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STAKEHOLDER ENGAGEMENT PLAN

GPSA INDONESIA

Women's Voices in the Monitoring and Improvement of Universal Health Care Insurance Services

This document will explain the stakeholder engagement activities in the local, provincial, and national level throughout the project lifecycle. The GPSA project aims to achieve collaborative social accountability, which means that many issues regarding management of social risks are embedded in the project through engagement of project stakeholders.

1. Introduction / project description

Many social accountability initiatives are not sustained because of the lack of involvement from grass root organizations that already have a long history in the community. In addition, such initiatives are also not sustained because they are not built in the collaborative mechanism between government and grassroot organizations. Grassroot organizations can develop such collaborative mechanism while at the same time remain being critical and provide constructive feedbacks to government.

Women faith-based organizations have a potential role in developing the productive and critical social welfare and social accountability. These organizations generally have a large number of volunteers (which sometimes referred to as cadres). These cadres can be organized to work together with government to improve public service delivery, especially in health and maternal health issue.

In this project, AKATIGA collaborates with Fatayat NU – one of the largest Muslim women faith-based organization. The objectives of this program is to contribute in improving access and quality of health services delivery for poor and vulnerable population in selected districts of Indonesia through collaborative social accountability mechanisms among stakeholders, which includes: (i) Poor communities, defined as those who are eligible to receive Indonesian health card, and assisted by Fatayat; (ii) Health providers affiliated with the National Health Insurance network; (iii) National Health Insurance policy makers at local and national level.

Project activities:

Collaborative mechanism is already embodied in several activities of the project. Activity component in 1.D, 2.C, 2.D, 2.E, and 3.B are stakeholder engagement activities.

1) Capacity-Building and Development of Collaborative Social accountability Mechanisms
    A. Review Data, Mapping targets, problems & recruitment of cadres
    B. Elaboration of information, education and communication materials
    C. Information system development and equipment
    D. Developing standard operating procedures (SOP) and training implementation for Fatayat Cadres
    E. Piloting during and after capacity building training
2) Collaborative Social accountability Mechanisms to improve targeted service delivery

    At the local level:

A. Data collection
B. Patients' assistance, and data input
C. Organizing periodic policy dialogues with key health stakeholders in local level

At the national level:

D. Implementing collaborative framework at the inception phase with health institutions (regularly sharing health users' data and monitoring follow-up actions)
E. Organizing periodic policy dialogues about the findings related to gaps in JKN services with key health stakeholders

3) Improving Knowledge and Learning on Social Accountability in the Indonesian Health Sector
   A. Setting up the project's monitoring, evaluation and learning (MEL) system
   B. Conducting regular internal project MEL sessions focused on adjusting the project's social accountability strategy and operations
   C. Dissemination of the project's Knowledge and Learning products to key target audiences
   D. Facilitate and promote knowledge and learning about collaborative social accountability

Under component 1 on developing SOP and training implementation, guideline for engagement with the poor communities assisted (patients) will be made to elaborate the communication structure in this project and how cadres and patients address the grievance.

Component 2 explains the collaborative social accountability mechanism which comparable with stakeholder engagement activities during project preparation and implementation. In activity 2.D, collaborative framework at the inception phase with health institutions aims to build ownership of the collaborative social accountability mechanism among them and to get input for this project from a broader perspective. The engagement with stakeholders in this activity will result in approval and agreement for collaboration. In activities 2.C and E, organizing policy dialogues with key stakeholders in local and national level serves to discuss the gaps and findings in project implementation (cadres' experience in assisting patients) and to propose/discuss bigger lessons learned and policy action. This meeting also serves as a grievance mechanism where ministries, agencies, BPJS, hospital, and other key stakeholders can address their grievance openly and then discuss for the solution.

Under component 3 on internal MEL sessions focused on adjusting the project's social accountability strategy and operations. Grievance mechanism from the stakeholders—including patients, cadres, and local health facilities—is a part of MEL that will give meaningful input for the project implementation. The grievance can be addressed to several channel openly or privately or anonymously and will be facilitated in M&E process (where the independent evaluator will re-check the patients)

Project partners: Fatayat NU will be responsible for organizing the fieldwork with volunteer cadres, field monitoring and coordination of local-level dialogues with key stakeholders.

Beneficiaries: The project will directly target project partners Fatayat NU members and poor communities (eligible for subsidized health card) assisted by Fatayat

Locations: Series of districts located in several provinces with Fatayat NU's branch offices (e.g. West Java; Central Java; East Java; North Maluku; South Sulawesi; Jambi). After first year preparation some areas will be reduced to concentrate in areas that could have greater impact.

2. Brief summary of previous stakeholder engagement activities

Discussions between AKATIGA and Fatayat NU has already started since 2016. We have conducted several meetings to discuss the preparation and design of the project, also (financial) reporting mechanism. Engagement and public consultation with other stakeholders has already started since 2016, the details can be seen in Annex 2.

No	Stakeholders	Key discussion points	Time
1	Central government (National Development and Planning Agency, Ministry of Health)	• Support and input for the project design • Policy discourse on universal health care insurance system • Central government's target on health issues	May 2016, 2018
2	Legislatives	• Support and input for the project design • Policy discourse on universal health care insurance system	2018
3	Presidential staff	• Policy in health sector • BPJS monitoring and evaluation	January 2017
4	NGOs conducting evaluation on BPJS (BPJS Watch) and NGOs with collaboration in public budget (Bina Swadaya and ACE)	• Findings from former evaluation and studies • Input for the project design and implementation, especially in financial reporting	May 2016
5	Head District of Kulon Progo and Banyuwangi, also a member of Indonesian Medical Association. Currently the head of Population and Family Planning Agency (BKKBN)	• Input from the medical side for the implementation • Common gaps of services in certain health problems • BPJS implementation in Kulon Progo – DIY • Input for alternatives in BPJS funding (District Government, Province Government or BPJS)	August 2018, June 2018
6	Women faith based organisation (Aisyiyah, Muslimat NU, WKRI) and other NGO (Wahana Visi). All has long history in supporting the poor to access health service and promoting social accountability to public health services.	• Organizations' scope of work • Health issue in MAMPU Project • Input for the project design according to their experience in grass root level • (Informal) agreement to collaborate in the project • Collaboration project scheme between Wahana Visi and AKATIGA	May, 2016, June 2016, July 2018, July 2019, October 2019
7	Ombudsman RI. One of their activities is monitoring quality of BPJS services based on complaint coming to Ombudsmand.	• BPJS socialization • Project's introduction of collaborative social accountability in health sector with women faith based organisation • Common maladministration reported regarding	April, June 2016

		BPJS and health sector	
8	Research and Development division of BPJS	• Initial meeting with BPJS • Challenge and problems regarding PBI data	May 2016
9	Pusat Kebijakan dan Manajemen Kesehatan (Center for Health Policy and Management), Gadjah Mada University. This research center that helped BPJS to evaluate their program.	• Exploring BPJS and universal healthcare issues Potential research collaboration on medical side of gap • Input from the medical side for the implementation	June 2014, May 2018, July 2018

AKATIGA and Fatayat have consulted with the World Bank team in Washington and Jakarta regarding the proposal since 2016.

3. Stakeholder identification and analysis

Several groups at different levels will be distinguished to identify appropriate and accessible communication and engagement methods among stakeholders throughout the project implementation process. The stakeholder identification and grouping will be updated throughout the project implementation. The groups identified are as follows, while analysis of stakeholders' interest and area of influence is provided in Annex 1:

a. Groups/people/organization that will gain direct and/or indirect benefit from the project. These target beneficiaries include: 1) the direct, and 2) secondary beneficiaries.

    1) Direct beneficiaries are Fatayat NU and poor communities (eligible for subsidized health insurance) assisted by Fatayat NU. The project will provide a series of trainings to strengthen the capacity of Fatayat NU cadres in voicing the voiceless, especially women and children in vulnerable group. This project promotes inclusivity, which means that the assistance will cover all of the poor and vulnerable group in the criteria that is willing to be involved. Fatayat NU has an extensive experience in assisting vulnerable groups especially women, for example, assisting women and children who experiences domestic violence. Vulnerable group's aspiration and experience in accessing health service (gap data) will be conveyed by Fatayat NU cadres and AKATIGA to the policy makers and related stakeholder to formulate the solution about gap.

    2) Secondary beneficiaries are the policy makers at the national, province, and local level, as well as stakeholders in health sector or who have concern in basic public services for poor and vulnerable group. These stakeholders will either be benefited from the information generated by the project or take up elements of collaborative social accountability processes to apply, sustain or scale collaborative social accountability. The activities in this project (component 2.C, 2.D, 2.E and 3.E) has already incorporated policy dialogues and joint problem-solving sessions with the policy maker and related stakeholders.

b. Potentially adversely impacted communities (if any): None

c. Interested groups as follows:

This project implements collaborative social accountability mechanism which indirectly targeted to various stakeholders, that includes policy maker, service provider, and non-government organization, to adopt the collaborative mechanism and gain input for the improvement of health service. Therefore, the stakeholders in secondary beneficiaries intersects with stakeholders in interested groups.

National Level	Ministry of Health, BPJS Kesehatan; Ministry of Social Affairs; Ministry of National Development Planning (Bappenas); Legislative - People's Representative Council (DPR Komisi IX); Ombudsman RI; BPJS Watch; Associations of health practitioners and specialists; Hospital or health service provider association; Associations or support groups of patients; Related NGOs and professional associations in national level; Fatayat NU, Muslimat NU, Aisyiyah, and other women faith based organization
Provincial Level	Provincial Health Agency; Provincial BPJS Kesehatan; Provincial Social Agency; Provincial Development Planning Agency (Bappeda); Provincial Hospital (RSUD Provinsi); Fatayat NU (PW – Pengurus wilayah); Related NGOs and professional associations in provincial level
District Level	Bupati or Walikota; District Level Health Agency; District Level BPJS Kesehatan; District Level Social Agency; District level Development Planning Agency (Bappeda); District level Hospital (RSUD Kota/Kab); Fatayat NU (PC – Pengurus cabang); Related CSOs and professional associations in district level
Sub district, Village, and Community level	Village head / kepala desa; Sub district head / Camat; Puskesmas or first level health facilities (Faskes 1); Local communities, especially household members of direct project beneficiaries

d. Implementing agencies and agencies with authorities for the management of environmental and social risks include institutions and agencies that influence and make decisions on the project implementation:
AKATIGA and Fatayat NU are the implementing agencies in this project

4. Stakeholder engagement strategy

The main approach of this project is collaborative social accountability where the gap experienced in implementation and its solution will be discussed periodically with related stakeholders—government, service provider, and NGO in village up to the national level. Therefore, involvement and engagement of stakeholders are essential as the main approaches to this project. Series of collaboration with the stakeholders will be conducted regularly in the local and national level. Overall, the collaborative action and meeting will discuss (i) the gap (between BPJS' guideline and the actual experience) in the assistance process; (ii) solution for the gap; (iii) response from service provider and health stakeholders; (iv) information disclosure regarding the project; (v) collaborative social accountability mechanism among stakeholders; (vi) input for the project implementation. In the meeting and action, there is mainstreaming of health issues of vulnerable group especially poor women and children. Several cases to be advocated are women and children who experience domestic violence and sexual abuse because these cases are not covered by the insurance (BPJS).

Not every issue will be discussed with all stakeholders, the issues will be tailored according to the role and function of the stakeholders.

Overall, the activities of stakeholder engagement throughout the projects are:

No	Stakeholder engagement strategy	Component activity in this project	Objectives	Time	Stakeholders
1	Workshop with the health sector stakeholders in the early (preparation) of the project	Activity Component 2.C and 2. D	The workshop aims to build ownership of the collaborative social accountability mechanism in between stakeholders in the health sector who are pro-community. This workshop also aims at learning from stakeholders' knowledge as an input for this project from a broader perspective.	Early phase of the project (preparation time)	National level stakeholders: associations of health practitioners and specialists, associations or support groups of patients, Ministries, BPJS Watch, and other NGOs/CSOs working on healthcare issue
2	Initial meeting with local health institution when implementation starts	Activity Component 2.C and 2D	This meeting aims get the support (approval and **agreement for collaboration**) for implementing the project in their location. The expected outcome of these meetings is an agreement or MoU between BPJS or Bupati/Walikota and AKATIGA regarding this project	Early phase of the project (preparation time) and at the first year of the implementation	Local health agency, hospital, Bupati/ Walikota, and BPJS
3	Developing SOP of project implementation including code of conduct for cadre and poor communities (patients) assisted	Activity Component 1.D	The SOP will elaborate the communication structure in this project and how the grievance from facilitators and poor communities (patients) assisted. The SOP also aims to protect the patient.	The first year of the implementation and will be reviewed periodically	Fatayat and AKATIGA
4	Monthly meeting in project locations	Activity Component 3.B	This monthly meeting will discuss data, information, and findings about the facilitation progress. To gather the data and information about the experience of assistance in the project location, we will develop an information system for the cadre (Facilitator have to input the data and information about the facilitation weekly. There will be a monthly discussion on the data and information between AKATIGA dan	Monthly	AKATIGA, Fatayat, and Facilitators (cadre)

No	Stakeholder engagement strategy	Component activity in this project	Objectives	Time	Stakeholders
			Fatayat. This monthly meeting is also part of the grievance mechanism. The cadres can express their grievance and discuss the solution. The grievance can be addressed openly or privately or anonymously depending on the convenience of facilitators.		
5	Regular meeting with local stakeholders every three months	Activity Component 2.C	AKATIGA will compile the data and information from cadre and analyze it. The compilation will be discussed in the series of meeting with the stakeholders. This meeting also serves the role as a grievance mechanism where local agency, BPJS, hospital can address their grievance openly and then discuss for the solution	Three-monthly	District agencies, BPJS, hospital, puskesmas, sub-district, and village heads.
6	Meeting with national level stakeholders every six months	Activity Component 2.E	For the bigger lessons learned, findings, and policy action, AKATIGA will discuss it to the national level stakeholders	Six-monthly	BPJS Kesehatan, Ministry of Health, Ombudsman, and DPR Komisi 9
7	Grievance mechanism for patients	Activity Component 3.B	The patients that have been assisted can expressed the grievance through local Fatayat office openly or privately or anonymously. The solution will be discussed among Fatayat and AKATIGA in the monthly meeting, except for emergency case. If Fatayat finds the grievance is emergency, it will be discussed immediately. If the patient cannot convey the grievance through Fatayat (because of the disagreement etc.), it will be facilitated in M&E process (where the independent evaluator will re-check the patients)	Anytime	Patients/poor communities assisted
8	Grievance mechanism for health facilities	Activity Component 3.B	Local health facilities can expressed the grievance through local Fatayat office openly or privately or anonymously. The solution will be discussed among Fatayat and AKATIGA in the monthly meeting, except for emergency case. If Fatayat finds the grievance is emergency, it will be discussed immediately. If the patient cannot convey the grievance through Fatayat (because of the disagreement etc.), it will be facilitated in M&E process	Anytime	Puskesmas, hospital

No	Stakeholder engagement strategy	Component activity in this project	Objectives	Time	Stakeholders
			(where the independent evaluator will re-check the health facilities)		

5. Covid-19 Protocols for stakeholder engagement activities

In Covid-19 pandemic, stakeholder engagement activities will be carried out online, if possible. Stakeholder engagement activities that involve vulnerable people (pregnant women, people over 60 years old, and people with underlying comorbidities) are encouraged to avoid travel and face-to-face meeting, online meeting is prioritized for them.

For the activities which online meeting is not possible, e.g. local meeting, we will apply WHO standard protocols[1] before, during, and after the meeting.

A. Before the meeting
   1) We will develop and agree a preparedness plan to prevent infection at the meeting, which include:
      - Considering whether a face-to-face meeting or event is needed, and whether we can replace it by a teleconference or online?
      - Whether we could limit or scale down the meeting so that fewer people attend
      - Ensuring and verifying information and communication channels in advance with key partners such as public health and health care authorities.
      - Pre-ordering sufficient supplies and materials, including tissues and hand sanitizer for all participants
      - Actively monitoring where COVID-19 is circulating. Advise participants in advance that if they have any symptoms or feel unwell, they should not attend.
   2) We will develop and agree a response plan in case someone at the meeting becomes ill with symptoms of COVID-19 (dry cough, fever, malaise). This plan should include at least:
      - A plan for how they can be safely transferred from there to a health facility: identify the nearest local health facilities and its hotline number
      - Understanding on what to do if a meeting participant, staff member or service provider tests positive for COVID-19 during or just after the meeting
      - An agreemeent plan in advance with our partner healthcare provider or health department

B. During the meeting, we will:
   1) Provide information or a briefing in verbal and writing, on COVID-19 and the measures that the project is taking to make this meeting safe. The briefing will include:
      - Encouraging participants to wear mask. For vulnerable people, it is encouraged to wear medical mask

[1] https://www.who.int/docs/default-source/coronaviruse/getting-workplace-ready-for-covid-19.pdf?sfvrsn=359a81e7_6

- Advising participatns of no touching with each other
- Encouraging regular hand-washing or use of an alcohol rub by all participants at the meeting
- Encouraging participants cover their face with the bend of their elbow or a tissue if they cough or sneeze. We will supply tissues and closed bins to dispose of them in.

2) Display dispensers of alcohol-based hand rub prominently around the venue.
3) If there is space, we will arrange seats so that participants are at least one meter apart.

C. After the meeting:
1) If someone at the meeting was isolated as a suspected COVID-19 case, we will let all the participants know. We also advise other participants to monitor themselves for symptoms for 14 days and take their temperature twice a day.
2) If they develop even a mild cough or low-grade fever (i.e. a temperature of 37.3 C or more) they should stay at home and self-isolate. This means avoiding close contact (1 meter or nearer) with other people, including family members. They should also telephone their healthcare provider or the local public health department, giving them details of their recent travel and symptoms.

Besides protocols to prevent the spread in meetings, we will also follow protocol to prevent social stigma associated with Covid-19. The current COVID-19 outbreak has provoked social stigma and discriminatory behaviors against people of certain ethnic backgrounds as well as anyone perceived to have been in contact with the virus. How we communicate about COVID-19 is critical in supporting people to take effective action to help combat the disease and to avoid fueling fear and stigma. An environment needs to be created in which the disease and its impact can be discussed and addressed openly, honestly and effectively. We will follow this tips on how to address and avoid compounding, social stigma:

1. We will pay attention on words we sue. Certain words (i.e suspect case, isolation…) and language may have a negative meaning for people and fuel stigmatizing attitudes. This can drive people away from getting screened, tested and quarantined. We will use and recommend participatns and caders a 'people-first' language that respects and empowers people in all communication channels, including the media. Words used in media are especially important, because these will shape the popular language and communication on the new coronavirus (COVID-19). For example, we will not refer people with disease as Covid-19 cases or victims and do not talk about people transmitting, infecting, or spreading Covid-19. Instead, we will use "people who have or are being treated for Covid-19" and talk about people acquiring or contracting.
2. We will do various parts or ideas to drive stigma away, such as spreading the facts. Stigma can be heightened by insufficient knowledge about how the new coronavirus disease (COVID-19) is transmitted and treated, and how to prevent infection. In response, priorities the collection, consolidation and dissemination of accurate country- and community-specific information about affected areas, individual and group vulnerability to COVID- 19, treatment options and where to access health care and information. We will use simple language and avoid clinical terms.
3. We will use communication tips and messages. Things we can do are:
   - Correcting misconceptions, at the same time as acknowledging that people's feelings and subsequent behavior are very real, even if the underlying assumption is false.

- Promoting the importance of prevention, lifesaving actions, early screening and treatment.
- Sharing sympathetic narratives, or stories that humanize the experiences and struggles of individuals or groups affected by the new coronavirus (COVID-19)
- Communicating support and encouragement for those who are on the frontlines of response to this outbreak (health care workers, volunteers, community leaders etc).
- Sharing facts and accurate information about the disease.
- Challenging myths and stereotypes.
- Choosing words carefully

For stakeholders, AKATIGA, and Fatayat staffs who are required to travel to project location, there are things to consider according to WHO protocol:

A. Before traveling, we will:
   - Make sure project staff and volunteer have the latest information on areas where COVID-19 is spreading.
   - Based on the latest information, project staff and volunteer should assess the benefits and risks related to upcoming travel plans.
   - Avoid sending project staff and volunteer who may be at higher risk of serious illness (e.g. older employees and those with medical conditions such as diabetes, heart and lung disease) to areas where COVID-19 is spreading.
   - Make sure all persons travelling to locations reporting COVID-19 are briefed by a qualified professional (e.g. staff health services, health care provider or local public health partner)
   - Provide project staff and volunteer who are about to travel with small bottles (under 100 CL) of alcohol-based hand rub to facilitate regular hand-washing.

B. While traveling, we will:
   - Encourage project staff and volunteer to wash their hands regularly and stay at least one meter away from people who are coughing or sneezing
   - Ensure project staff and volunteer know what to do and who to contact if they feel ill while traveling.
   - Ensure that project staff and volunteer comply with instructions from local authorities where they are traveling. If, for example, they are told by local authorities not to go somewhere they should comply with this. Your employees should comply with any local restrictions on travel, movement or large gatherings.

C. When return from traveling:
   - We will have project staff and volunteer who have returned from an area where COVID-19 is spreading to monitor themselves for symptoms for 14 days and take their temperature twice a day.
   - If they develop even a mild cough or low grade fever (i.e. a temperature of 37.3^{o} C or more), we will have respective staffs/volunteers to stay at home and self-isolate. This means avoiding close contact (one meter or nearer) with other people, including family

members. They should also telephone their healthcare provider or the local public health department, giving them details of their recent travel and symptoms.

6. Feedback and grievance redress mechanism (FGRM)

For cadres, patients, and local health facilities

Grievance mechanism is to address concerns in a transparent manner that is culturally appropriate and readily accessible to all cadres, patients, and local health facilities at no cost and without retribution. In training activities, AKATIGA and Fatayat NU will inform the cadres about the grievance process in the course of its community engagement activities and will make publicly available a record documenting the responses to all grievances received. The grievance can be addressed openly or privately or anonymously depending on the convenience of cadres, patients and local health facilities.

The patients that are assisted by cadres can express grievance through local Fatayat office. The solution will be discussed among Fatayat and AKATIGA in the monthly meeting, except for emergency case. If Fatayat finds the grievance is emergency, it will be discussed immediately. If the patient cannot convey the grievance through Fatayat (because of the disagreement etc.), it will be facilitated in M&E process (where the independent evaluator will re-check the patients). The mechanism, including the contact numbers and emails to whom the cadres and workers can expressed their grievance, will be included in the guideline for cadres. Patient helped within this project will also be informally surveyed each 3 month related their view of this initiatives.

The grievance can be submitted through monthly meeting or informed directly to responsible staff anonymously. All grievance mechanism and the follow-up resolution will be provided at no cost to the cadres and workers. The project will provide multiple channels for cadres to express their grievance, which includes:

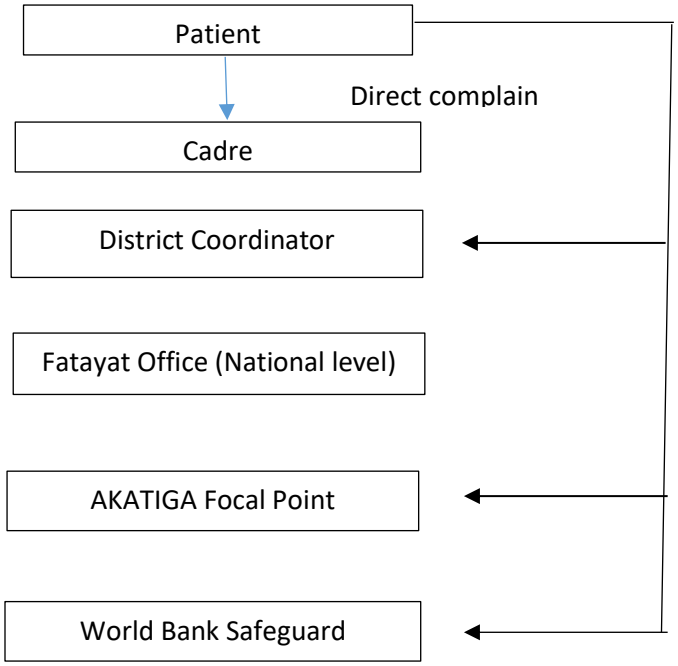
- Verbal and/or written grievance through SMS, WhatsApp Message, or email to the district coordinators
- Verbal or written grievance through SMS, WhatsApp Message, or email to Fatayat staff assigned for grievance mechanism
- Verbal or written grievance through SMS, WhatsApp Message, or email to AKATIGA staff assigned for grievance mechanism
- Written grievance through the three-monthly survey conducted by AKATIGA
- Written grievance through the grievance online form provided by the project's website developed by AKATIGA
- Written grievance to the World Bank

The project will also develop grievance mechanism for patients through the following outlets:

- Verbal and/or written grievance through SMS, WhatsApp Message to the cadres that assist them;

- Verbal and/or written grievance through SMS, WhatsApp Message, or email to the district coordinators;
- Verbal or written grievance through SMS, WhatsApp Message, or email to Fatayat staff assigned for grievance mechanism;
- Verbal or written grievance through SMS, WhatsApp Message, or email to AKATIGA staff assigned for grievance mechanism;
- Written grievance through the three-monthly survey conducted by AKATIGA;
- Written grievance through the grievance online form provided by the project's website developed by AKATIGA; and
- Written grievance to the World Bank

The procedure of grievance mechanism is described in the figure below.



In the event of dissatisfaction, sensitivity, or conflict of interest, patient could complain to higher level.

Contract person or focal point phone numbers and emails will be distributed.

Similar process also applies to cadres or Fatayat if there is any complaints or dissatisfaction with regards to safety and working condition.

<u>For related stakeholders</u>

Stakeholder in village, subdistrict, district, province level, and/or hospital can address their concerns in regular meeting (series of discussion) to AKATIGA or Fatayat NU. Their concerns will be discussed in the meeting to formulate the solution.

7. Information Disclosure and Public Consultation

AKATIGA will disclose the project information to allow stakeholders to understand the risks and impacts of the project, and potential opportunities. AKATIGA will provide stakeholders with access to the information regarding project purpose, duration, potential risk and impacts, stakeholder engagement

process, and grievance mechanism. The information will be disclosed in Bahasa Indonesia that can be understood easier by cadres in project location and broader audiences. There are two main strategies of information disclosure: (i) make ESF Documents available to be accessed publicly in AKATIGA's website; and (2) send the ESF documents to Fatayat NU to be forwarded to cadres in the project location. The latter strategy is also related to public consultation strategy.

This program uses social accountability approach where related stakeholders are encouraged to be engaged in regular focus group discussions or informal discussions. This engagement is a two way process to get input and initial views from the stakeholder regarding project design and BPJS Kesehatan issues. Public consultation in this project has begun in project planning process and will be carried out throughout the project lifecycle. AKATIGA has already started doing public consultation since 2016 to national level government, associations in health sector, women faith-based organization, legislatives, universities, and other related stakeholders[2]. The details of the consultation can be seen in Annex 2.

Public consultation regarding ESF documents, including risk and impacts of the project, with Fatayat NU was carried out online in June 2020. Online public consultation is prioritized according to Covid-19 protocols in chapter/part 5. Public consultation for cadres in project location will be carried out in July 2020 by Fatayat NU, and for other related local stakeholders will be carried out in the first semester of project implementation.

8. Monitoring and Reporting

AKATIGA will monitor the implementation of the SEP in the project locations. Monitoring will normally include recording information to track performance and establishing relevant operational controls to verify and compare compliance and progress. Monitoring will be adjusted according to performance experience, as well as actions requested by relevant regulatory authorities and feedback from stakeholders. Based on the results of the monitoring, AKATIGA will identify any necessary corrective and preventive actions, and will incorporate these in upcoming stakeholder engagement activities, in a manner acceptable to the Bank.

AKATIGA will report results of the SEP monitoring alongside with regular monitoring reports on the environmental, social, health and safety performance of the Project including but not limited to stakeholder engagement activities and functioning of the grievance mechanism(s). This will be reported every six months throughout project implementation.

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[2] Details in part/chapter 2

Annex 1:
Stakeholder Analysis

Stakeholder	Type	Interest	Area of influence	Project phase	Stakeholder Liaison	Engagement approach and tools	Frequency
	SUB DISTRICT, VILLAGE, AND COMMUNITY LEVEL						
Poor communities (eligible for PBI) assisted by Fatayat NU	Direct beneficiaries	Getting access to BPJS and health service	Willingness to be assisted	Implementation phase	Cadres	Assistance	Very frequent
Village head / kepala desa;	Interested groups and secondary beneficiaries	Greater access to health services for their citizen	Support to PBI[3] registration process	Preparation, implementation phase	Project officer	Consultation: Discussion, FGD	Very frequent
Sub district head / Camat;	Interested groups and secondary beneficiaries	Greater access to health services for their citizen	Support to PBI registration process	Preparation, implementation phase	Project officer	Consultation: Discussion, FGD	Very frequent
Puskesmas or first level health facilities (Faskes 1);	Interested groups and secondary beneficiaries	Provide health service	Willingness to be monitored and provide medical record	Implementation phase	Project officer	Consultation: Discussion, FGD	Very frequent
	DISTRICT LEVEL						
Bupati or Walikota;	Interested groups and secondary beneficiaries	Greater access to health services for their citizen	Responsive and agree to collaborate in health service monitoring	Preparation and Implementation phase	Project officer	Consultation: Discussion, FGD	Occasionally
District Level Health Agency;	Interested groups and secondary beneficiaries	Greater access to health services for their citizen	Support to PBI data, PBI registration, and health service monitoring	Implementation phase	Project officer	Consultation: Discussion, FGD	Frequent
District Level BPJS Kesehatan;	Interested groups and secondary beneficiaries	Expand BPJS' membership, providing inclusive health insurance	Support to BPJS data and agree to collaborate in health service monitoring	Implementation phase	Project Coordinator and Social Accountability Specialist	Consultation: Discussion, FGD	Frequent
District Level Social Agency;	Interested groups and secondary	Greater access to health services for the	Support to PBI data, PBI registration, and	Preparation, implementation	Project officer	Consultation: Discussion,	Frequent

[3] subsidized health insurance

Stakeholder	Type	Interest	Area of influence	Project phase	Stakeholder Liaison	Engagement approach and tools	Frequency
	beneficiaries	vulnerable communities	health service monitoring	phase		FGD	
District level Development Planning Agency (Bappeda);	Interested groups and secondary beneficiaries	Greater access to health services for their citizen, planning in health sector (budgeting and strategic issue)	Responsive and agree to collaborate in health service monitoring	Preparation, implementation phase	Project officer	Consultation: Discussion, FGD	Occasionally
District level Hospital (RSUD Kota/Kab);	Interested groups and secondary beneficiaries	Provide health service	Willingness to be monitored and provide medical record for assisted patients	Implementation phase	Project officer	Consultation: Discussion, FGD	Very frequent
Fatayat NU (PC – Pengurus cabang);	Implementing partner and direct beneficiaries	Greater access to health services for their member	Monitoring in grass root level	Preparation, implementation phase	Project officer	Consultation: Discussion, FGD	Very frequent
Related CSOs and professional associations in district level	Interested groups and secondary beneficiaries	Monitoring BPJS, sharing about BPJS issue	Collaborate in health service monitoring and policy action discussion	Implementation phase	Project officer	Consultation: Discussion, FGD	Occasionally
	PROVINCE LEVEL						
Provincial Health Agency;	Interested groups and secondary beneficiaries	Greater access to health services for their citizen	Regulatory and monitoring; Support to PBI data; PBI registration; and health service monitoring	Implementation phase	Project officer	Consultation: Discussion, FGD	Occasionally
Provincial BPJS Kesehatan;	Interested groups and secondary beneficiaries	Expand BPJS' membership, providing inclusive health insurance	Regulatory and monitoring; support to BPJS data; and agree to collaborate in health service monitoring	Implementation phase	Project officer	Consultation: Discussion, FGD	Occasionally
Provincial Social Agency;	Interested groups and secondary beneficiaries	Greater access to health services for the vulnerable	Regulatory and monitoring; support to PBI data; PBI	Implementation phase	Project officer	Consultation: Discussion, FGD	Occasionally

Stakeholder	Type	Interest	Area of influence	Project phase	Stakeholder Liaison	Engagement approach and tools	Frequency
		communities	registration; and health service monitoring				
Provincial Development Planning Agency (Bappeda);	Interested groups and secondary beneficiaries	Greater access to health services for their citizen, planning in health sector (budgeting and strategic issue)	Regulatory and monitoring: responsive and agree to collaborate in health service monitoring	Implementation phase	Project officer	Consultation: Discussion, FGD	Occasionally
Provincial Hospital (RSUD Provinsi);	Interested groups and secondary beneficiaries	Provide health service	Willingness to be monitored and provide medical record for assisted patients	Implementation phase	Project officer	Consultation: Discussion, FGD	Very frequent
Related NGOs and professional associations in provincial level	Interested groups and secondary beneficiaries	Monitoring BPJS, sharing about BPJS issue	Collaborate in health service monitoring and policy action discussion	Implementation phase	Project officer	Consultation: Discussion, FGD	Occasionally
	NATIONAL LEVEL						
Fatayat NU	Implementing partner and direct beneficiaries	Greater access to health services for their member	Monitoring in grass root level	All project phase	Project Coordinator and Project Officer	Capacity building: Workshop and training	Very frequent
Ministry of Health,	Interested groups and secondary beneficiaries	Greater access to health services for their citizen	Regulatory, service provider, monitoring; support to PBI data; PBI registration; and health service monitoring	Implementation phase	Project Coordinator and Social Accountability Specialist	Consultation: Discussion, FGD, lobbying	Occasionally
BPJS Kesehatan;	Interested groups and secondary beneficiaries	Expand BPJS' membership, providing inclusive health insurance	Regulatory, service provider, monitoring; support to BPJS data; and agree to collaborate in health service monitoring	Preparation, implementation phase	Project Coordinator and Social Accountability Specialist	Consultation: Discussion, FGD, lobbying	Occasionally
Ministry of Social	Interested groups	Greater access to	Regulatory and	Implementation	Project	Consultation:	Occasionally

Stakeholder	Type	Interest	Area of influence	Project phase	Stakeholder Liaison	Engagement approach and tools	Frequency
Affairs;	and secondary beneficiaries	health services for the vulnerable communities	monitoring; support to PBI data; PBI registration; and health service monitoring	phase	Coordinator and Social Accountability Specialist	Discussion, FGD, lobbying	
Ministry of National Development Planning (Bappenas);	Interested groups and secondary beneficiaries	Greater access to health services for their citizen, planning in health sector (budgeting and national strategic issue)	Budget policy; agreement to collaborate in health service monitoring	Implementation phase	Project Coordinator and Social Accountability Specialist	Consultation: Discussion, FGD, lobbying	Occasionally
Legislative - People's Representative Council (DPR Komisi IX);	Interested groups and secondary beneficiaries	BPJS and health service monitoring	Collaborate in health service monitoring and policy action discussion	Implementation phase	Project Coordinator and Project Officer	Consultation: Discussion, FGD	Occasionally
Ombudsman RI;	Interested groups and secondary beneficiaries	Public service monitoring, including in health sector	Collaborate in health service monitoring and policy action discussion	Implementation phase	Project Coordinator and Social Accountability Specialist	Consultation: Discussion, FGD	Occasionally
BPJS Watch;	Interested groups and secondary beneficiaries	Monitoring BPJS, sharing about BPJS issue	Collaborate in health service monitoring and policy action discussion	Preparation, implementation phase	Project Coordinator and Social Accountability Specialist	Consultation: Discussion, FGD	Occasionally
Associations of health practitioners and specialists	Interested groups and secondary beneficiaries	sharing about BPJS issue for BPJS improvement	Collaborate in health service monitoring and policy action discussion	Preparation, implementation phase	Project Coordinator and Social Accountability Specialist	Consultation: Discussion, FGD	Occasionally
Hospital or health service provider association;	Interested groups and secondary beneficiaries	sharing about BPJS issue for BPJS improvement	Collaborate in health service monitoring and policy action discussion	implementation phase	Project Coordinator and Social Accountability Specialist	Consultation: Discussion, FGD	Occasionally
Associations or support	Interested groups	sharing about BPJS	Collaborate in health	implementation	Project	Consultation:	Occasionally

Stakeholder	Type	Interest	Area of influence	Project phase	Stakeholder Liaison	Engagement approach and tools	Frequency
groups of patients	and secondary beneficiaries	issue for BPJS improvement	service monitoring and policy action discussion	phase	Coordinator and Social Accountability Specialist	Discussion, FGD	
Related NGOs and professional associations in national level;	Interested groups and secondary beneficiaries	Monitoring BPJS, sharing about BPJS issue	Collaborate in health service monitoring and policy action discussion	implementation phase	Project Coordinator and Social Accountability Specialist	Consultation: Discussion, FGD	Occasionally
Muslimat NU, Aisyiyah, and other women faith based organization	Interested groups and secondary beneficiaries	Monitoring BPJS, sharing about BPJS issue	Collaborate in health service monitoring and policy action discussion	Preparation and implementation phase	Project Coordinator and Social Accountability Specialist	Consultation: Discussion, FGD	Occasionally

Annex 2

Meeting details of previous engagement and public consultation

1. Ombudsman: pengawas pelayanan publik, termasuk kesehatan

The meeting with Ombudsman took place on April 6, 2016. The purpose of meeting was to introduce the project's idea to Ombudsman, since one of the Ombudsman's role was to receive complaints on BPJS implementation and the follow-up. Points of discussion:

- *Ombudsman receives complaint from doctor that the health insurance (BPJS) rates cannot cover all actions and treatments*
- *Other complaints are regarding (i) socialization is not optimal because most patients do not understand the reference system in BPJS, especially in first level health facilities; (ii) drugs or medicine is rarely available at the health facilities; (iii) Capitation fund system is not effective and efficient, the should be further study about this*
- *AKATIGA and women faith based organization can assist Ombudsman in monitoring health service in district and village level*

Peserta : Aprilia, Charina, Isono Sadoko, Titik Hatini
Tanggal Pertemuan : 6 April 2016
Tujuan pertemuan : Memperkenalkan program monitoring BPJS dengan *women faith based organization* kepada ombudsman yang fokus pada pengawasan layanan public

Butir pertemuan :

- Saat ini dokter memberikan komplain kepada Ombudsman terkait BPJS. Menurut mereka, tarif BPJS tidak bisa mencakup seluruh tindakan dan perawatan. Hal ini membuat dokter mengulang atau mengarang diagnosa, dan hal ini sangat buruk bagi seorang dokter. Dokter dihadapkan untuk melakukan pelayanan yang baik, namun biaya tidak tercakup seluruhnya.
- Ombudsman sedang melakukan systemic review terkait aturan BPJS. Mereka membuka regulasi tentang JKN dan BPJS, dan dianalisis. Saat ini kegiatan tersebut masih berlangsung meskipun sudah pernah didiseminasikan kecil - kecil untuk mendapatkan masukan dari pihak luar.
    - Sosialisasi diakui tidak dilakukan maksimal dan banyak pasien yang tidak mengetahui fungsi rujukan, terutama di fasilitas kesehatan pertama.
    - Obat sering tidak ada di rumah sakit, sehingga pasien harus mencari sendiri dan jika dicari ke apotik lain yang non BPJS, obat bisa ditemukan.
    - Kapitasi lebih menguntungkan Pemda, terutama Puskesmas yang sifatnya Badan Layanan Umum Daerah (BLUD). Jadi, banyak pusat layanan kesehatan yang sebenarnya tidak melayani sebanyak yang diberikan kapitasi tersebut. Sedangkan ada pusat layanan lain yang melebih dari dari kapitasi. Jadi kurang aadil dan perlu dikaji ulang, sesuai dengan beban si pemberi layanan.
- BPJS sendiri sudah memiliki lembaga khusus yang akan mengawasi pelaksanaannya, yaitu Dewan Jaminan Sosial Nasional dan yang sangat spesifik adalah Dewan Pengawas Badan Penyelenggara Jaminan Sosial Kesehatan. Karena kedua lembaga ini sudah ada, maka Ombudsman lebih pada systemic review (regulasi), meskipun mereka juga melakukan pengamatan di pelayanan kesehatan untuk membandingkan aturan dengan pelaksanaannya.
- Saat ini Dewan Pengawas BPJS baru dibentuk dan sedang merumuskan sistem pengawasan BPJS, Akatiga bisa mendekati Dewan Pengawas selama tahap perumusan.

- Ombudsman tidak memiliki tangan ke kabupaten, meskipun sudah memiliki sekitar 30 Ombudsman propinsi. Akan tetapi, tidak bisa untuk mengawasi pelayanan di tingkat bawah. Di sini posisi AKATIGA dan Muslimat NU bisa membantu Ombudsman.

2. BPJS Kesehatan : Research and Development Division

The meeting with BPJS Kesehatan took place on May 31, 2016. This initial meeting was to introduce the AKATIGA and GPSA project to BPJS Kesehatan. Points of discussion:

- *BPJS and JKN are two different entity. JKN is the regulator and BPJS is the implementer. The main tasks of BPJS are recruiting membership of insurance, collecting fees, and spending funds. The recruitment of membership and collecting fees are not optimal, this impacts on losses BPJS.*
- *Input for GPSA: cadres are expected to have capacity on (i) educating communities on the importance of registering BPJS and how to register; (ii) ensure the member to pay the monthly fee regularly; (iii) participate in preventive action (educate communities to live healthy)*

Peserta : Charina
Tanggal Pertemuan : 31 Mei 2016
Tujuan pertemuan : initial meeting dengan BPJS untuk project Global Partnership of Social Accountability (GPSA)
Butir-butir pertemuan:

- Perlu membedakan antara BPJS dan JKN, JKN adalah yang memiliki kekuatan untuk mengatur, membuat aturan, dll. Sedangkan BPJS adalah badan yang menyelenggarakan JKN ketika disepakati. Tugas pokok BPJS ada 3 yang utama, yaitu (1) merekrut peserta BPJS, (2) mengumpulkan iuran / pendapatan, (3) membelanjakan dana. Oleh karena itu, untuk pelayanan dan monitoring pelayanan kesehatan, lebih baik juga menanyakan ke JKN atau langsung ke bagian pelayanan.
- Posisi BPJS di tengah Kemenkes dan Kemenkeu karena berkaitan dengan layanan yang harus mengikuti standar dan kemenkes (dan JKN) serta aturan dan analisis keuangan dari kemenkeu.
- BPJS melakukan evaluasi internal pada 3 tugas pokok di atas. Belum banyak kepada pelayanan. BPJS juga melakukan evaluasi kapitasi, dan ini juga merupakan rekomendasi dari KPK. Terdapat ujicoba kapitasi berbasis kinerja di Padang dan Palembang. Selain itu, terdapat juga evaluasi kepuasan kepada peserta BPJS.
- Untuk JKN, evaluasi yang dilakukan JKN secara umum lebih banyak pada akses kesehatan merata, peningkatan derajat kesehatan rakyat Indonesia, keadilan dalam pelayanan
- BPJS masih mengalami kerugian karena peserta yang terdaftar ternyata tidak lagi rutin membayar dan tidak maksimal dalam merekrut peserta. BPJS masih dibiayai dari APBN, namun hal ini membuat BPJS sangat dikontrol akuntabilitas, profesionalisme, dan kinerjanya
- Masukkan untuk GPSA : kader lebih baik mengambil yang sudah mengerti mengenai perannya, memiliki personaliti yang persuasif dan sudah terbukti bekerja, misalnya banyak kader dari Dinas Sosial atau Kader Puskesmas. Kader diharapkan mampu (1) memberikan edukasi dan pengetahuan kepada warga pentingnya BPJS dan membanytu kelengkapan administrasi, (2) secara rutin menagih iuran BPJS sehingga pendanaan terus berjalan, bukan hanya daftar tetapi tidak bayar, namun bayar secara rutin adalah yang paling diinginkan BPJS, (3) memberikan edukasi kepada warga untuk hidup sehat, karena saat ini BPJS mau melakukan banyak program di preventif, namun belum banyak dilakukan.

3. Ministry of Health: Expert staff on decentralization

The meeting with MoH took place on May 25, 2016. The purpose of meeting was to introduce AKATIGA and GPSA project, and get input for the project design. Points of discussion:

- *After 2-3 years of BPJS implementation, 60% of the cost is for non communicable disease, e.g. dialysis, heart disease, and diabetes*
- *Regarding health insurance/BPJS, MoH responsibles in health service aspect and membership (funding). The PBI (poor communities that is subsidized by the government) is regulated by Ministry of social affair, but it is not updated regularly*
- *Input for GPSA: the project can refer to the minimum service standard from health facilities. The standards include health infrastructure, drugs availability, management, etc.*

Peserta : Charina, Aprilia, Titik Hartini
Tanggal Pertemuan : 25 Mei 2016
Tujuan pertemuan : initial meeting dengan Kemenkes untuk project Global Partnership of Social Accountability (GPSA)
Butir pertemuan:

- Kartu JKN menurutnya banyak dianggap masyarakat sebagai kartu kredit penyakit, yaitu ketika melakukan registrasi langsung digunakan untuk penyakit - penyakit yang berat seperti operasi jantung, cuci darah, dan bedah lainnya.
- Dari 2 - 3 tahun BPJS berjalan, ternyata 60 % biaya adalah perawatan untuk penyakit tidak menular seperti cuci darah, jantung, diabet. Sedangkan penyakit menular lebih sedikit, namun untuk perawatan lebih kompleks karena biasanya langsung masuk ke ICU (seperti DBD, malaria).
- JKN di Kemenkes lebih pada aspek pelayanan dan kepesertaan (pembiayaan), sedangkan di Kemensos lebih banyak mengurus aspek PBI (Penerima Bantuan Iuran) yang iurannya ditanggung pemerintah. Sayangnya, data PBI ini yang berasal dari data TNP2K dan BPS yang sifatnya by name, by adress tidak terupdate dengan baik.
- Dia menyarankan, jika bisa seluruh data disinkronkan, misalnya dengan EKTP, seluruh data bisa terintegrasi untuk kebutuhan lainnya seperti kartu BPJS. Sedangkan saat inis aja, 1 NIK (Nomor Induk Kependudukan) bisa memiliki 4 nama di Dinas Kependudukan dan Catatan Sipil.
- Masukkan untuk GPSA: mengambil SPM dari rumah sakit, disitu ada standar infrastruktur, ketersediaan obat, dan manajemen, dll). Selain itu, untuk SPM bidan dan dokter, ambil saja indikator kerja pegawai dan seharusnya setiap rumah sakit memilikinya.

4. Presidential Staff Office

The meeting with presidential staff (represented by Yanuar Nugroho) took place on May 25, 2016. This initial meeting was to introduce GPSA project to the presidential staff and get input for the project design. Points of discussion:

- *Presidential staff office (KSP) wants to encourage policy changing regarding health insurance. Focus on universal health coverage and budget efficiency are two different paradigms. Indonesia is one of the lowest on health spending in Southeast Asia, the BPJS mechanism is designed to loss. To achieve universal health coverage, 13-15% of national budget have to be allocated for health spending. KSP advices AKATIGA to involve in policy discussion regarding this.*

Peserta : Charina, Aprilia, Titik Hartini
Tanggal Pertemuan : 25 Mei 2016

Tujuan pertemuan : initial meeting dengan KSP untuk project Global Partnership of Social Accountability (GPSA)
Butir Pertemuan :

- Untuk BPJS, KSP lebih ingin mendorong fasilitasi dan solusi perdebatan policy changing, yang memang cukup radikal. Persoalan mendasar dari KSP, harusnya ada ketegasan pilihan dari pemerintah, apakah lebih pada prinsip universal health coverage atau pada pandangan budget efficiency? Karena ada dua kubu yang berbeda. Misalnya saat ini, 5% APBN untuk kesehatan tidak cukup. Ada peneliti Harvard yang diminta KSP untuk meneliti ini dan Indonesia merupakan negara kedua terendah di Asia Tenggara, dan model-model layanan kesehatannya membuat defisit. Mekanisme BPJS ini dirancang untuk defisit.
- JIka mau minimum health coverage, minimal harus 11 persen dana APBN, bahkan dianggap tidak cukup, harus 13 – 15% dari APBN untuk bisa mengcover layanan kesehatan sektor informal. Tapi paradigma di ring 1 presiden adalah penghematan anggaran, bagaimana mendorong non PBI untuk ikut membayar? Butuh momentum yang pas untuk mendorong ini.
- JIka akatiga mau ikut ke isu layanan BPJS, maka KSP menitipkan untuk tolong masuk ke dalam kompleksitas paradigma. Pemerintah sangat haus akan uang karena memang APBN menurun terus dan tidak ada uang, makanya Jokowi terkesan mencari – cari swasta untuk kerjasama karena memang tidak ada uang.
- Dua unsur yang dititipkan KSP untuk project monev BPJS: (1) bagaimana kelas menengah bisa bayar? (2) bagaimana pemda/APBD juga mau menyumbang?

5. Women faith based organisations: Muslimat NU, Wanita Katolik, Aisyiyah, Fatayat, dan ACE

The meeting with women faith based organisations took place on May 30, 2016. The purpose of this meeting was to gain knowledge about the organisations' experience on BPJS monitoring and get input for the project design. Points of discussion:

- *There is significant gap between policy and reality in the field. Aiyiyah found that the implementation of BPJS is vary in each location. Aisyiyah assisted its poor communities to register as PBI (subsidized BPJS members). WKI conducted BPJS monitoring in east Indonesia and focused of maternal child health.*
- *The challenge in this project is to prepare cadres to collect data that is decent for advocacy. AKATIGA is mostly responsible for building the database and the women faith based organization mostly in organizing cadres in grassroot level.*

Peserta : Charina, Isono Sadoko, Titik Hartini
Tanggal Pertemuan : 30 Mei 2016
Tujuan pertemuan : AKATIGA ingin melihat pengalaman organisasi perempuan basis agama dalam mengawasi JKN
Butir Pertemuan :

- Ada gap yang besar antara kebijakan di atas dengan kenyataan di daerah. Aisyiyah sudah coba melihat implementasi BPJS di beberapa kabupaten dan hasilnya sangat beragam. Aisyiyah sudah melakukan pendampingan dalam bentuk membantu anggotanya yang miskin untuk masuk PBI, saat ini di Ngawi sudah mencapai 700an orang yang menjadi PBI karena pendampingan Aisyiyah. di Cianjur banyak yang kembali ke dukun untuk masalah kesehatan reproduksi dan melahirkan. Hal ini dikarenakan sebelumnya mereka mendapatkan Jampersal, tetapi ketika harus berubah ke BPJS, maka harus mendaftarkan seluruh keluarganya. Banyak yang tidak mampu jika harus langsung satu keluarga ikut BPJS.

- Aisyiyah memiliki kepentingan untuk screening untuk Papsmear dan NIFAS. Aisyiyah selalu mendesak ada layanan gratis untuk PBI
- DKI Jakarta akan mengeluarkan aturan baru mengenai akses BPJS. BPJS belum memasukkan visum. Beberapa LSM di daerah, karena tidak dicover BPJS. WKI sedang advokasi karena biasanya yang meminta adalah polisi ke rumah sakit, jadi belum ada mekanisme penggantiannya.
- WKI mengawasi BPJS di daerah Indonesia Timur seperti Flores dan Manggarai (namun tidak semua kabupaten), dan lebih pada kesehatan Ibu dan Anak.
- Sebenarnya sudah ada SPM dari Kemenkes, tetapi Depdagri juga mengeluarkan SPM umum dan ini menggugurkan SPM yang sudah disusun.
- Yang menjadi tantangan ini, adalah menyiapkan kader yang bisa membangun basis data yang bunyi untuk advokasi. Kita harus membekali diri, data efektif apa yang bisa dicari oleh kader tanpa harus membenani kader.
- AKATIGA lebih banyak bagaimana membangun basis data, sedangkan organisasi perempuan lebih banyak untuk bagaiamna mengorganisasi kader di level bawah untuk melakukan pendampingan.
- Rumah sakit Muhamadiyah bisa hutang berapa milyar dalam satu tahun. Yang harus ditekankan adalah di faskes pertama. Kapitasi di Faskes 1 sangat besar, harus ada akuntabilitas dana BPJS di faskes 1 karena dana sangat besar tetapi Puskesmas kejanya memberikan rujukan terus ke rumah sakit.

6. Head district: Kulon Progo and Banyuwangi

The meeting with head district of Kulon Progo and Banyuwangi took place on April 12 and July 9, 2018. The purpose of this meeting was to deepen the BPJS issues and possibility to pilot the BPJS monitoring in their districts. Points of discussion:

- *Deficit of BPJS is irrational. There should be piloting for more effective and efficient implementation of BPJS.*
- *The proposals from the head districts regarding BPJS: delegation of capitation authority to provincial level; collaboration of local government and BPJS kesehatan; certainty of BPJS coverage; insentive for best practice of BPJS, etc.*
- *For the BPJS monitoring, it is important to check from the supply side (hospital as a health service provider)*

Peserta : Charina, Acep, Isono Sadoko, Herlina Wati
Tanggal Pertemuan : 12 April 2018, 9 July 2018
Tujuan pertemuan : Diskusi tentang pendalaman masalah untuk penajaman proposal monitoring BPJS di Jogjakarta
Butir Pertemuan:

- Perlu ada pilot project untuk pengelolaan BPJS yang lebih efisien dan efektif. Latar belakangnya adalah untuk mencoba mengelola dana BPJS dan mengurangi defisit BPJS yang selama ini semakin tinggi per tahunnya. Menurutnya defisit BPJS tidak rasional.
- Beberapa poin yang bisa masuk ke proposal antara lain adalah:
    a. mendelegasikan wewenang kapitasi ke tingkat 1, tingkat propinsi yang membelanjakannya, sehingga Jamkesda dan Jamkesta bisa menjadi komplemen bagi BPJS (Cat: di berita, kapitasi BPJS menjadi potensi korupsi).

b. Badan pengelola BPJS bisa bekerjasama dengan Pemda, terutama Pemda harus mencover komplemen dari BPJS.
c. Ketegasan batasan apa yang dicover BPJS, dengan limitasi coverage yang berkeadilan (efisien dan realistis).
d. Mengejar service of excellence di layanan kesehatan dengan menggunakan aturan – aturan daerah
e. Mengkaji UU JKN
f. Insentif untuk kinerja/pengelolaan/inovasi BPJS yang baik.
g. Kerjasama dengan PKMK UGM adalah merumuskan problem statement dan research questions yang dibutuhkan agar upaya ujicoba ini lebih fokus

- Tetapi, untuk memulai ujicoba ini, dengan bantuan AKATIGA dan Bappenas, harus ada MOU kerjasama agar secara legalitas juga kuat dan bukan upaya penyalahgunaan anggaran
- Dalam studi BPJS, hal-hal yang ingin diketahui atau perlu lebih jelas adalah : 1)Bagaimana peran Pemda 2) Bagaimana orang yang miskin mendapatkan BPJS dan layanan sesuai aturan BPJS 3) Bagaimana yang tidak miskin mendapatkan layanan sesuai aturan BPJS
- Untuk menjawab pertanyaan tersebut, di Kulonprogo sendiri ada 2 rumahsakit (sebagai penyedia layanan) dari sisi supply side untuk dicek. Perlu juga dilakukan pengecekan dari segi medis, seperti: 1) Untuk pembiayaan siapa yang harus menyelesaikan? Pemda atau BPJS? 2)Apa saja pembiayaan yang paling banyak dikeluarkan oleh pasien? 3) Berapa lama claim rumahsakit dibayarkan oleh BPJS?

7. **Women faith based organisations: Fatayat, Aisyiyah, WKI**

The meeting with women faith based organisations took place on April 12, 2018. The purpose of this meeting was to gain knowledge about the organisations' experience in BPJS monitoring, lesson for the project, and update for the project progress. Points of discussion:

- *Facilitator or assistant responsible in doing outreach and advocacy based on data collected, for example is regarding patients' rights. Simple instrument is needed for cadres to record the gap*
- *BPJS focuses on recruiting members from the big companies instead of from poor communities. This project can focus on poor communities, including recruitment and socialization of patients' rights*
- *Location criterias for project: responsiveness of local government and ths strength of WFB organization in location*

Peserta : Charina, Isono Sadoko, Titik Hartini, Fauzan Djamal
Tanggal Pertemuan : 12 April 2018
Tujuan pertemuan : AKATIGA ingin melihat pengalaman organisasi perempuan basis agama dalam mengawasi JKN
Butir Pertemuan :

- Aisyiyah tidak berperan kepada pendampingan, tetapi pada monitoring dari setiap tahapan pelayanan kesehatan, dari awal sampai bagaimana pasien dirawat.
- Ada 2 hal untuk pendamping: Dia melakukan outreach, lalu dia melakukan advokasi dari data yang telah dimiliki (dibunyikan) misalnya tentang hak pasien di dinas kesehatan, puskesmas, atau di kabupaten
- Harus ada instrumen yang akan memotret ketimpangan. Misalnya kita harus pakai standar BPJS, tetapi bagimana mana yang mau diambil dan tidak membuat kader bingung. Sebisa mungkin sederhana, misalnya check list.

- Kunci dari monitoring adalah menemukan gap, dari apa yang real didapat dengan aturan yang ada
- Jika melihat BPJS, siklusnya saat ini kepesertaan dan akan fokus ke kelompok miskin, jadi advokasi dan pendampingannya bisa fokus. Misalnya, membuat BPJS lebih banyak suka soisalisasi di perusahaan, bukan di masyarakat. Sosialisasi yang sering di lakukan BPJS saat ini adalah untuk kepesertaan saja, belum sosialisasi hak pasien dan layanannya.
- Lebih baik menggunakan data yang sudah ada, misalnya kita meminta ke desa untuk menyerahkan nama - nama orang miskinnya. Kalau untuk Aisyiyah dan Fatayat, saya yakin di wilayah sudah pada tahu dimana daerah - daerah yang banyak kelompok miskin dan belum dapat BPJS.
- Kriteria daerah: 1) pemerintah daerahnya responsif kepada organisasi anda, (2) lokasi yang organisasi andanya kuat.

8. University of Gajah Mada: PKMK UGM

The meeting with PKMK UGM (represented by Shita) took place on May 30 and July 30, 2018. The purpose of this meeting was to gain knowledge about PKMK's research on BPJS and deepen the BPJS issue in implementation. Points of discussion:

- *Common reason of why poor communities cannot register as PBI BPJS is they do not have identity card or family card. We can advocate this to the population agency in certain districts.*
- *GPSA project have to consider what kind of disease or service that is assisted in this project. For the disease, project can focus on maternal child health and non communicable disease that have clear clinical pathway*

Peserta : Herlina, Hilda, Isono Sadoko
Tanggal Pertemuan : 30 Mei 2018, 30 July 2018
Tujuan pertemuan : Mengetahui penelitian PKMK terkait BPJS dan memperdalam isu dalam pelaksanaan BPJS
Butir pertemuan :

- Medical record bisa diperlihatkan ke pasien dan keluarga inti tapi tidak untuk dibawa. Dalam UU hanya disebutkan informasi medical record milik pasien, artinya hanya informasinya saja yang boleh. Medical record pun hanya bisa dilihat di RS, lazimnya, FKTP tidak memiliki medical record.
- Data PBI di daerah dan pusat itu *by name* dan *by address*, seharusnya pemda mengetahui mana yang dibayarin pusat dan daerah. Tidak ada ketentuan pemda harus bayar berapa, tergantung kemampuan pemda masing-masing. Data masyarakat miskin BPJS berasal dari kemensos, daerah punya list lain lagi karena kemungkinan standar kemiskinan berbeda. Pembagian pembayaran PBI pusat dan daerah diatur oleh perda, Bappeda yang berwenang
- Ada KBKP: kapitasi berbasis komitmen playanan. Puskesmas dikasih standar pelayanan harus melakukan abc biar kapitasi diturunkan 100%. Belum tentu ditentukan oleh jumlah pasien yang datang, bisa jadi ada program outreach. Semakin sering ada rujukan ke RS nilai puskesmas makin jelek, kecuali yag memang tidak dilayani di dokter umum. Klinik pratama swasta juga mendapat perlakuan sama kayak puskesmas.
- Yang membuat masyarakat miskin tidak bisa bergabung dnegan BPJS adalah mereka tidak punya KK dan KTP, atau KTPnya daerah luar. Rekomendasi bisa disampaikan ke disdukcapil untuk mengakomodasi orang miskin yang tidak punya identitas

- Harus mempertimbangkan scoopnya penyakit apa/ pelayanan tertentu apa. Saran lingkup penyakit yang memiliki clinical pathway jelas: (1) kesehatan ibu-anak tapi perlu dilihat juga sampai balita atau usia berapa karena proses sangat panjang. KIA bisa fokus di ibu-balita atau ibu-anak baru lahir. (2) PTM hipertensi diabetes karena harusnya bisa ditangani di level pertama, tidak lanjutan. Kalo dia tidak terdeteksi di tingkay pertama biasanya sudah komplikasi makanya biayanya mahal.
- Hasil penelitian JKN, biaya katastropik yang dikeluarkan JKN tidak berpengaruh signifikan karena ada bantuan lain misalnya dari keluarga, tetangga, dll

9. Bappenas/ National Planning and Development Agency: Deputy of Population and Labor

The meeting with Bappenas (represented by Pungky Sumadi) took place in 2018. The purpose of this meeting was to introduce the social accountability mechanism in BPJS monitoring and get support from Bappenas. This meeting discussed about the role of Bappenas in monitoring BPJS, because BPJS still get funding from national budget. Bappenas has been willing to advocate the social accountability mechanism or the result of monitoring when the project eventually is being implemented.

Peserta : Isono Sadoko
Tanggal Pertemuan : 2018
Tujuan Pertemuan : memperkenalkan project monitoring GPSA dan meminta dukungan dari Bappenas

- Bappenas merupakan salah satu badan yang berperan di monev BPJS karena anggaran dari APBN
- Pak Pungky bersedia untuk membantu advokasi hasil dari monitoring maupun mekanisme akuntabilitas sosial dalam monitoring BPJS. AKATIGA akan follow up ketiga WB telah memberi kejelasan dalam pelaksanaan project.

10. Asosiasi dokter / professional associations (dermatologist, oncologist, and urologist)
The meeting with professional associations (represented by dr. Aru and dr. Yanti) took place in 2019. The purpose of this meeting was to get the perspective from medical side of the BPJS implementation. This meeting discussed the coverage of BPJS on cancer disease and victims of sexual assault that is rarely covered by BPJS because the authority is not clear between BPJS or the police.

Peserta : Isono Sadoko
Tanggal pertemuan : 2019
Tujuan pertemuan : mendapat perspektif dari sisi medis terkait pelaksanaan BPJS

- Korban kekerasan seksual kebanyakan diurus di kepolisian, tidak oleh BPJS
- Sejauh mana pengobatan kanker di-cover BPJS dan keluhan yang biasa diterima

11.Legislatives Representatives

The meeting with the egislative member (represented by Hetifah Sjaifudian dan Anggia Ermarini) took place in 2016 and 2018. This meeting discussed the support from legislatives to advocate the monitoring result.

Peserta : Isono Sadoko
Tanggal pertemuan : 2016, 2018

Tujuan pertemuan : memperkenalkan project GPSA dan dukungan untuk AKATIGA terkait monitoring BPJS

- Mendapat dukungan dari perwakilan DPR perempuan dan Kowani
- Membantu advokasi hasil dari monitoring dan pendampingan yang dilakukan dari GPSA

12. Wahana Visi

The meeting with Wahana Visi (represented by Elvi) took place on October 25, 2019. This meeting was to discuss the collaboration between AKATIGA and Wahana Visi to conduct monitoring and evaluation for the GPSA Project. Elvi from Wahana Visi will be the independent evaluator for this project

Peserta : Isono Sadoko, Herlina
Tanggal pertemuan : Jumat, 25-10-2019
Tujuan pertemuan : Diskusi kerjasama dan rencana kolaborasi antara Akatiga dan Wahana Visi

- Input project desain berdasarkan pengalaman wahana Visi
- Mekanisme kerjasama wahana visi dengan independent evaluator untuk project GPSA
- Mekanisme kerjasama wahana visi jika bekerjasama dengan Akatiga

13.Fatayat NU

The purpose of the meeting is to update Fatayat with the progress of the paper work and the project implementation plan. Fatayat NU was represented by Ibu Anggia (parliament member), Ibu Arifah, Ibu Ayu, and Ibu Efri. Beside project update, the meeting also discussed the content and purpose of ESF documents and Fatayat code of conduct.

Peserta : Titik, Sonny, Nurul, Lina, Hilda, Charina, Sari
Tanggal pertemuan : 28 Juni 2020
Tujuan pertemuan : update perkembangan proyek GPSA dan menjelaskan ESF documents
Butir pertemuan :

- Update perkembangan dokumen proyek GPSA: Sejak pertemuan terakhir antara AKATIGA, Florencia (GPSA Bank Dunia), dan Fatayat di kantor AKATIGA bulan Agustus 2019, perkembangan yang terjadi adalah:
    - Semua dokumen project dengan beberapa perubahan telah difinalkan setelah melalui revisi bolak-balik antara AKATIGA, GPSA (terutama dengan Maria Poli dan Alina), serta Elvina (TTL untuk proyek ini di Bank Dunia Jakarta).
    - AKATIGA juga bertemu dengan bagian finance dan procurement Bank Dunia Jakarta yang memeriksa SOP keuangan dan procurement AKATIGA. Satu hal yang diminta Bank Dunia dan harus ada sebelum proyek mulai adalah SOP keuangan antara AKATIGA dan Fatayat.
    - Mengenai gambaran timeline kapan tanda tangan kontrak, secara optimis dalam tiga bulan ini, tetapi control di luar kita. Gambaran tiga bulan diperoleh dari: keinginan WB agar proyek ini tetap masuk di tahun anggaran 2019-2020, ada waktu jeda tiga sejak akhir Juni 2020 utk memasukkan proyek dalam tahun anggaran tersebut.
- AKATIGA memproses semua dokumen terkait safeguard. Pada intinya, dokumen safeguard itu persyaratan untuk menjamin bahwa kegiatan kita tidak akan merusak lingkungan atau mengeksploitasi orang dalam pekerjaan (misalnay, tidak menggunakan buruh anak atau slave labour). Yang diperlukan dari teman-teman Fatayat adalah semacam dokumen tertulis terkait

nilai-nilai Fatayat (code of conduct) yang dapat menjadi rujukan untuk dokumen safeguard. Semua revisi dari AKATIGA dijadwalkan masuk pada Selasa, 30 Juni 2020 dikirmkan ke Alina di Bank Dunia Jakarta. GPSA juga meminta Environmental and Social (ES) focal point bekerja yang lebih intensif untuk mengontrol project.

Documentation of online meeting: