1) FP, 2) MNCH, 3) immunizations, and 4) nutrition (Ministry of National Development Planning 2019). The study aimed to analyze the more upstream processes of the government, in terms of how the central government provided technical and budget guidance to maintain these essential services, how district health officials revised their budgets and the public financial management (PFM) issues they faced, and how PHC providers dealt with these changes on the ground and how this impacted the population.

The research team conducted 28 focus group discussions (FGDs) with key stakeholders from the central and district levels, as well as PHC providers across four provinces and eight districts in Indonesia – DKI Jakarta Province (South and East Jakarta), West Java Province (Bandung and Depok), East Java Province (Surabaya and Sidoarjo), and South Sulawesi Province (Makassar and Bone). These geographies were purposively selected based on the regions that were most affected by COVID-19. The team also conducted quantitative analyses of budget and utilization data in the same geographies. Figure 1 below provides an overview of the methods used for this study.

Figure 1. Study activity matrix.

BUDGET RESPONSE FOR EHS AT THE CENTRAL LEVEL

The major budget revisions that the GoI put in place during COVID-19 were made within the existing decentralized structure of how funds flow from the central government through the districts and down to facilities. In Indonesia, there is a mandatory national budget for the health sector, which is managed by several central level agencies. The most relevant to this brief are the Ministry of Health (MoH), the Family Health Directorate (FHD – which manages FP and
MNCH), the Surveillance and Health Quarantine Directorate (SHQD – which manages immunizations), and the Nutrition Directorate. These central agencies receive funds from the Ministry of Finance and channel funds to local governments via a series of fund mechanisms, including the physical special allocation fund (DAK Fisik) and the non-physical special allocation fund (DAK Non-Fisik) in the form of health operational assistance - BOK (Mahendradhata et al. 2017).

Shortly after COVID-19 appeared in Indonesia, the GoI mandated that the central budget was to be refocused and reallocated towards addressing the impending crisis. The immediate priorities from the 14 regulations issued for COVID-19 included the procurement of key supplies (e.g. PPE, ventilators, oxygen), strengthening hospital infrastructure for the response, and epidemiological investigations of viral spread. This also gave the the local governments authority to conduct similar refocusing and reallocation of their local budgets (APBD) towards the COVID-19 response (President of the Republic of Indonesia 2020a; Ministry of Home Affairs Indonesia 2020c; Ministry of Finance Indonesia 2020b).

This mandate also included the refocusing of budgets away from essential services for COVID-19. The FHD refocused more than 50% of its budget (including for FP and MNCH), with the implementation of activities like health worker trainings, policy socializations, and program monitoring and evaluation (M&E) moved to virtual platforms and their funds reallocated towards COVID. The SHQD reallocated 80% of its budget to vaccine procurement and 20% to immunization operational activities and program implementation. About 23% of the Nutrition Directorate’s budget underwent refocusing, including the tracking of the nutrition program indicators.

While these agencies tried to target activities in their budgets that could no longer be conducted due to COVID-19 containment measures, many study participants felt that activities key to program implementation were cut. The central agencies aimed to cut activities such as official travel expenditures, meeting package payments and honorariums, and certain monitoring activities in the field. However, many respondents felt that key activities, such as the monitoring of nutrition status conducted at integrated health posts, were miscategorized as “meetings” and thus cut. They felt that activities such as these are critical to assess the growth and health status of children under-five and not tracking them could have irreversible and long-term effects.

A key challenge was that while the first case of COVID-19 was detected in Indonesia in early March 2020, the first issuance of any regulations or technical guidelines around the four essential services took nearly three months (in June 2020). Because the GoI was largely focused on how the different government agencies would respond to COVID-19, they did not prioritize how the health system – from central to district to providers – would handle the maintenance of routine essential services. Thus, District Health Offices (DHOs) and PHC facilities were left on their own to figure out how to respond to the rising number of COVID-19 cases in their communities, as well as how to continue to provide the key routine. This includes a lack of national guidance on how to isolate COVID-19 patients from other patients and how to task-shift certain types of services to outreach workers, such as midwives. Postponing these services may have had detrimental effects for the community; for instance, the delay of immunizations could lead to the resurgence of preventable infectious diseases.

Another key challenge related to budget and technical guidance was that the central level agencies – such as those responsible for FP, MNCH, immunizations, and nutrition – did not coordinate well with each other. Each of the four essential programs eventually put out separate guidance for service adjustment, rather than developing a single integrated set of guidelines for DHOs and providers. Several respondents noted that many of the activities across the four programs overlap with one another and an integrated set of guidelines could have helped ease confusion when implemented at the lower levels.

**Budget Response for EHS at the District Level**

Local governments were also asked to refocus and reallocate their budgets – including on the four essential services – towards the COVID-19 response in their jurisdictions. The funds dedicated to COVID-19 were primarily used for procurement of PPE, upgrading facility infrastructure, and management of COVID-19 patients. The districts followed a similar process of trying to reallocate funds around meeting activities and capital expenditure – such as procurement of vehicles and office equipment, building renovations, and other
infrastructure development – which could be postponed for the next fiscal year.

Our study revealed that many districts struggled with the budget revision process, which delayed the submission of budgets back to the central level for approval and the eventual disbursement of funds. Many district officials noted that their PFM capacity was limited even before the COVID-19 pandemic, and it was laid bare during the crisis as many had difficulty processing the multiple budget revision guidance issued by the central level throughout pandemic. The sheer number of funding streams – from DAK and BOK to BTT (the contingency funding stream), with their own specific procedures and guidance – proved to be a major barrier for districts to quickly revise and submit budgets so that much-needed funds could be disbursed. However, several districts noted that even when revised budgets were submitted, disbursement – which in policy should only take one day – often took too much longer than anticipated.

Many districts used alternative financial means in their immediate response as they struggled with their budget revision processes. One common practice was to use the contingency funds that were provided early in the pandemic for immediate COVID-19-related needs, like PPE, infrastructure costs, and recruiting surveillance personnel. Some DHOs also used their remaining 2019 procurement budget, as well as excise and tobacco profit sharing funds (DBHCHT), to acquire and provide the polymerase chain reaction (PCR) tests for their jurisdictions.

After the districts dealt with their struggles with revising the budgets, sampled districts clearly had different approaches to allocating their budgets across the four essential services. As seen in Figure 2, there was a decrease in MNCH program budgets across nearly all sampled districts, but budget decreases varied across the districts for immunizations and nutrition services. FP data was not available for most districts. For those districts who did report FP budgets, we observed significant decreases – more than a 52% decrease in DKI Jakarta, for instance. There was a significant increase (43%) in the nutrition budget for Sidoarjo due to additional funds being added for provision of food for health workers and COVID-19 patients.

**Figure 2. Percentage budget change per essential service area, across sampled districts.**

<table>
<thead>
<tr>
<th>District</th>
<th>MCH</th>
<th>Immunization</th>
<th>Nutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>DKI Jakarta Province</td>
<td>-50%</td>
<td>-30%</td>
<td>43%</td>
</tr>
<tr>
<td>Bandung</td>
<td>-40%</td>
<td>-20%</td>
<td>0%</td>
</tr>
<tr>
<td>Depok</td>
<td>-60%</td>
<td>-40%</td>
<td>-20%</td>
</tr>
<tr>
<td>Sidoarjo</td>
<td>-80%</td>
<td>-60%</td>
<td>-40%</td>
</tr>
<tr>
<td>Makassar</td>
<td>-100%</td>
<td>-80%</td>
<td>-60%</td>
</tr>
<tr>
<td>Bone</td>
<td>-120%</td>
<td>-100%</td>
<td>-80%</td>
</tr>
</tbody>
</table>

* 2 districts removed due to data issues; FP could not be separated from MNCH.

**EFFECT ON PHC PROVIDERS**

The budget revisions at the central and district levels had a cascading effect on PHC providers within the sampled districts. Due to the multiple delays at the higher levels for technical guidance and disbursement of essential service funds, many PHC facilities struggled and varied widely in their adapted responses. The weak PFM capacity at PHC facilities themselves led to similar challenges in revising their facility budgets and sending them back up the chain. For instance, PHC facilities in this study had variable success in using BOK funds – only those who were able to process the considerable paperwork were able to use these funds.

Our study found that PHC facilities with semi-autonomous status (BLUD) status were more successful in having and reallocating funds to the COVID-19 response and maintenance of essential services. In Indonesia, some public health facilities (only 20% of over 10,000 Puskesmas) have a semi-autonomous status, which gives them the authority to flexibly retain and manage their own revenue. These facilities did not have to wait for the delayed fund disbursement from the higher levels of government. Prior to the pandemic, these PHC facilities stated that the BLUD revenue was prioritized for operational expenditure (e.g. payment for electricity, telephone, water, internet, etc.) and supported the delivery of health services. During COVID-19, the PHC facilities with BLUD status directly spent these funds without having to process the disbursement of funds through the district government budget team, as other non-BLUD facilities were required to do. DHOs and PHC facilities also received donations – often in the form of PPE – from the community, foundations, and companies, which proved to be very useful at the start.
of the pandemic, as many had not received funds from the central government due to these issues.

Eventually, all sampled PHC facilities – BLUD or non-BLUD – made significant revisions to their budgets pertaining to the four essential services. As seen in Figure 3, all sampled PHC facilities reduced their MNCH budget to some degree. Often, budget was shifted away from MNCH activities, such as honorariums, transport for home visits, classes for pregnant and new mothers, as well as M&E of these services. Like the DHOs, most PHC facilities did not report the FP budgets for most PHC facilities, except for South Jakarta and Sidoarjo. The South Jakarta PHC reduced their FP budget by 76.3% budget, whereas the Sidoarjo PHC did not reduce the FP budget whatsoever. The budget for immunization services was not affected nearly as much as the other three services. Most PHC facilities in the study continued indoor immunization services, but with some key adjustments to practices (as noted below). In facilities where budgets were adjusted, it was largely for immunization trainings, supervision, campaigns, and community socialization. For nutrition, only three PHC facilities reduced their budgets, largely for honorariums, transportation for home visits, M&E, as well as provider and patient trainings (e.g. exclusive breastfeeding).

Figure 3. Percentage budget change per essential services, across sampled PHC facilities.

The budget revisions, as well as the national COVID-19 containment measures, led to significant adjustments in how these PHC facilities delivered MNCH services on the ground. Most PHC facilities limited the number of patients they received, only allowed visits for emergency cases, and urged patients to instead visit ancillary providers, such as midwives (Ministry of Home Affairs Indonesia 2020b). However, midwives interviewed noted that they had to turn away patients because they had not received the necessary PPE. As a result, most midwives noted the use of phone calls or mobile instant messaging (e.g. WhatsApp), particularly in providing regular check-ups and non-emergency cases. Post-delivery services continued as usual, except for changes to the second and third visits, which were replaced with home visits by volunteer community health workers, known in Indonesia as “cadres” (Ministry of Home Affairs Indonesia 2020b).

These delays and adjustments contributed to considerable dips in MNCH service utilization following the COVID-19 outbreak in 2020. Figure 4 shows how all sampled PHCs stated that they experienced reductions in every type of MNCH service offered. The largest reduction was for ’pregnancy class,’ which is a health promotion activity for pregnant women intended to increase knowledge and change attitudes and behavior of mothers on pregnancy, childbirth, postpartum and newborn care. These activities were largely canceled due to COVID-19 restrictions, while many PHCs also provided fewer curative services – such as ANC and deliveries – during the second quarter of 2020 compared to the same period in 2019. While upstream delays in funding and guidance likely played a role in the dip in service use, the natural hesitancy among the population to visit health facilities during the initial stages of the pandemic likely played a role as well. Hence, MNCH services that are less preventative and more clinical – such deliveries – experienced less of a decline.

PHC providers also adjusted how they provided FP to populations in their jurisdictions, often encouraging the temporary use of short-term methods, and saw an initial decrease in FP utilization followed by a sharp recovery increase in May 2020. Both PHC facilities and private midwives urged clients that used long-acting reproductive contraceptives (LARCs) to temporarily switch to using short-term methods; methods that are
often available in local pharmacies and shops. This finding is supported by the data from National Population and Family Planning Board that indicated an initial decrease of all FP methods, followed by a significant increase from April to May 2020 of short-term methods (e.g. oral contraceptive pills and injections) and implants, which are more easily administered than the intra-uterine device (IUD) (Figure 5). Providers also shifted to an appointment-based system and often limited the number of patients seen per day and reduced their open hours. Most private midwives admitted a decrease in client visits during the pandemic, ranging from 25% to 70%. Private midwives, cadres, and FP field staff tried to increase their distribution of oral contraceptive pills and condoms in their communities.

Figure 5. Trend of shifted contraceptive methods from January to June 2020.

Most PHC facilities in our study continued indoor immunization services but made several adjustments to service delivery. PHC facilities limited the number of patient visits per day, scheduled patient visits via an appointment system, and created large waiting areas using public spaces, such as using schools (Makassar PHC facilities) and large parking areas (South Jakarta PHC facilities). Private midwives providing immunization services also changed their schedules to avoid crowded patient visits (e.g. less busy times of the day or specific days during the week).

Coverage of basic immunization services reduced considerably in 2020 compared to 2019, as reported by the MoH (Figure 6). The largest dip in coverage between the two years was in May (34.5%) and remained at least 20% lower until November 2020, where the coverage difference between the two years reduced to 13.9%. Many PHC providers noted that the lack of an immunization playbook during the initial response – which was not released by the central government until June – left providers with little guidance on how to maintain routine coverage. Once the guidelines were issued, the coverage gap narrowed from July to November. Even at the time of publication, while the GoI has provided instructions on ‘Provider & Patient Safety’, there is still uncertainty regarding the financing of these services at the sub-national level.

Figure 6. Basic immunization coverage, 2019 vs. 2020.

The coverage of basic immunization services during COVID-19 varied widely across the different regions of Indonesia. By November 2019, 164 districts had at least 85% coverage of basic immunizations. In November 2020, the MoH reported that only 83 districts had met that threshold, with the largest gaps occurring in the more rural, Eastern regions (as demonstrated in Figure 7). The Eastern regions experienced larger gaps in coverage across all essential services. This is consistent with these Eastern DHOs struggling to revise budgets due to weak PFM capacity, thus preventing critical funding arriving to frontline providers in a timely manner. Naturally, provinces that had higher numbers of COVID-19 cases also saw an even greater decline in immunization coverage, as providers scrambled to respond to the virus while patient demand likely plummeted due to the pandemic spread and panic.
Many nutrition services were task-shifted down to private midwives and volunteer cadres. These services included monthly visits to obtain nutritional supplements, distribution of nutritional food supplements to high-risk pregnant women and under-five children with malnutrition, monitoring weight and height for infants and children, as well as reporting and documenting acute malnutrition cases. Supplementary iron tablets for young women in schools were adjusted according to each region's capacity and availability of iron tablets. Some PHC facilities distributed these supplementary iron tablets to the houses of young women through cadres, while others postponed the program indefinitely.

While task-shifting to frontline workers was an oft-used policy during the pandemic, many of these frontline workers noted that they were not properly resourced and guided to deliver services during COVID-19. Many midwives and cadres noted the lack of PPE, especially in the first two months of the pandemic, which made it difficult for these frontline workers to continue providing essential services to their communities. Support for these workers largely came from their professional organizations rather than from the DHOs or PHC facilities, even though they are an integral part of the PHC networks. Many of these workers were even forced to purchase PPE themselves (without reimbursement). Moreover, there was very little supervision or instruction given to these midwives and cadres on the four essential services, which may have had a negative impact the on quality-of-service provision and accuracy of reporting. Only 2 out of 16 midwives interviewed reported that they received supervision from the PHC in their jurisdictions. Moreover, two other midwives reported that they received no supervision whatsoever (even virtually). Many midwives also noted consistent issues with internet connectivity, which became even more important during the pandemic where face-to-face interactions between health system actors were limited. This impacted how these frontline workers were able to communicate and document the delivery of essential services.

**CONCLUSION**

While the central government rapidly responded to the immediate COVID-19 threat, there was a more delayed response on how to maintain EHS. The GoI released a Presidential Mandate, budget revisions, and technical guidance across government agencies almost immediately after COVID-19 arrived in Indonesia in early 2020 (President of the Republic of Indonesia 2020a). In that response itself, there was a significant reallocation of funds away from essential services to COVID-19. Moreover, resources and guidance for how districts and providers should maintain routine health services was delayed by two to three months. Exacerbating this delay, the separate central agencies for FP and MNCH, immunizations, and nutrition did not align their resources nor technical assistance across their agencies. This led to confusion at the subnational and provider levels, as well as wide variation on how they planned and managed EHS during the crisis.

There were sizable fund flow bottlenecks at the DHOs, who struggled to rapidly revise multiple siloed budgets for EHS. Many DHOs, especially outside of Java, demonstrated limited PFM capacity to rapidly absorb guidance, revise budgets accordingly, and send back multiple budgets, each with their own instructions and processes. This was especially difficult because COVID-19 hit after the annual budget process was completed and the DHOs had just completed their revision processes. These bottlenecks contributed to significant pots of money sitting at the central level, unused during the immediate crisis.

These upstream challenges had a cascading effect on frontline providers, often leaving them isolated and
paralyzed with limited funds, guidance, and autonomy. With little funds trickling in due to challenges at the national and district levels, frontline providers were often not able to use other funds for the immediate response due to most having little financial autonomy. Out of over 10,000 PHCs across the country, only 20% have BLUD status, which grants them special autonomy status to use funds coming into the facility. BPJS-K rapidly adjusted its JKN capitation regulations so that these funds were not still adjusted by utilization. However, only those few facilities with BLUD status were able to use these freed-up capitation funds. Those without BLUD status had the capitation funds flow to the DHO, where the provider then needed to go through long, bureaucratic processes to gain access to these funds. With a lack of funds and guidance, this study found that there was also significant informal and disorganized task shifting of these essential services to midwives and CHWs who often lacked the necessary PPE or supplies.

RECOMMENDATIONS

At the central level, how EHS are maintained during a crisis needs to be reformed across the assortment of responsible line ministries. Contingency fund mechanisms, like the BTT, need to be design for immediate use emergency surge funding directly to frontline providers. Emergency coordination structures should be reviewed, and gaps addressed to improve the alignment and streamlining of funds and guidance across the MoH during a crisis. This study also found that a major limitation of the GoI’s 2020 COVID-19 response was that it focused primarily on hospitals. The 2021 block grants for COVID-19 already look far improved, as they provide funds not just for curative services related to COVID-19, but also for diagnostic (e.g. testing and tracing), vaccinations, and health systems strengthening.

For the next crisis, the GoI could better leverage their national health insurance scheme in their response. JKN has more capacity to purchase from private providers, directly pay facilities (rather than channel funds through the DHOs) and use more active purchasing techniques to incentivize provider behavior. PHC capitation from JKN could be optimally utilized as a direct funding mechanism for DHOs or facilities during a crisis. There is positive progress on this front, as the government is exploring how JKN, rather than the MoH, can be now used for COVID-19-related claims, especially as COVID-19 moves from a crisis to a more endemic disease. There seems to be hesitation among government leadership to trust the young NHI scheme with the pandemic response, rather than the more experienced MoH. However, the dynamism that JKN offers, and its increasingly central role in purchasing in the country, make it a natural choice for the next crisis.

At the district level, PFM capacity needs to be improved among DHOs (especially in the Eastern regions), while the burden on these DHOs needs to be minimized during a crisis. More time and technical assistance need to be offered to DHOs to socialize and prepare them for crisis budget revisions, especially when it comes outside of the normal annual budget cycle (Utomo, Ihsan, and Isfandiarni 2012). More rural DHOs, especially in the Eastern parts of Indonesia, should be prioritized, as it was clear that they struggled the most during the COVID-19 crisis. As mentioned earlier, this guidance needs to be clearer and more aligned across the different central government agencies to reduce the burden and processes DHOs must maneuver in a crisis. There is growing global guidance the GoI can pull from on how to improve these PFM processes during an emergency response (Barroy et al. 2020; Saxena and Stone 2020).

At the frontline, the GoI needs to reassess how providers can flexibly use funds and how guidance is targeted to this audience during a crisis. The consequences of the multitude of facilities that lack BLUD status, especially at the PHC level, were made clear during the COVID-19 pandemic. The GoI needs to review granting more facilities with this status generally, and potentially on a temporary basis during a crisis. The balance between accountability and flexibility remains a complicated issue and the GoI needs to critically analyze this situation considering what happened on the ground during COVID-19. Moreover, the GoI needs to develop stronger regulations and guidance on task shifting (e.g. to midwives, cadres, and telemedicine) that can be rapidly put into place during a crisis. This includes how resources should be mobilized and allocated for these cadres, especially for essentials such as PPE and key supplies (Jhpiego 2020; World Health Organization 2020). The GoI should also consider developing a more effective budget tracking mechanism to ensure the accountability, appropriateness, and efficiency of health spending across different administrative levels (Barroy et al. 2020; World Bank 2020). In this way,
frontline providers can be more prepared and empowered to respond to both the crisis and maintain essential health services that their populations rely on.

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For more information, please visit our website at https://thinkwell.global/projects/sp4phc/.

For questions, please write to us at sp4phc@thinkwell.global.

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