INDONESIA – SUPPORTING PRIMARY HEALTH CARE REFORM (I-SPHERE)
PROGRAM-FOR-RESULTS (PFORR)
P164277

ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT REPORT (ESSA)

May 22, 2018

Prepared by the World Bank

ABBREVIATIONS AND GLOSSARY

TERM	EXPANDED TERM/ DEFINITION
AIDS	Acquired Immunodeficiency Syndrome
AMDAL	Environmental Impact Analysis or *Analisis Dampak Lingkungan*
APBN	National Budget or *Anggaran Pendapatan dan Belanja Negara*
ART	Antiretroviral Therapy
BAPPEDA	District Planning Agency or *Badan Perencanaan Pembangunan Daerah*
BCC	Behavioural Change Communication
BCG	Bacillus Calmette–Guérin Vaccine
BLHD	Regional Environmental Agency or *Badan Lingkungan Hidup Daerah*
BOD	Biochemical Oxygen Demand
BOK	Health Operational Assistance Funds or *Bantuan Operasional Kesehatan*
BPJS	National Social Health Insurance Agency or *Badan Penyelenggaran Jaminan Sosial*
BPKP	Finance and Development Monitoring Agency
BPN	Land Agency or *Badan Pertanahan Nasional*
COD	Chemical Oxygen Demand
DAK	Special Allocation Funds or *Dana Alokasi Khusus*
DAK Akreditasi	Special Allocation Funds for Accreditation or *Dana Alokasi Khusus Akreditasi*
DAK non-fisik	Non-physical Special Allocation Funds or *Dana Alokasi Khusus non-fisik*
DDG	Deputy Director General
DG	Director General
DHIS2	District Health Information System – 2
DHO	District Health Office
DLI	Disbursement Linked Indicator
DPT	Diphtheria, Pertussis (whooping cough), and Tetanus Vaccine
EHS	Environment, Health, and Safety
ESSA	Environmental and Social Systems Assessment
Fasyankes	*Fasilitas Pelayanan Kesehatan*
GERMAS	Community Campaign for Healthy Living or *Gerakan Masyarakat Hidup Sehat*
GIIP	Good International Industry Practice
GOI	Government of Indonesia
GRS	Grievance Redress System
HCF	Health Care Facilities
HIP	Healthy Indonesia Program
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HWMS	Healthcare Waste Management System
I-SPHERE	Indonesia – Supporting Primary Health Care Reform
ISQua	International Society for Quality in Healthcare
JKN	National Health Insurance Program or *Jaminan Kesehatan Nasional*
KAFKTP	Accreditation Commission for Primary Health Care Facilities *or Komisi Akreditasi Fasilitas Kesehatan Tingkat Primer*
KARS	Hospital Accreditation Commission or *Komisi Akreditasi Rumah Sakit*
KBK	Commitment Based Capitation or *Kapitasi Berbasis Komitmen*
KKS	Family Welfare Card or *Kartu Keluarga Sejahtera*
KTP	Civil ID Card *Kartu Tanda Penduduk*
LGBT	Lesbian, Gay, Bisexual, and Transgender
MENKES	Ministry of Health or *Kementerian Kesehatan* (same as MOH)
MKDKI	Indonesian Medical Disciplinary Board or *Majelis Kehormatan Disiplin Kedokteran Indonesia*
MOEF	Ministry of Environment and Forestry

TERM	EXPANDED TERM/ DEFINITION
MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
NCD	Non-communicable Disease
NH3	Ammonia
NSPK	Norms, Standards, Procedures and Criteria or *Norma, Standard, Prosedur, Kriteria*
NTT	*Nusa Tenggara Timur*
Nusantara Sehat	Healthy Indonesia Program
OOPE	Out of Pocket Public Expenditure
PAD	Project Appraisal Document
PBI	Premium Assistance Beneficiaries
PCN	Project Concept Note
PCU	Program Coordinating Unit
PDO	Project Development Objective
Perde	Local Government Regulation
Perpres	Presidential Regulation
PforR	Program-for-Results
PHC	Primary Health Care
PHO	Provincial Health Office
PIS-PK	Healthy Indonesia through the Family Approach Program or *Program Indonesia Sehat melalui Pendekatan Keluarga*
PKAM	P*engawasan Kualitas Air Minum*
PKKL	Protected Area Conservation Center or *Pusat Konservasi Kawasan Lindung*
PLKN	National Service Training Programme or *Program Latihan Khidmat Negara*
PLM	*Pengelolaan Limbah Medis*
PMTC	Prevention of Mother to Child Transmission
PNPM	National Program for Empowerment Program or Program Nasional Pemberdayaan Masyarakat
PNS	Civil Servants or *Pegawai Negeri Sipil*
PO4	Phosphate
Polindes	Village level delivery posts or *Pondok bersalin desa*
Posyandu	Village health posts
PPJK	Center for Financing and Health Insurance or *Pusat Pembiayaan dan Jaminan Kesehatan*
PSC	Program Steering Committee
Puskesmas	Public Primary Health Center
Pustu	Auxiliary *puskesmas*
QSDS	Quantitative Service Delivery Survey
RA	Result Area
Rorenggar	Bureau of Planning and Budgeting
RPJMN	Medium-Term National Development Plan
RSUD	Hospital or *Rumah Sakit Umum Daerah*
SOP	Standard Operating Procedure
STBM	*Sanitasi Total Berbasis Masyarakat*
TB	Tuberculosis
UDB	Unified Database
UHC	Universal Health Coverage
WB	World Bank
WBG	World Bank Group
WHO	World Health Organization
WKDS	Compulsory Service of Specialist Doctor or *Wajib Kerja Dokter Spesialis*
WWTP	Wastewater Treatment Plant

TABLE OF CONTENTS

LIST OF ANNEXES

LIST OF TABLES

EXECUTIVE SUMMARY

1. **This is a report on the Environmental and Social System Assessment (ESSA) process and findings for the I-SPHERE Program for Results (PforR).** The scope of the ESSA process includes the assessment of:

a. potential environmental and social risks and benefits;
b. environmental and social systems that apply to the program;
c. implementation experience and capacity;
d. whether system and performance are consistent with key principles; and
e. steps to be taken to improve scope of system or capacity.

2. **The proposed Program Development Objective (PDO) of the I-SPHERE PforR is: "**Strengthening performance of Indonesia's primary health care system." The Program is expected to improve performance through strengthening accountability, improving management of health services, and enhancing performance-based financing.

3. **The I-SPHERE PforR will focus on supporting key aspects of the existing Government of Indonesia's (GoI) Healthy Indonesia Program (HIP).** The HIP is built on a series of interventions with the goal to improve health and nutritional status of the community through health and community empowerment efforts, backed by equitable distribution of health services and financial protection, particularly to the poor and vulnerable.

4. **The PforR will be hosted within the Ministry of Health (MOH).** [1] However, counterparts relevant to the management of environmental and social aspects of the PforR will be sub-national health offices (Provincial Health Offices and District Health Offices) as well as primary health care service providers (*Puskesmas* and Private Clinics).

5. **The supporting processes for accreditation systems for *puskesmas* and private clinics were the main focus for the assessment.** Other national systems governing waste management and public and worker health and safety, as they relate to environmental risks, were also assessed. The process for assessment was informed by information review, consultations and a visit to facilities in Maluku Province. The preparation of this I-SPHERE PforR was informed through engagement with key national agencies and in Maluku subnational agencies, affected and beneficiary communities, health care providers, and health care workers.

6. **Potential environmental and social risks are likely to result from lack of capacity, commitment and processes and/or implementation of the processes in place.** Risk areas of concern include safe-handling of medical waste, health service providers' health and safety, patient and public safety and poor consent processes and inadequate grievance systems. With varying capacity of health providers to manage such risks, careful management is required and needs to be mainstreamed in the I-SPHERE PforR's Program Action Plan.

7. **The I-SPHERE PforR is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of health care facilities (HCF).** There are no anticipated adverse impacts to natural habitats, physical cultural property, natural resources, or to assets or livelihoods of people based on the activities supported by the I-SPHERE PforR. System assessments with regards to environmental and social risk and impact management emerging from

1 Institutional and Implementation Arrangements: A national Program Steering Committee (PSC) will comprise MOH, *BPJS*, MOF, *Bappenas* and MOHA and will provide policy guidance, implementation oversight and ensure cross-ministry and subnational coordination.

land acquisition, land conversion and infrastructure activities are therefore not within the scope of this ESSA.

8. **The I-SPHERE PforR is expected to enhance inclusion of Indigenous Peoples and vulnerable groups by strengthening primary healthcare accreditation processess through improved community engagement, patient care and safety, cultural appropriateness of service delivery as well as consultation and concent procedures, including the handling of complaints.** The supporting processes for the accreditation system for *puskesmas* and private clinics do not discriminate against groups or individuals and are therefore not expected to adversely any groups, including Indigenous Peoples. Strengthening the system for better outreach, improved community engagement, and tailored primary health care services is expected to ensure appropriateness of service delivery and reduce discriminatory practices which will in turn translate into enhanced social acceptance and accessibility of primary health services.

9. **The accreditations systems for primary health care adequately cover social aspects relevant to the program: community engagement and consultations, including access to information; consent processes; patient rights including complaint handling; and, access and inclusion**. Each health facility is responsible for how they implement the provisions in the accreditations standards, with different capacity and resulting in varied practice. The Program Action Plan together with the PforR results areas aims to support improvement of clinical and managerial performance of primary healthcare facilities (Result Area 2) through support to accreditation processes. If managed well the measures in place will cover social performance on the concerns identified in the ESSA.

10. **The combination of Indonesia's existing national legislation system and the accreditation system for primary health care adequately cover environmental aspects relevant to the program: handling of medical wastes; license to operate; occupational health and safety; patient safety and public health and safety.** However, the capacity of the management of *puskesmas* and private clinics to implement the provisions in the accreditation standards depends on the capacity of the competent person in managing environmental health issues. The capacity is still low for HCFs to manage potential environmental impacts especially with regards to the operation of incinerators (for HCFs that have incinerators), hazardous waste (infectious, toxic chemicals) handling including burial technique, liquid wastewater handling, laboratory waste and radiation. Therefore, the Program Action Plan and the PforR results areas aims to minimize risk and enhance the improvement of clinical and managerial performance of primary healthcare facilities (Result Area 2) especially in managing environmental health

11. **A set of environmental and social actions have been developed and consulted with relevant stakeholders:**

a. Strengthening district oversight of complaint reporting and feedback; and
b. Strengthening accreditation facilitator and surveyor capacity on: medical waste handling, environmental sanitation; emergency response preparedness; complaints handling; and consent processes and patient's rights.

12. **A consultation workshop on the draft ESSA was undertaken on March 15, 2018 with representatives from MOH, DHO and primary health care facilities from the Jakarta area.** The draft ESSA report was circulated prior to the meeting and a summary in Bahasa was also shared. Observations from the workshop have been incorporated into the ESSA report and a complete list of participants and a summary of their comments is included in Annex 3. The final draft of the ESSA report will be disclosed publicly through the World Bank external website and public comments will be solicited during a period defined and reserved for comments.

13. **Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance redress mechanism or the WB's Grievance Redress Service (GRS).** The GRS ensures that complaints received are promptly reviewed in order to address

pertinent concerns. Affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www. worldbank. org/GRS. For information on how to submit complaints to the World Bank Inspection Panel, please visit www. inspectionpanel. org.

A BACKGROUND AND SCOPE

A.1 Program Description

14. **The proposed Program Development Objective (PDO) of the I-SPHERE PforR is: "Strengthening performance of Indonesia's primary health care system."** The I-SPHERE PforR will improve primary health care performance through strengthening accountability, improving management of health services, and enhancing performance-based financing.

15. **In line with the PDO, the I-SPHERE PforR will focus on supporting key aspects of the Government of Indonesia's (GOI) existing Healthy Indonesia Program (HIP).** [2] The HIP (Table 1) is built on a series of interventions with the goal of improving health and nutritional status of the community through health and community empowerment efforts, backed by equitable distribution of health services and financial protection, particularly to the poor and vulnerable.

Table 1: GOI Healthy Indonesia Flagship Program

Priority outcomes: ▪ **Family health – including maternal and child health;** ▪ **Nutrition; and** ▪ **Disease control and environmental health, including both:** o **Communicable diseases (HIV and AIDS, TB and malaria); and** o **Non-communicable diseases (Diabetes Mellitus, Hypertension, cervical and breast cancer, obesity and mental health).**		
Pillar 1: Promoting a Healthy Paradigm	**Pillar 2: Strengthening Health Care Services**	**Pillar 3: The National Health Insurance Scheme**
Objective		
Strengthening preventative and promotional efforts "Healthy Indonesia" through the Family Approach Program (***PIS-PK***) and community campaign for Healthy Living (***GERMAS***)	Improving access to quality primary care, hospital care and referral through accreditation and Human Resources for Health (HRH).	Improving beneficiary enrolment and expansion of benefits at the same time as achieving better quality and controlling costs.
Sub-programs		
-Health prevention, promotion and community empowerment	- Quality primary care - Quality referral care - Pharmaceutical & Equipment - Food and Drug Regulation - Human Resources for Health	-National Health Insurance (*JKN*)
Cross-cutting programs		
-Management, research and development, health information systems; and, -Health financing		

16. **The HIP consists of three pillars:**

a. Pillar 1 Promoting a Healthy Paradigm. This pillar is currently being implemented through strengthening preventive and promotional efforts such as the Healthy Indonesia through the Family Approach Program or *Program Indonesia Sehat melalui Pendekatan Keluarga* (*PIS-PK*) and through a community campaign for healthy living (*Gerakan Masyarakat Hidup Sehat* or *GERMAS*);

2 The Healthy Indonesia Program (HIP) encompasses the entire public health expenditure, through central and local governments, and is valued at IDR 178 trillion (USD 13.2 billion) in 2016.

b. Pillar 2 Strengthening Healthcare Services. This pillar is envisioned to strengthen healthcare services to improve access to quality primary healthcare and hospital services and referral systems, particularly by strengthening accreditation and human resources;
c. Pillar 3 The National Health Insurance. This pillar is focused on beneficiary enrolment and expansion of benefits as well as quality and cost control.

A.2 I-SPHERE Program Boundaries and Activities

17. **The PforR Program will focus on supporting key aspects of the HIP to improve the performance of primary health care service delivery across Indonesia, with an additional focus on the three lagging provinces of *Nusa Tenggara Timur* (*NTT*), Maluku and Papua.** The three coordinated and converging results areas under the PforR are:

a. **Results area 1:** Strengthening performance monitoring for increased local government and facility accountability. Key activities include:
   - Developing a "performance dashboard" using the District Health Information System – 2 (DHIS2) that pulls together agreed performance indicators from various information systems already in place. This will help benchmark performance across districts, make the results public and therefore help improve performance orientation of districts. Another key activity will be to increase the interoperability of key information systems such as the auto-filing of data between BPJS-Health and MOH systems. This will also support the increased use of data verification protocols to improve quality; and
   - Supporting MOH in the development and use of Mobile Health or mHealth[3] as an innovation to support key programs that are delivered by frontline workers, particularly to support the Healthy Indonesia through the Family Approach Program *(PIS-PK*). [4]
b. **Results area 2:** Improving implementation of national standards for greater local government and facility performance. Key activities include:
   - This will support the Accreditation Commission for Primary Health Care Facilities *(Komisi Akreditasi Fasilitas Kesehatan Tingkat Primer – KAFKTP)* to increase its capacity, improve its processes to gain credibility, and become an independent commission, which is a key milestone to achieve ISQua accreditation. This will include developing a business and financing plan, building its capacity, ensuring necessary regulations are in place to be legally independent, begin covering the private sector and applying for ISQua accreditation. In addition, this will support the commission to gain credibility by improving its transparency by publicly disclosure of standards and results. Quality assurance systems such as sample validation of surveyor results as

3 mHealth is a tele-communication platform, operated by frontline health workers to enable beneficiary enrolment and tracking, creating worklists for frontline workers, enabling real time reporting and better supervision to teleconsultations and tele diagnostics, for a range of disease conditions, from immunization to TB to NCDs.

4 The Healthy Indonesia through the Family Approach Program (PIS-PK) is MOH's key intervention which was developed with four main objectives: (i) improving family access to a comprehensive healthcare package covering prevention services, health promotion, basic curative care and rehabilitation; (ii) supporting the local governments to achieve the Minimum Service Standards (MSS) by improving access to health care and health screening; and (iii) improving community awareness to become a JKN member. The first step to implementing PIS-PK is a visit by puskesmas staff to each family to develop a database of 12 health indicators for all families in its catchment area. Analysis of the collected data, will produce a Healthy Family Index (Indeks Keluarga Sehat or IKS) for village, sub-district, district, province and national level. The puskesmas will plan and conduct follow up home visits to address identified risks through behaviour change communication and by facilitating appropriate clinical care, as needed. PIS-PK, supported by mHealth interventions, would enable more accountable and efficient frontline service delivery. Currently, PIS-PK has been implemented in around 30% (2,926) puskesmas in 514 districts, and 34 provinces.

well as introducing better facilitator training and oversight will be introduced. This will also support MOH's target of 5,600 sub-districts with at least one accredited *puskesmas* by 2019;

- Strengthening the clinical and managerial capacity as well as provide the human resources required for the *puskesmas* to achieve accreditation nationally as well as an additional focus on the three provinces in Eastern Indonesia. At the national level, the focus will be on supporting *puskesmas* to achieve higher levels of accreditation (top two out of four levels), which are associated with a more stringent application of clinical quality, community outreach, and managerial performance standards, and will be more difficult to achieve. This will also ensure lagging regions such as Eastern Indonesia are not left behind while pursuing national level targets by ensuring that *puskesmas* in these areas achieve any level of accreditation, which will be difficult by itself;
- Strengthen implementation of priority programs for maternal and child health, including immunization, as well as nutrition, communicable (especially TB) and non-communicable diseases. This will also support to implement necessary continuous quality improvement approaches at the *puskesmas*;
- Providing support for the placement of primary health care teams in remote and difficult to reach areas (lagging regions, disaster-prone areas, border areas, small islands) through the Nusantara Sehat program;
- Strengthening the primary care "gate-keeping" function, and the referral system, through expanding use of an integrated referral information system;
- Addressing the key gender gap of maternal mortality through the improvement of quality of services provided to pregnant women. The above five areas, along with the financial incentives provided in Results area 3, will directly improve the quality of services (family planning, ante-natal, intra-natal, and post-natal services) provided to pregnant women, including in areas with higher MMR, such as Eastern Indonesia. Also, the mHealth application to be used with PIS-PK, will improve demand for these services, and encourage more women to opt for institutional deliveries. Providing quality institutional delivery, or care at child birth, is directly correlated with reduction in maternal mortality, both globally5 and in Indonesia6. Thus, institutional delivery, along with improved and timely referral care (part of the larger Government program), will help address the key gender gap of maternal mortality; and,
- Developing and implementing a capacity building program for improving public sector management functions for lagging districts by conducting intensive workshops for data-driven planning and budgeting concentrated on the development of multi-year plans and annual budgets. These would result in more efficient resource budget allocations but also enable these lagging districts to make more evidence based requests for financing through the *DAK*.

c. **Results area 3:** Enhancing performance orientation of health financing for better local service delivery:

- The PforR Program will support the *MOH* and *MOF* to implement performance-based elements into *DAK* allocations. One important element would be to reward local governments that achieve results in prior years with additional allocations. The Program will also improve the transparency of these allocations to incentivise better performance by enabling local governments to understand how much of their allocations is based on performance. Further, it would enable local governments, and the public to benchmark their "performance based" allocation amounts with others. The program will also support the Government to undertake verification of data used to determine the performance-based allocations, as one means of limiting gaming.
- The Program will support the enhancement of the performance based capitation mechanism to strengthen *JKN*'s role in promotive and preventive health interventions, health system and

[5] Ending Preventable Maternal and Newborn Mortality and Stillbirths; The British medical Journal, 2015

[6] Revealing the Missing Link: Private Sector Supply Side Readiness for Maternal Health in Indonesia, World Bank report, 2017

provider performance improvement, in addition to its current use as a cost containment instrument. The number of performance-based indicators and the quantum of the financial penalty to the providers will both be increased. The joint monitoring of performance financing implementation by MOH and *BPJS–Health* will also be improved. Further details on the Result Framework agreed with MOH are appended in Annex 1.

A.3 Scope of the ESSA

18. **Result Area 2, of the I-SPHERE PforR, on strengthening primary health care to implement national standards for improved clinical and managerial performance, particularly the processes to support accreditation, has informed the scope of the ESSA which is to assess:**

a. potential environmental and social risks and benefits;
b. environmental and social systems that apply to the program;
c. implementation experience and capacity;
d. whether system and performance are consistent with key principles; and
e. steps to be taken to improve scope of system or capacity.

19. **The environmental and social screening assessment (Annex 2) indicated that potential social and environmental risks and impacts associated with the activities supported by the PforR are moderate, with environmental risks in particular requiring further measures.** The program boundaries have changed since concept stage to exclude vertical hospital and accreditation of referral facilities. The screening matrix reflects these changes. The screening exercise on revised framework indicated the potential for the following key environmental and social risks: poor waste management; lack of or ineffective implementation of health and safety measures leading to impacts on patients, workers, and the public; multiple and poor complaint handling procedures; and training and capacity of workers in managing those risks.

20. **Equity in access to health care remains low, with disparities in geographical access, health worker distribution, and quality of services.** Critical concerns for health and well-being in Indonesia are maternal and child health, nutrition, adolescent fertility, and the growth of non-communicable diseases (NCDs), many of which are exacerbated by gender inequalities. The program will contribute to addressing equity issues by including a focus on accreditation of health facilities in three lagging provinces of Eastern Indonesia of Maluku, Nusa Tenggara Timur and Papua, by supporting the national *Nusantara Sehat* program which allocates health worker teams to remote areas, and supporting lagging districts with targeted capacity building for managing health resources. Program support for the Healthy Indonesia through Family Approach (*PIS-PK*) mobile application will address issues of maternal and child health, nutrition, fertility and NCDs, as will the increased performance orientation of "*DAK non-fisik"* and *JKN*. Inclusion of these indicators in the performance dashboards will improve accountability for improvements.

21. **Risks are likely to result from lack of capacity, commitment and processes and/or implementation of the processes in place.** Risk areas of concerns include safe-handling of medical waste, health service providers' health and safety, patient and public safety and poor consent processes and inadequate grievance systems. With varying capacity of health providers to manage such risks, careful management of such risks is required and needs to be mainstreamed in the I-SPHERE PforR's Program Action Plan.

22. **The PforR is not envisioned to support infrastructure investments and/or infrastructure-financing instruments for the construction and rehabilitation of healthcare facilities (HCF).** There are no anticipated adverse impacts to natural habitats, physical cultural property, natural resources, or to assets or livelihoods of people based on the activities supported by the I-SPHERE PforR. System assessments with

regards to environmental and social risk and impact management emerging from land acquisition, land conversion and infrastructure activities are therefore not within the scope of this ESSA.

A.4 Approach to the ESSA

23. **The ESSA process is guided by the key policy elements as established by the Bank Policy Program-for-Results Financing (December 2017) and as they apply to the assessment of the GOI systems and the relevant agencies' capacity to plan and implement effective measures for managing environmental and social risks and impacts.** The key policy elements with regards to environmental and social management systems of the Bank Policy are:

a. promote environmental and social sustainability in the PforR Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts;
b. avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the PforR Program;
c. protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the PforR Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the PforR Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards;
d. manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist the affected people in improving, or at the minimum restoring, their livelihoods and living standards;
e. give due consideration to the cultural appropriateness of, and equitable access to, PforR Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups; and
f. avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

24. **There is not a single and overarching environmental and social system relevant to the ESSA since the I-SPHERE PforR is built on various GOI's sub-programs under the umbrella HIP.** Various systems were assessed as part of the ESSA process, depending on how such systems are relevant in the management of potential environmental and social risks and impacts. The assessment of the GOI's systems for the management of environmental and social aspects takes into account relevant elements within the existing broader systems and selection was based on the level of potential environmental risks and impacts as well as social considerations. The assessment focuses on the adequacy of the relevant systems, including implementation and the GOI's capacity to enforce. The system review is approached in two parts:

a. Identification of relevant systems that are pertinent to the ESSA will be addressed in **Section C** on Review of Policy, Regulatory, and Institutional Frameworks; and
b. Analysis on the implementation of the systems including capacity and enforcement of certain environmental and social measures will be addressed in **Section D**.

25. **The program marks the re-engagement of the World Bank with MOH after a decade without a lending operation.** The institution has gained experience and knowledge in managing environmental and social risks relevant to the program. Capacity building initiatives on HCF environmental sanitation for staff at both MOH and sub-national agencies (PHOs and DHOs) are delivered on a regular basis. This program

is delivered and facilitated by the MOH's Board for Development and Empowerment Human Resource of Health[7].

26. **The ESSA process focused on the systems to address primary health care provision risks associated with:**

a. Environmental considerations: waste management; worker and public health and safety focusing on emergency response; patient safety focusing emergency response; and
b. Social considerations: patient and community participation specifically focused on consent processes, patient rights (including complaint and feedback handling), and level and types of support provided to enable patients and families to understand health care needs and participate in an informed manner.

27. **The ESSA has the following key objectives:**

a. To independently assess and verify environmental and social performance of relevant GOI systems using the Bank Policy Program-for-Results Financing (December 2017) and the Bank's interim note on ESSA as guidance, as well as against good practice in order to:
    - Establish the current status of the potential environmental and social risks and impacts (within constraints of scope and time);
    - Identify key challenges, including gaps, and opportunities to maximise environmental and social benefits; and
    - Make recommendations to address these key challenges and shortcomings.
b. To understand and note the environmental and social value added by the I-SPHERE PforR, and opportunities for operational sustainability.

28. **The ESSA was informed by review of relevant information on the environmental and social systems underpinning the program, engagement and site visits to understand the operationalization of those systems, including the infrastructure in place to support and capacity to implement them.** The ESSA process encompassed**:**

a. Information review of relevant environmental and social management procedures, standards institutional responsibilities that will apply to the I-SPHERE PforR:
    - A review of guidelines for, and regulations related to, *puskesmas* accreditation and relevant journal articles served as the initial identification (screening) of key environmental, social and operational sustainability issues, as well as "red flags" associated with the investment to inform screening for the Project Concept Note (PCN). The screening matrix (Annex 2) was reviewed and revised throughout project preparation to reflect the changing objectives and results areas of the I-SPHERE PforR;
    - Information gathered as part of a joint mission between the WBG and MOH to Maluku Province, and as a result of further refinement of program documentation, informed the Program Appraisal Document (PAD).
b. Consultations for the ESSA undertaken at national (MOH) and Maluku Province (provincial, district and village levels) to discuss the Program's environmental and social intended benefits and potential adverse effects; government counterparts' systems and capacity to manage environmental and social risks; and sustainability.

[7] Badan Pengembangan dan Pemberdayaan SDM Kesehatan, http://www.bppsdmk.kemkes.go.id/web/

c. Site visits in Maluku (11 – 14 November 2017) were undertaken to assess the program systems with key policy elements and attributes defined in the Program-for-Results Interim Guidance Note on ESSA. These visits focused on system assessments at the health office, the provincial planning agencies, hospitals, *puskesmas* and *posyandu*.

29. **The ESSA process enabled the identification of gaps in the documented systems and their implementation, enabling the development of specific actions for improving environmental and social performance (Section E) through support for the implementation of the Program.** The actions outline measures to address environmental and social risks and impacts, when the actions are considered complete, as well as the timeframe, responsibility and resource requirements. The majority of the actions are focused on environmental risks that have been identified while the social is focused on effective systems to understand and manage complaints and consent processes, as well as protection of patient rights. These measures have yet to be discussed and agreed on between the relevant stakeholders and the World Bank and once agreed and finalised will need to be included in the activities to be supported by the World Bank as part of the Program Action Plan.

30. **A consultation workshop on the draft ESSA was undertaken on March 15, 2018 with representatives from MOH, DHO and primary health care facilities from the Jakarta area.** The draft ESSA report was circulated prior to the meeting and a summary in Bahasa was also shared. Observations from the workshop have been incorporated into the ESSA report and a complete list of participants and a summary of their comments is included in Annex 3. The final draft of the ESSA report will be disclosed publicly through the World Bank external website and public comments will be solicited during a period defined and reserved for comments.

B STAKEHOLDER ENGAGEMENT

31. **This section provides a summary of the engagement activities undertaken for the I-SPHERE PforR and specifically for the ESSA as well as future engagement activities for the disclosure of the ESSA.**

32. **Stakeholder groups consulted with include: key agencies (national and subnational); affected and beneficiary communities; health care providers; and health care workers.** Details of the stakeholders consulted with as part of the preparation are presented in Table 2.

Table 2: Stakeholders consulted in the preparation of the I-SPHERE Program.

Stakeholder Group	Stakeholders
National Level	
Government	**Ministry of Health** Secretary General: - Bureau of Planning and Budgeting - Bureau of Finance - Center of Data and Information - Center of Health Financing and Insurance - Center of International Cooperation - Center of Health Determinant Analysis - Health System Strengthening Unit Directorate General of Health Services - Secretariat of the DG of Health Services - Directorate of Primary Health Services - Directorate of Referral Health Services - Directorate of Health Services Quality and Accreditation Directorate General of Community Health - Secretariat of DG Community Health - Directorate of Child Health - Directorate of Environmental Health - Directorate of Nutrition - Directorate of Family Health - Directorate of Health Promotion Directorate General of Disease Control: - Directorate of Surveillance and Quarantine - Directorate of Directly Transmitted Communicable Diseases - Directorate of Non-Communicable Diseases Inspectorate General National Health Workforce Agency (BPPSDM) - Center of Health Workforce Planning and Empowerment National Institute of Health Research and Development (*Litbangkes*) **Ministry of Finance** Directorate General of Fiscal Balance **Finance and Development Monitoring Agency (*BPKP*)** **BPJS-Health** - Directorate of Health Service Insurance - Directorate of Compliance, Law, and Inter Agency Collaboration
Maluku Province	
Government	District Development Planning Agency (*BAPPEDA*) Land Agency (*BPN*) Provincial Health Office Ambon City Health Office
Health Care Providers	Haulussy Provincial Hospital, Ambon (*RSUD*) National Social Health Insurance Agency (*BPJS-Health*), Haulussy Hospital

Stakeholder Group	Stakeholders
	Puskesmas Karang Panjang Masohi District Hospital (*RSUD*) *Puskesmas* Amahai, Masohi Posyandu Amahai, Masohi
Health Care Workers	Hospital Haulussy, Ambon (Head of different programs and head of the hospital) Hospital Masohi, Masohi (Head of different program/unit, health care senior staffs, newly graduated doctors and specialists) *Puskesmas* Amahai, Masohi (Doctor and nurses) *Posyandu* Amahai, Masohi (Cadres and midwifes)
Affected Communities and Beneficiaries	Amahai communities (consisted of patients visiting the *puskesmas* and *posyandu* Amahai).
Jakarta Province – Draft ESSA Consultation	
Government	Provincial Health Agency
Health Care Providers	*Puskesmas* Pasar Rebo *Puskesmas* Kemayoran *Puskesmas* Gambir *Puskesmas* Setiabudi *Puskesmas* Tanjung Priok *Puskesmas* Grogol Petamburan *Puskesmas* Kebun Jeruk *Puskesmas* Tebet *Puskesmas* Kebayoran Baru *Puskesmas* Menteng
International Organizations	
Development Agencies	**World Health Organization**

33. **Engagement on the Program with key stakeholders commenced in November 2015 to inform the program concept and has continued throughout project preparation to inform the assessments informing the program design.** Details of the consultations can be found in Annex 3. Engagement methods included one-to-one meetings, formal presentations, focus group discussions and the sharing of project documentation.

34. **The I-SPHERE PforR is expected to enhance inclusion of Indigenous Peoples and vulnerable groups by strengthening primary healthcare accreditation processes through improved community engagement, patient care and safety, cultural appropriateness of service delivery as well as consultation and consent procedures, including the handling of complaints.** The supporting processes for accreditation systems for *puskesmas* and private clinics do not discriminate against groups or individuals, and hence are not expected to adversely impact any group. Furthermore, strengthening the system for better outreach, improved community engagement, and tailored primary health care services will translate to better outcomes. The program will contribute to addressing equity issues by including a focus on accreditation of health facilities in three lagging provinces of Eastern Indonesia of Maluku, *Nusa Tenggara Timur* and Papua, by supporting the national *Nusantara Sehat* program which allocates health worker teams to remote areas, and supporting lagging districts with targeted capacity building for managing health resources. Program support for the Healthy Indonesia through Family Approach (*PIS-PK*) mobile application will address issues of maternal and child health, nutrition, fertility and NCDs, as will the increased performance orientation of *"DAK non-fisik"* and *JKN*. Inclusion of these indicators in the performance dashboards will improve accountability for improvements. Annex 4 provides further information on community participation, access and inclusion.

35. **A consultation workshop on the draft ESSA was undertaken on March 15, 2018 with representatives from MOH, DHO and primary health care facilities from the Jakarta area.** The draft

ESSA report was circulated prior to the meeting and a summary in Bahasa was also shared. Observations from the workshop have been incorporated into the ESSA report and a complete list of participants and a summary of their comments is included in Annex 3. The final draft of the ESSA report will be disclosed publicly through the World Bank external website and public comments will be solicited during a period defined and reserved for comments. Grievance redress is discussed as part of the systems assessment and proposed actions.

C POLICY, REGULATORY AND INSTITUTIONAL FRAMEWORKS

36. **The review of systems covers the primary health care accreditation systems for *puskesmas* and private clinics as well as systems that fall outside of the accreditation and are of relevance to the risks identified.** The section covers:

a. Relevant systems outside the accreditation systems, particularly in the management of environmental risks and impacts that result from the delivery of health services both in primary health care and referral facilities will be reviewed in view of sustained enhancement of environmental good practices and opportunities in the day-to-day operations of these facilities.
b. The primary health care accreditation systems supported by the proposed program serve as an overarching health governance platform and will be reviewed as they form the entry point for the enhancement of environmental and social outcomes. These systems will be applicable to the operations and management of existing *puskesmas* and private clinics.

37. **Following a consideration of the relevant policy, legal and regulatory frameworks, a summary of the institutional responsibilities is provided as they relate to environmental and social performance both as part of the accreditation processes and any responsibilities that falls outside.**

C.1 Policy, Legal, and Regulatory Frameworks

C.1.1 Government of Indonesia Provisions

38. **Review of pertinent policies, laws and regulations is presented in the following table. Further analysis on enforcement, capacity, as well as challenges will be further elaborated in Section D.**

Table 3: National Policy, Legal and Regulatory Frameworks.

Aspect	Policy/Law/Regulation	Assessment
Handing of Medical Wastes	Law No. 32/2009 on The Protection and Environmental Management, requires management of materials and wastes that are classified as dangerous and/or poisonous or B3 (*Bahan Berbahaya dan Beracun*). Government Regulation No. 74/2001 on Management of Hazardous Materials), Government Regulation No. 101/2014 on Management of Toxic and Hazardous Waste, Government Regulation No. 27/2012 on Environmental Permit). MOEF Regulation no 56/2015 on Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities or Fasyankes and Kepbappedal No 03/Bapedal/09/1995 on Emission standards from Incinerators. MOH Regulation No. 46. Year 2015 regarding Accreditation for Primary Health Care Facilities (specific assessment on this regulation is presented in Table 4). Enforcement of these regulations is carried out through the Provincial/District/Municipal Environmental Impact Management Agency (*BLHD*) for district and provincial level health facilities and Ministry of Environmental and Forestry for vertical hospitals managed by MOH.	No significant gaps with regards to policy and law and regulations. As part of *puskesmas* Accreditation requirements, HCFs are required to develop Standard Operating Procedures (SOPs) in the handling of both medical solid and liquid wastes and also expired chemicals/reagents/medicines and radioactive waste. The requirements in MOEF Regulation no 56/2015 are equivalent to the WBG EHS Guidelines for Healthcare Facilities as they cover good international industry practice (GIIP) such as labelling and symbols for hazardous materials and waste, waste reduction, segregation, storage, transportation (manifest), treatment and handling (with autoclave, incineration), health workers occupational health and safety and public health and safety. The missing element is the necessity to develop a Healthcare Waste Management System (HWMS) and the engineering design consideration in establishing a healthcare facility.
	Furthermore, the GOI system has as permit mechanism for storage, collection, transportation and disposal of hazardous waste including medical waste, i. e. Government Regulation (PP) No. 101/2014 on Management of Toxic and Hazardous Waste.	Government Regulation No. 101/2014 on Management of Toxic and Hazardous Waste regulates the proper management of hazardous waste covering; (i) method of identifying, reducing, storing, collecting, transporting, utilizing, processing, and disposing of hazardous wastes; (ii) risk mitigation and emergency responses to address environmental pollution caused by hazardous waste. The country management of hazardous waste is based on the principle “cradle to grave” as per

Aspect	Policy/Law/Regulation	Assessment
		GIIP with a rigid manifest system (in some provinces already using barcode system) and is a part of proper audit evaluation (Government Environmental Performance Audit for around 2,000 companies nation-wide). Medical waste is listed as hazardous waste due to its infectious characteristics. Any activities from temporary storage, transportation, utilizing and disposal/treatment will require valid license. The sub-national government has only the authority to issue permit for temporary storage, while other activities are managed by national level at MOEF. The regulation also covers the disposal of combustion residue from medical waste incinerators, fly ash and bottom ash as well as provision of incinerator. No sub-national government has a licensed hazardous waste landfill facility for accepting medical waste that cannot be treated at medical facilities (combustion residues, toxic chemicals etc.). Indonesia has only one final disposal facility at *PT PPLI Cileungsi Bogor*, operated by Waste Management International since 1994 and now is owned by a Japanese company and MOEF. Nonetheless, the MOEF Regulation no 56/2015 allows the disposal of incinerator residue (e.g. fly ash and bottom ash) to be disposed at municipal sanitary landfill, provided that pre-treatment e.g. immobilization by solidification using cement or encapsulation with bitumen has been done in advance, and the toxicity characteristic leaching procedure (TCLP) test result of the treated residue meets the stipulated standard.
	Medical Solid Wastes:	No significant gaps with regards to policy and procedures.

Aspect	Policy/Law/Regulation	Assessment
	As regulated in the MOEF Decree No 56/2015 above and MOH Decree No 1204/Menkes/SK/X/2004 on Provision of Hospital Environmental Sanitation, all medical waste packages shall use color-coded waste plastic bags (with symbol) and containers[8] to segregate different waste streams thereby providing assurance that hazardous wastes are being properly handled (e. g. use of safety boxes for disposal of syringes to reduce exposure of hospital staff to sharp-related injuries). Solid medical wastes generated by primary healthcare facilities (*Puskesmas*), where treatment facility is not existent, shall be transported and treated at hospitals/facilities with capacity to handle such wastes. PP 101/2014 and MOH Decree no 1204/Menkes/SK/X/2004 on Provision of Hospital Environmental Sanitation specifies incinerator requirements and outlines requirements for safe-handling of hazardous waste materials, for instance sterilization of wastes with infectious characteristics (e. g. autoclave, incineration, chemical disinfection, returning to suppliers, particularly for cytotoxic wastes, expired medicines in large quantity. MOH Decree no 1204/Menkes/SK/X/2004 provides specific treatment for each type of medical wastes. Incineration is recommended for highly infectious wastes, used sharps (e. g. syringe, glass, pipettes), pharmaceutical waste, and cytotoxic wastes. The combustion residue (ash) is categorized as hazardous waste and must be sent to licensed hazardous waste landfill at PPLI Cileungsi Bogor, West Java or treated as per provision of the MOEF Regulation no 56/2015 for incinerator residue. MOH Regulation No. 46. Year 2015 regarding Accreditation for Primary Health Care Facilities (specific assessment on this regulation is presented in Table 4).	
	<u>Medical Liquid Wastes</u> The MOH Decree no 1204/Menkes/SK/X/2004 (aligned with WHO's guidelines) require HCFs to apply the following measures in the handling of medical liquid wastes: Where possible, hospitals should be connected to municipal wastewater treatment plants (WWTP). Hospitals that are not connected to municipal WWTPs should install compact on-site sewage treatments (i.e. primary and secondary treatment, disinfection) to ensure that wastewater discharges meet applicable thresholds.	No significant gaps with regards to policy and procedures for handling the wastewater. The GOI system has also the effluent standard that specifically regulate hospital's effluent similar and to the WBG EHS Guidelines for Health Care Facilities (Performance Monitoring), even for specific parameter it is stricter, for example 100 mg/L for COD (Indonesia) and 250 mg/L (WBG Guidelines).

[8] Yellow for infectious waste, violet for cytotoxic waste, brown for chemical and pharmaceutical wastes, and red for radioactive waste

Aspect	Policy/Law/Regulation	Assessment
	Puskesmas and hospitals in remote locations should provide for minimal treatment of wastewater through affordable means (e. g. use of lagoons or wastewater treatment septic tanks) to achieve an acceptable level of purification, followed by infiltration of final effluent to the land). Sewage from hospitals should never be used for agricultural or aquaculture purposes; Sewage should not be discharged into or near water bodies that are used for drinking water supply or for irrigation purposes (i. e. infiltration to soil must take place outside of the catchment area of aquifers. Convenient washing and sanitation facilities should be available for patients and their families, and hospital staff to minimize the potential for unregulated wastewater discharge MOH Regulation No. 46. Year 2015 regarding Accreditation for Primary Health Care Facilities (specific assessment on this regulation is presented in Table 4). MOE Decree No 58/1995 on Hospital Effluent Discharge Standard includes pH, BOD, COD, Temperature, NH3, PO4, Microbiology (e-Coli) and Radioactive (11 elements, 12 isotopes). MOH Regulation No 37/2012 about Laboratory Management for *puskesmas* covers provisions about liquid and hazardous waste from hospital laboratory.	
License to Operate	MOH Regulation No. 56/2014 about the Licensing and Classification of Hospitals. MOH No. 46. Year 2015 regarding Accreditation for Health Care Facilities (specific assessment on this regulation is presented in Table 4).	No significant gap found.
Occupational Health and Safety	The Indonesian Law No. 36/2009 on Health (section XII) promulgates that PHOs/DHOs are required to oversee and ensure occupational health and safety for health workers and provide them with preventive, treatment, and rehabilitation services. Policies and guidelines are issued by MOH. By regulation, every health worker is also required to be enrolled in the JKN to obtain social protection related to work-related accidents or work-related diseases (Law No. 24/2011 on BPJS and Presidential Regulation No. 109/2013). Government Regulation (PP) No. 50/2012 on Practice of Health and Safety Management.	No significant gap found. The regulation ensures the right of every worker to protection, health and safety to achieve optimal work productivity, and requires implementation of a health and safety system. If compared to WBG EHS Guidelines for Healthcare facilities for personnel safety, the Indonesian requirements are generally equivalent.

Aspect	Policy/Law/Regulation	Assessment
	Appendix VIII of MOEF Decree no 56/2015 about Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities provides guidelines on health worker protection, health and safety. MOH No. 46. Year 2015 regarding Accreditation for Primary Health Care Facilities (specific assessment on this regulation is presented in Table 4).	
Patient Safety	Appendix III of MOEF Decree no 56/2015 about Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities regulates the requirement for hazardous storage location to protect patient safety and visitors. Furthermore, the regulation for building standards, ventilation from the Ministry of Public Works. MOH Regulation No. 46. Year 2015 regarding Accreditation for Primary Health Care facilities Article 3 states that all health facilities mentioned is compulsory to be accredited that also cover patient safety aspect. MOH Regulation No. 75 Year 2014 on *puskesmas*, Article 39 states that in order to maintain quality service, all *puskesmas* need to be accredited periodically once every three (3) years. Decree of the Minster of Health No. 59 of 2015 on the commission on accreditation of health facilities at the first level.	No significant gap found. The national laws and the accreditation laws ensure that patient safety is very important and has the necessary process and standards to ensure that high-quality management of *puskesmas* and private clinics are expected.
Public Health and Safety	MOE Decree no 16/2012 about AMDAL Document preparation contains provisions about Public Health and Safety consideration (Appendix II and III). Article 15 and Appendix III, V, VI of MOEF Decree no 56/2015 about Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities regulates the requirement for the minimum distance of incinerators, hazardous storage location to school, public facilities, residential area (about 30 m) protect surrounding community's health and safety. The MOH Decree no 1204/Menkes/SK/X/2004 on Provision of Hospital Environmental Sanitation. MOH Regulation No. 46. Year 2015 regarding Accreditation for *puskesmas*, Private clinic, Private Practice Doctor and Dentist Article 3 states that all health facilities mentioned is compulsory to be accredited.	The requirements in MOEF Decree no 56/2015 and MOH Decree on 1204/Menkes/SK/X/2004 are equivalent to the WBG EHS Guidelines for Healthcare Facilities as they cover GIIP related to public health and safety such as pest management, decontamination and disinfections, proper incineration technique, manifest system for transportation of hazardous waste, and competency requirement for the environmental health officer. This includes the packaging system of medical waste, colour coding and symbol system to prevent people coming into contact with medical waste on route to the final disposal area or at the

Aspect	Policy/Law/Regulation	Assessment
	Permenkes 75/2015- Appendix 1- regulates the requirement of the location of the *puskesmas* that must be free from natural hazards such as hurricanes, floods, earthquake (faults), steep slope, tsunami, at river bank area (erosion potential). Article 39 states that in order to maintain quality service, all *puskesmas* need to be accredited Decree of the Minister of Health No. 59 of 2015 on the commission of accreditation of health facilities at the first level	waste facilities. A thorough manifest system regulated in Appendix IV of the PemenLH 56/.
Patient Rights including Consent	Several laws guarantee patient rights. Protection of confidentiality, information about treatment and costs, and informed consent to any procedures as well as rights to refuse any medical treatments/procedures and seek for second opinion (Law No. 29/2004 on Medical Practice, Article 52 and the Health Act, the Hospital Act and the Medical Practice Act). Citizens have the right to choose services, to be treated without prejudice and discrimination, to have access to information regarding services, to be heard and complaint as well as legal access to litigation (Law No. 8 of 1999 on Consumer Protection). Access to health services for people with special needs is also protected by law, with health providers required to ensure their facilities are accessible and services are non-discriminatory. The information regarding the illness, treatment, prognosis, and alternative treatments should be accessible to patients and families regardless information requests. Medical negligence and litigation implicating medical professionals (doctors and dentists) is investigated by the Indonesian Medical Disciplinary Board (*Majelis Kehormatan Disiplin Kedokteran Indonesia/MKDKI*). The MKDKI is an autonomous body of the Indonesian Medical Council (KKI) and is authorized to issue testimony/statements with regards to negligence or mistakes or ethical issues in medical practices as well as remedial measures necessary including sanctions.	In terms of regulations and procedures, patient rights are fully protected and comprehensively defined. However, enforcement varies with sanctions being rarely enforced. Access to information with regards to the quality of health services is limited both in public and private health facilities (Indonesia Health System Review, 2017). Accreditation status may serve as an indication of the quality and credibility of services provided by accredited facilities.
Grievance Management	By law, patients have the option to file a law suit in court or to appeal to the Indonesian Medical Disciplinary Board (MKDKI) (Law No. 8/1999 on Consumer Protection). The role of MOH in terms of addressing complaints tends to be on an ad-hoc basis and the current operating GRM platform (Halo *Kemkes* 1500-567, SMS 081281562620, fax (021)5223002, 52921669 and/or kontak@kemkes. go. id) is not specifically designed to address health-related grievances, but rather overall health administration which is	The legal recourse is likely to be inaccessible based on the inability of most patients to engage with the system or afford the process and costs of raising a complaint. It is difficult to charge medical professionals under the criminal code (*Kitab Undang-Undang Hukum Pidana*) despite neglect and/or

Aspect	Policy/Law/Regulation	Assessment
	challenging to track specific health issues by specific health facilities unless the issues are captured in the mass-media.	malpractices leading to injury, disabilities or even deaths. Under these circumstances, the use of civil code (*Kitab Undang-Undang Hukum Perdata*) may be pursued and complaints may be settled through financial compensation for improper services. There is no centralised grievance redress process or procedure for managing patient complaints.
Access and Inclusion	Access to healthcare is guaranteed under the Indonesian Constitution. Citizens have the right to choose services, to be treated without prejudice and discrimination, to have access to information regarding services, to be heard and complaint as well as legal access to litigation (Law No. 8 of 1999 on Consumer Protection). Procedures governing access to *JKN* require the possession of an ID Card (*Kartu Tanda Penduduk or KTP*) which then impacts on people being able to access healthcare. The National Social Security System (Law No. 40/2004) provides a framework for the development of social security programs. This law was passed with a vision to protect all citizens, particularly the vulnerable, from financial risks arising from sudden shocks and disasters, such as illnesses, injuries, and old age. The National Social Security Council (*Dewan Jaminan Sosial Nasional*) oversees the implementation of this law. Under the framework of this law, all citizens are required to be enrolled in social security schemes through individual or employer contributions or government subsidies for the poor. Recipients of the government subsidies are regulated in the GOI's Regulation No. 101/2013 and targeting is based on the Unified Database (UDB). All poor Indonesian citizens (lowest quintiles) are eligible for the subsidies provided that they are registered in the UDB. The benefit package for the *JKN* was stipulated in the MOH Regulation No. 69/2013 on the implementation guidelines for the national health coverage program. To date, *JKN* is considered to be the most comprehensive government health insurance program, covering outpatient and inpatient care from primary up to tertiary hospital levels. Some exclusion or partial coverage applies to certain treatments (e. g. cosmetic procedures, including prosthetic dental care, fertility programs, alternative therapy, etc.) as well as price caps for certain equipment (e. g. wheelchairs, hearing aids, etc.).	The government plans, programs, laws and regulations cover universal access to primary healthcare. The health system does not discriminate citizens based on ethnicities and socio-cultural characteristics. People in very remote areas, including Indigenous Peoples and those who are not formally registered or transient populations (including nomadic, seafaring, farming communities, temporary and migrant workers) often lack access to health services. Unregistered individuals (those without KTP) may not be formally recognized as residents, and therefore not proposed for social assistance programs and *JKN*. In addition, because of the non-permanent nature of their residence and/or civil status, they not be included in censuses/surveys and outreach activities by *puskesmas*. Limited coverage of civil registration may be due to lack of legal services, complex bureaucracies and long distances to register at the district level, as well as lack of awareness of the need for such legal identity documents (PUSKAPA and KOMPAK, 2016). Indonesian national laws are largely silent with respect to LGBT (lesbian, gay, bisexual, and transgender) people, and neither explicitly

Aspect	Policy/Law/Regulation	Assessment
	With the objective of achieving a Universal Health Coverage (UHC) as envisioned in the country's Medium-Term Strategic Plan (RPJMN 2015 – 2019), the National Social Security Scheme, which attempted to integrate various government health insurance schemes, was rolled out in 2014. *BPJS-Kesehatan* (National Social Security Agency for Health) is responsible for the overall management of the program. To lay the groundwork for *JKN*, the GOI has developed a road-map towards achievement of UHC. Access to health services for people with special needs is also protected by law, with health providers required to ensure their facilities are accessible and services are non-discriminatory. The information regarding the illness, treatment, prognosis, and alternative treatments should be accessible to patients and families regardless information requests.	criminalize them nor protect them, though in their application they are often used to harass and discriminate against LGBT people. Further, at the local level, there are provinces, cities, and regencies that explicitly criminalize LGBT people.

C.1.2 Accreditation System Provisions

39. **Accreditation serves as a platform to promote good practices in environmental and social management of healthcare facilities.** Initially, hospital and medical service standards[9] were developed in 1993 as a benchmark for delivering quality services (MOH decree No. 436/MENKES/SK/VI/1993). These standards consisted of criteria around patient safety, infection control, waste and utility management, and access to care and continuity of services that hospitals were encouraged to achieve. However, compliance to these criteria varied and was aspirational in some cases since they were not made mandatory. A program for accreditation of hospitals began in 1995 to further mainstream these standards in the health system with the establishment of a hospital accreditation body known as *KARS* (*Komisi Akreditasi Rumah Sakit* or Commission for the Accreditation of Hospitals). [10] At the inception stage, the program was voluntary and had low coverage (Hort, Djasri and Utarini, 2013).

40. **Independent accreditation systems aim to promote greater accountability, synchronization, and standardization of health services both provided by public and private healthcare providers in addition direct oversight by relevant health offices.** In Indonesia, there are three levels of government with roles and responsibilities for health care and hospital regulations. The national government (MOH) is responsible for regulations and oversight at central hospitals (Vertical Hospitals), the Provincial Government for provincial hospitals (both public and private), and the District Government for district hospitals (both public and private). Delivery of primary healthcare is provided through a chain of services, with a network of *puskesmas* spearheading basic health services at the community level as well as through private clinics of doctors and midwives. Accreditation systems for both hospitals and *puskesmas* are currently in place, with the latter being relatively new.

41. **Accreditation has been increasingly used in Indonesia as a platform to monitor, maintain and improve the quality and safety performance of primary healthcare facilities (*Puskesmas*/PHC).** MOH through the Directorate of Primary Health (*BUK*) has undertaken a process to develop PHC accreditation since 2011. The Norms, Standards, Procedures and Criteria (*NSPK*) were developed in 2014 and an accreditation commission, currently under the purview of MOH, was also established in the same year (MOH Decree No: HK. 02. 02/MKES/59/015). The *RPJMN* (the National Medium-Term Plan) sets out annual targets for PHC accreditation over the period between 2015 – 2019[11] with an exponential increase of 100% each year. By December 2017, 4,200 *puskesmas* have been accredited as of December 2017, of which 30% have received the basic level (*dasar*) and 58. 5% midlevel (*madya*) accreditation.

42. **Through accreditation, improvement and maintenance of primary care health services is approached through periodic reviews and accreditation renewal and/or upgrade every three years.** Government oversight is performed by the MOH, and provincial and district health offices (PHOs and DHOs), depending on the jurisdictions and status of hospitals, with PHCs remaining in the purview of DHOs.

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9 The standards include 1) administration and management, 2) medical services, 3) acute and emergency services, 4) high risk perinatal services, 5) nursing care services, 6) anaesthesia services, 7) radiology services, 8) pharmaceutical services, 9) laboratory services, 10) medical rehabilitation services, 11) nutritional services, 12) medical records, 13) services on health, fire, and disaster preparedness, 14) operating theatre, 15) intensive care, 16) hospital infection control, 17) sterilization services, 18) infrastructure maintenance, 19) other services, 20) library.

10 KARS has been a member of the International Society for Quality in Health Care (ISQUA), an international accreditation organization.

11 The RPJMN sets out PHC annual accreditation targets from 2015 – 2019 i.e. 2015: 350 PHCs, 2016: 700 PHCs, 2017: 1400 PHCs, 2018: 2800 PHCs, 2019: 5,600 PHCs.

43. **The following table summarises the relevant environmental and social aspects of the accreditation systems for primary health care.** A more detailed description of the accreditation system and processes with reference to environment and social aspects is provided in Annex 5**.**

Table 4: Accreditation Policy, Plan, and Procedures.

Aspect	Accreditation Aspect	Assessment
Handing of Medical Wastes	<u>*Puskesmas*</u> - Chapter 2 on *puskesmas* leadership and management in ensuring that (Standard 2. 1) *puskesmas* location and (Element criteria 2. 1. 4) on *puskesmas* infrastructure which is available, maintained and functioning properly to support access, security, smoothness in providing services in accordance with the services provided. - The required infrastructure includes: clean water sources, sanitation installations, electrical installations, air systems, lighting systems, fire prevention and handling, mobile health center vehicles, fences, corridors, health manpower offices, and other infrastructure as required. - *Puskesmas* also required that (Element criteria 2. 1. 5) medical and non-medical equipment is available, maintained and functioning properly to support access, safety, smoothness in providing services in accordance with the services provided. This include medical and non-medical equipment requiring permits have permits that apply. - The management of *puskesmas* (Chapter 2, Standard 2. 6 Maintenance of Facilities and Infrastructure) needs to ensure *puskesmas* facilities and equipment must be maintained in order to be used as required and in accordance with applicable regulations. - In handling any third-party contract (Chapter 2, Standard 2. 5 Third Party Contracts), any or if some activities are contracted out to a third party, the manager guarantees that the implementation by a third party meets the established standards. This might be applicable in managing third party contractors especially in handling the disposal of medical waste. - This is also stated in (Chapter 8 Clinical Services Support Management, Standard 8. 5 Management environmental protection) which covers compliance with applicable legal, regulatory and licensing requirements especially in handling medical wastes. - The other provision in the same chapter includes (Element Criteria 8. 5. 2 Inventory, management, storage and use of hazardous materials	No significant or material gaps with the requirement from GIIP as stipulated in WBG EHS Guidelines for Healthcare Facilities to achieve the objective of staff, patient, visitors and public health and safety. The only concern is about the ability to achieve accreditation with poor performance of the as the basic level of accreditation can still be granted with a score of 20% in four of the nine accreditation chapters (quality improvement; community health leadership; management of clinical services; and clinical quality and patient safety). One of the four chapters covers hazardous wastes, sending mixed signals about compliance with the prevailing laws and regulations about waste management. The standard needs to be applied more rigorously to ensure that *puskesmas* to comply with the requirements as part of getting accreditation.

Aspect	Accreditation Aspect	Assessment
	and control and disposal of hazardous wastes) shall be carried out in accordance with adequate planning. - It states in (Element Criteria 8. 5. 3 Effective program planning and implementation) that the *puskesmas* needs to ensure that the safety of the physical environment is managed by a competent officer.	
	<u>Private Clinics</u> - Chapter 3 Clinical Services Support Management covers laboratory management (if any) (Standard 3. 1, Element Criteria 3. 1. 1.) would be carry out by competent person and experienced to implement and interpret monitoring results. He/she is responsible (Element Criteria 3. 12) to ensure that relevant policies and procedures for every type of laboratory activities. It will cover the necessary monitoring procedures for medical waste (hazardous and non-hazardous). - Chapter 3, Standard 3. 3. requires clinics that provides radio diagnostic services (if any) needs to have a safety protection program for radiation including written procedures on how to manage and dispose of infectious and toxic materials. They are also required to report their safety program report at least once a year or if there is any incident.	
Licence to Operate	<u>*Puskesmas*</u> - All *puskesmas* are required to follow (Chapter 1, Standard 1. 2 Access and Implementation of activities) when determine the type of health activities that is allowed and to provide in accordance with applicable national legislation and guidelines from the MOH. - All *puskesmas* (Chapter 2, Standard 2. *1Puskesmas* location, Element Criteria 2. 1. 1) needs to have the necessary valid building permits and in accordance with the spatial layout of the district/cities. For ensuring smooth operation, *puskesmas* needs to have (Element Criteria 2. 1. 2) buildings that fulfil healthy environmental requirements.	No significant gaps with the requirement of licensing to operate or the permitting system for effluent of wastewater and incinerator emission (Chapter about legal aspect of the HCF)
	<u>Private Clinics</u> - All clinics are required to follow (Chapter 1, Standard 1. 1, Element Criteria 1. 1. 1 and 1. 1. 2) All clinics needs to have the necessary permit to operate, valid building permits and in accordance with the spatial layout of the district/cities. For ensuring smooth operation, all clinics need to have buildings that fulfil healthy environmental requirements.	

Aspect	Accreditation Aspect	Assessment
Occupational Health and Safety	*Puskesmas* - All *puskesmas* (Chapter 2, Standard 2. 1*Puskesmas* location, Element Criteria 2. 1. 1) needs to have the necessary valid building permits and in accordance with the spatial layout of the district/cities. For ensuring smooth operation, *puskesmas* needs to have (Element Criteria 2. 1. 2) buildings that fulfil healthy environmental requirements. - The management of *puskesmas* are required (Element criteria 2. 3. 13 Work environment) to provide safe working environment to minimize risk for *puskesmas* users and employees. The definition of work environment includes occupational conditions including physical, environmental and other factors such as noise, temperature, humidity, lighting or weather to the safety of environmental disturbances. The criteria also require remedial solution for the potential impacts due to challenging work environment. - All *puskesmas* needs to ensure that (Chapter 8, Standard 8. 5 Management environmental protection) it covers compliance for environmental protections are within the applicable legal, regulatory and licensing requirements. In (Element Criteria 8. 5. 1) this criterion, it requires that *puskesmas* physical environment, electrical installation, water, ventilation, gas and other systems to be regularly checked, maintained and repaired as necessary	No significant or material gaps with the requirement from GIIP as stipulated in WBG EHS Guidelines for Healthcare Facilities to achieve the objective of staff, patient, and visitors' health and safety. However, the guidelines for accreditation could be strengthened by putting examples of the OHS's regulatory application at the PHC level as the basis for SOP development stipulated in the standards.
	Private Clinics - Chapter 3 Clinical Services Support Management covers laboratory management (if any) will ensure that the competent person is responsible (Element Criteria 3. 1. 2) to ensure that relevant policies and procedures for every type of laboratory activities. It covers the routine monitoring schedule for the use of protection gear and the implementation of worker health safety procedures. - Chapter 3 (Element Criteria 3. 1. 8) on the preparation of safety program needs to be planned, implemented and documented for working in laboratory. - Chapter 3, Standard 3. 3 requires clinics that provides radio diagnostic services (if any) requires all staffs that operates the radio diagnostic equipment to attend orientation on the procedures and safety practice.	
Patient Safety	*Puskesmas*	

Aspect	Accreditation Aspect	Assessment
	- All *puskesmas* are required to implement Chapter III, VI and IX, which provides the guidelines for the standards that focused on improving quality and patient safety. - The quality and performance improvement of *puskesmas* is consistent with the values, mission, mission and objectives of the *puskesmas*. (Chapter 3, Standard 3.) - It is the responsibility of the Head of *puskesmas* and team *puskesmas* (Element criteria 3. 1. 4) to evaluate the performance improvement activity through internal audit that carried out periodically. - There are guidelines for Quality and Performance Improvement (Element criteria 3. 1. 1) and it is prepared jointly by Quality Management as it is responsibility of the Head of *puskesmas*. - Chapter 7 Patient- Oriented Clinical Services, Standard 7. 1 Patient Registration Process) requires all *puskesmas* to (Element criteria 7. 1. 1) takes into account on patient and patient safety from when the patient first contacts with *puskesmas*, thus the registration procedure already reflects the application of patient safety efforts, especially in-patient identification. - With Standard 7. 2 Assessment (Element criteria 7. 2. 1.) requirement, all *puskesmas* would need to prepare preliminary early assessment procedures (including physical examination and investigation and social studies) to identify the various needs and expectations of patients and families of patients including medical, medical and nursing service. - As part of patient safety, (Element criteria 7. 2. 3) allows patients with emergency needs, urgent, or immediately given priority for assessment and treatment. This include infection that is air-borne which could pose health threats to communities if not treated properly. - In Chapter 4 Targeted Public Health Efforts, (Standard 4. 1, 4. 2 and 4. 3) requires all *puskesmas* to plan the need for public health efforts consisted of the needs of the community and aspiration in terms of health care. It also includes how to allow access to communities and how to target community health effort activities. The Head of *puskesmas* and responsible *puskesmas* are required to evaluate the performance of the implementation of activities *puskesmas* in	No significant or material gaps with the requirement from Good International Industry Practice to achieve the objective of patient health and safety.

Aspect	Accreditation Aspect	Assessment
	achieving goals and meet the needs and expectations of the community /target activities objectives. - For *puskesmas* that has laboratory services (Chapter 8 Clinical Services Support Management, Standard 8. 1 Laboratory services) requires that (Element Criteria 8. 1. 2) there are specific policies and procedures for each type of laboratory examination. This include proper SOP or guidelines in lab safety and lab operation, action, monitoring, storage and disposal for hazardous medical waste. All safety program for labs needs to be planned, implemented and documented as part of the accreditation process (Element Criteria 8. 1. 8). - As part of ensuring the accuracy and precision of the results, essential reagents and other necessary daily materials are always available and evaluated (Element Criteria 8. 1. 5). - If *puskesmas* offers radio diagnostic services, (Standard 8. 3) it will ensure that the services provided will meet the patient's needs, and comply with applicable national standards, legislation and regulations. - All *puskesmas* are required to implement the standards in Chapter 9 for improving clinical quality and patient safety. This includes preparing and implement standard operation protocols for evaluating indicators and standard for measuring clinical quality and patient safety. Head of *puskesmas* is responsible to ensure that clinical quality and patient safety program and activities are planned and implemented.	
	<u>Private Clinics</u> - The planning, monitoring and evaluation of clinical quality and patient safety is the responsibility of all clinical staff (Chapter 4 Improving clinical quality and patient safety, Standard 4. 1). - Private clinics are required to measure, collect and evaluate the clinical quality and targets to achieve for improving patient safety (Standard 4. 3). - There should be an organizational chart for indicating each person's responsibilities to ensure the improvement of clinical quality and patient safety would be achieved through a working team (Standard 4. 4, Element Criteria 4. 4. 1).	

Aspect	Accreditation Aspect	Assessment
Public Health and Safety	*Puskesmas* - *Puskesmas* is responsible for ensuring the implementation of activities professionally and on time, on target in accordance with the purpose of activities based *puskesmas* needs and expectations of society (Chapter 4, Standard 4. 1, Standard 4. 2). - To ensure the health of local communities that is near the location of *puskesmas* are not exposed to any environmental hazard risk. (Chapter 8, Standard 8. 5 Management environmental protection covers compliance with applicable legal, regulatory and licensing requirements). - One way to ensure is to (Element Criteria 8. 5. 1) required that all *puskesmas* physical environment, electrical installation, water, ventilation, gas and other systems to be regularly checked, maintained and repaired as necessary - All *puskesmas* needs to do inventory, management, storage and use of hazardous materials and control and disposal of hazardous wastes shall be carried out in accordance with adequate planning (Element Criteria 8. 5. 2). - All effective program planning and implementation to ensure the safety of the physical environment is managed by a competent officer (Element Criteria 8. 5. 3) Private Clinics - All clinics are required to prepare policies, procedures and documents that will ensure the implementation of clinical services to patients (Standard 2. 6).	No significant or material gaps with the requirement from GIIP as stipulated in WBG EHS Guidelines for Healthcare Facilities to achieve the objective of public health and safety. For improvement, the guidelines for accreditation could be equipped with template to implement public health and safety regulatory requirements at the PHC level. Standard 8. 5. 2 included the availability of the packaging system of medical waste, colour coding and symbol system to prevent people coming into contact with medical waste on route to the final disposal area or at the waste facilities. A thorough manifest system regulated in Appendix IV of the PemenLH 56/2015 also serves to prevent the potential adverse impact to public during transportation and is part of the accreditation system for *puskesmas* that always being endorsed by Local Environmental Agency in cooperation with Local Health Agency. For *puskesmas* that have the incinerator and decontamination facilities the medical waste generation is reduced as they now only produce combustion residue and general waste. Other *puskesmas* that don't have such facilities would generate more medical waste and waste reduction effort as regulated at PermenLH 56/2015 at such *puskesmas* is highly recommended.
Community engagement and consultations, including access to information	*Puskesmas* - Chapter 1 on *puskesmas* Service Delivery calls for a participatory assessment of health needs and services with community representatives to inform *puskesmas* annual plans (Standards 1. 1, 2. 3). Various approaches could be used such as surveys, one-on-one communication, meetings, outreach, workshops, etc. - *Puskesmas* are also required to develop a strategy with clear indicators to enable performance evaluation by service users and sustained quality improvements with defined roles and responsibilities (Standards 1. 3, 3. 1, 6. 1). Documentation of these consultation,	Being in the public sector, *puskesmas* are required to have mechanisms and measures in place to ensure that community needs and aspirations in terms of health care are fully reflected in their annual plans through participatory processes. This requirement is not mandatory for private clinics. Furthermore, standards with regards to community outreach and empowerment are applicable to *puskesmas.*

Aspect	Accreditation Aspect	Assessment
	engagement, evaluation and quality improvement processes forms the basis of the facility performance assessment. - Information with regards to the types of services as well as schedules must be made available and accessible to the public (Standards 1. 1, 1. 2). Patients and families should be well informed about their rights and responsibilities as well as information that may arise through diagnostic assessments (standards 7. 1, 7. 2). - Health education and counselling services are available for patients and families (Standard 7. 8).	
	<u>Private clinics</u> - Available services are communicated and made accessible to the wider public (Standard 1. 3, Criteria 1. 3. 6). - Information with regards to registration protocols, tariffs, types of services, referral facilities should be made available and accessible to the public (Standard 2. 1). - Development of treatment plans shall be made jointly with patients and families in a transparent manner (Standard 2. 4). - Health education and counselling services are available for patients and families (Standard 2. 8).	
Consent processes	<u>*Puskesmas*</u> - *Puskesmas are* required to develop clear procedures with regards to obtaining consent from patients and families prior to administration of medical treatments (Standard 7. 4). - Informed consent shall be applicable throughout treatment cycles and duly documented (Criteria 7. 4. 4);	Both *puskesmas* and private clinics are required to have procedures in place with regards to obtaining consent, including documentation from patients and families prior to administration of medical treatments. PHC accreditation standards do not specify specific treatment categories requiring consent and leave such classification open-ended. Relevant information with regards to treatments, consequences and side effects including possible consequences shall be provided by health care providers. Since accreditation surveys would rely on the existence of such procedures as well as available documentation, the implementation quality of consent processes as well as patients' perceptions and understanding may not necessarily inform scoring since these aspects may be difficult to be obtained during the three-day assessment.
	<u>Private clinics</u> - Treatment plans and medication shall be coordinated and decisions must involve patients and families (Standard 2. 4). - Informed consent shall be acquired prior to administration of medical treatments (Standard 2. 4).	

Aspect	Accreditation Aspect	Assessment
Patient rights including complaint handling	<u>*Puskesmas*</u> - *Puskesmas* are required to develop a mechanism and strategy through which citizen feedback, including complaints, can be accommodated, documented and followed up for improvements (Standards 1. 2, 3. 1, 4. 2, 7. 6). - Patient registration procedures shall be made accessible with clear protocols to be duly followed by *puskesmas* staff (Standard 7. 1). - Information with regards to patients' rights and responsibilities should be widely disseminated and accurately reflected in *puskesmas*' codes of conduct and overall management (Standard 2. 4, 5. 7). - *Puskesmas are* required to develop clear and transparent referral procedures (Standard 7. 5). - Codes of conduct including measures to protect confidentiality with regards to management of patients' clinical conditions/medical records and diagnosis shall be available and followed (Criteria 7. 5. 3, Standard 8. 4). - Patients and families have the rights to refuse certain treatments or referrals (Standard 7. 6).	Standards with regards to patient rights including their families are elaboratively defined for both *puskesmas* and private clinics. This includes access to grievances redress and feedback mechanisms. Every facility is required to have such mechanisms in place. However, the accreditation standards, including the survey protocols may not necessarily reflect the functioning and accessibility of such mechanisms.
	<u>Private Clinics</u> - Information with regards to patient rights and responsibilities shall be widely made accessible to the wider public. Focus is on customer-oriented service provisions (Standard 1. 4). - There are procedures to assess customers' satisfaction and appropriate follow-ups (Standard 2. 1). - Patients and families' rights and responsibilities are due informed during registration (Criteria 2. 1. 3, Standards 2. 1, 2. 2). - Patients have the rights to accept decisions with regards to administration of treatments, including refusal of certain services (Standards 2. 4, 2. 6). Their needs, including grievances shall be identified during treatment processes and there are procedures for follow-ups and grievance resolution (Standard 2. 6).	

Aspect	Accreditation Aspect	Assessment
	- Codes of conduct including measures to protect confidentiality with regards to management of patients' clinical conditions/medical records and diagnosis (Standard 3. 4)	
Access and Inclusion	<u>*Puskesmas*</u> - *Puskesmas* are required to ensure that services are accessible and appropriate (based on participatory and consultative assessments with community representatives – Standard 1. 2) - There are efforts to empower communities to improve overall health outcomes (Standard 2. 3). - This includes optimizing *puskesmas* networks with other facilities and referral services to expand availability and access to services (Criteria 2. 3. 14). - *Puskesmas are* required to minimize barriers with regards to health care services stemming from language, physical disabilities, socio-cultural factors (Standard 7. 1). - Clinical treatments shall be meaningfully developed with patients by considering their biological, psychological, social, customary and spiritual needs (Standard 7. 4).	*Puskesmas*, being in the public sector, are responsible to ensure that their services are accessible and inclusive. Specific programs aimed at community empowerment and outreach form the basis of the accreditation assessment. However, the accreditation survey may be unable to capture information with regards to the quality and delivery of such programs. Issues around exclusion may not be necessarily captured in the overall accreditation processes due to their complex and nuanced nature. Community outreach and access are not mandatory standards for private clinic accreditation.
	<u>Private Clinics</u> - Clinics are required to minimize barriers with regards to health care services stemming from language, physical disabilities, socio cultural factors (Standard 2. 1). - Clinical treatments shall be meaningfully developed with patients by considering their biological, psychological, social, customary and spiritual needs (Standard 2. 4).	

C.2 Institutional Responsibilities

44. **The PforR will be hosted within the MOH. [12] However, counterparts relevant to the management of environmental and social aspects of the PforR will be sub-national health offices (PHOs and DHOs) as well as primary health care service providers (*Puskesmas* and Private Clinics).** A national Program Steering Committee (PSC) will comprise MOH, BPJS-Health, MOF, *Bappenas* and Ministry of Home Affairs (MOHA) and will provide policy guidance, implementation oversight and ensure cross-ministry and subnational coordination. Program implementation will involve the following MOH implementing units: Bureau of Planning, Directorate of Primary Health care, Directorate of Referral Health Care, Directorate of Health Facilities, Directorate of Health Care Quality and Accreditation, Directorate of Health Promotion, Directorate of Environmental Health, Center of Data and Information, Center of Health Financing and Insurance, Center of Health Workforce Planning and Empowerment, and various Directorates within the DG of Disease Control. In addition, the program will also require the participation of selected units within BPJS-Health, MOF and MOHA, and the Accreditation Commission. The Directors of these units will form a technical committee, providing overall technical guidance for the program. Internally, MOH will use existing managerial decision-making structures to direct implementation of the Program. Implementing units involved in the program will report to their respective Director Generals. The Head of the Bureau of Planning will be the Director of the Program Coordinating Unit (PCU), consisting of a technical working group and a management group. The technical working group will consist of technical staff specialized in areas relevant to the core needs of the program. The management group will organize, for example, program monitoring and evaluation, engagement with the Independent Verification Agent, and preparation of the program financial statements. Depending on the skills required, staff will be seconded from the Directorates/Centers or, where there is a lack of capacity, consultants will be hired. The provincial and district health offices will implement the program in the three eastern Indonesia provinces. The PCU will mobilize technical assistance as needed to support implementation in the three provinces.

45. **Within the decentralized health system[13], the relationships between MOH, PHOs, and DHOs is not a strictly hierarchical one, with each level having its own authority and mandates.** PHOs and DHOs are under their respective provincial and district governments, which are under the Ministry of Home Affairs. Decentralization is associated with fragmentation of the health system with disconnection of authority lines between MOH and sub-national health agencies (PHOs and DHOs). This creates challenges in ensuring accountability as well as performance benchmarking in terms of health services (availability and quality). [14] However, there are still many roles retained by the central government such as defining requirements and quotas for civil servants (PNS), controlling financing (such as through *JKN* and *DAK*), establishing the regulatory framework, and some strategic interventions in areas such as immunization, management of disease control, and maternal and child health. Accreditation systems serve as a quality control platform and governance tool managed by the central level through independent entities.

46. **The accreditations systems and the supporting processes for primary health care adequately cover social aspects relevant to the program: community engagement and consultations, including access to information; consent processes; patient rights including complaint handling; and, access and**

12 Institutional and Implementation Arrangements: A national Program Steering Committee (PSC) will comprise MOH, BPJS, MOF, Bappenas and MOHA and will provide policy guidance, implementation oversight and ensure cross-ministry and subnational coordination.

13 According to Law No.32/2004, decentralization is defined as transfers of authority by the central governments to autonomous regional governments to regulate and manage their own affairs.

14 Despite the existence of a national information system (SIKNAS) linked with district-level health information systems (SIKDAs), communication across levels of governments has been challenged by lack of inter-operability of these information systems (different formats, software, datasets) and voluntary reporting requirements from district to province and province to central (often with weak verification). Such issues also apply to the private sector. This has consequently presented barriers for health planning, budgeting as well as targeting.

inclusion. Each health facility is responsible for how they implement the provisions in the accreditations standards, resulting in varied capacity and practice. There are some weaknesses in terms of

a. access and inclusion where the accreditation survey may not necessarily be able to capture information with regards to the quality and delivery of primary health care services;
b. exclusion may not be necessarily captured in the overall accreditation processes due to the issues being complex and nuanced in nature;
c. the accreditation standards, including the survey protocols may not necessarily reflect the functioning and accessibility of grievance redress mechanisms; and
d. the implementation quality of consent processes as well as patients' perceptions and understanding may not necessarily inform scoring since these aspects may be difficult to be obtained during the three-day assessment.

47. **Considering the detailed requirements for environmental health, as outlined in** Table 4 **including the need to have competent officers in handling these aspects, capacity is low in primary healthcare provision to manage potential environmental risks.** This is particularly so with regards to the operations of incinerator (for those facilities that have incinerators), hazardous waste (infectious, toxic chemicals) handling (including burial technique), liquid wastewater handling, laboratory waste, and radiation.

48. **The following table provides a summary of the institutional responsibilities with respect to environmental and social performance.**

Table 5: Institutional Responsibilities for Environmental and Social Performance within the I-SPHERE PforR.

Institutions	E&S Institutional Responsibilities
National	
Ministry of Health (MOH)	- Setting standards, regulatory frameworks and strategic directions including regulatory frameworks pertaining to the handling of medical wastes, occupational health and safety, patient care, etc. - Ensuring availability of financial and human resources (including distribution). - Mediation of grievances (although on an ad-hoc basis). - Managing *puskesmas* accreditation system. The accreditation commission is still retained within MOH.
Accreditation Commission for PHC facilities ***KAFKTP***	- Managing accreditation system for *puskesmas* and Private Clinics and developing roadmap for the establishment of an independently accreditation body.
MOEF	- Issuing Permit for Hazardous Waste Transportation and Disposal – Central MOEF. - Issued Permit for Medical Waste Handling and Disposal, including the revocation of permit to waste transporter/disposal facility. - Conducted audit – MOEF to check licence/permit requirements during proper audit. - MOH issued license to operate. - Issued Ministerial Regulation related to Patient Safety – MOEF and MOH. - Issued Ministerial Regulation related to Public Health and Safety – MOEF and MOH.
Subnational	
Provincial Health Offices (Maluku, ***NTT***, Papua Provinces)	- Provision of technical oversight and monitoring of DHOs, including formulation of technical policies/SOPs with regards to health services and management of wastes if needed. - Facilitate cross-district coordination (e. g. managing exchanges of specialists to fill gaps, capacity building) and extension of MOH for the implementation of national programs[15]. - Mediation of grievances (although on an ad-hoc basis).
District Health Offices	- Organizing and implementing various health interventions such as epidemiology surveillance, communicable and non-communicable diseases, environmental health, HRH, promotional and preventive health measures. - Management of *puskesmas* (and their auxiliary facilities (*Pustu* and *Polindes* as well as private clinics).

15 Although PHOs serve as an extension to MOH, there is no clear statement/regulation requiring DHOs to answer/ report to PHO unless PHO is managing specific transfers from MOH for certain programs

Institutions	E&S Institutional Responsibilities
	- Mediation of grievances (although on an ad-hoc basis).
District Environmental Agencies	- For Hazardous Waste Storage – District Head or Governor.
Frontline service providers: *puskesmas* (and their auxiliary facilities) and private clinics.	- The frontline health services are provided by *puskesmas* and their auxiliary facilities (*Pustus*). *puskesmas* usually provide outpatient care but those with better infrastructure can also operate inpatient services, with an average capacity of 11 beds (Directorate of Health Services, 2014). *Pustus* function as an extension of *puskesmas* and is staffed by a nurse. *Pustus* are responsible for outreach facilities and basic health services for remoter parts of *puskesmas*' catchment areas. In addition to *Pustus*, villages may also be supported by *Poskesdes* (village health posts) and *Polindes* (village midwife posts) for birthing services and *posyandu* for monthly health monitoring (as well as immunization) for infant, pregnant mothers, and the elderly. In some regions, further outreach is provided by Mobile *puskesmas.* - Such services are both provided by both public and private providers (both profit and non-profit) as well as private doctor and midwife practices. - Head of *puskesmas* – ensures all medical waste management requirement fulfilled. - Head of *puskesmas* – ensures all the health and safety requirements are fulfilled. Responsible Program Leader / *puskesmas* and responsible service and program implementers. - Plant operator, EHS officer follow the guidelines and SOPs.

D CAPACITY AND PERFORMANCE ASSESSMENT

49. **This section summarises the key findings or gaps of the assessment of implementation of systems including capacity of the relevant institutions to effectively implement the environmental and social management systems summarised in the previous section**. The section also summarises the extent to which the applicable systems are consistent with the key elements (details of the analyses is presented in the matrices in Annex 6) as well as statements on the commitment of the relevant institutions to undertake measures to address the key gaps.

D.1 Environmental Considerations

50. **Potential Program impacts that fall outside healthcare facilities, include from the transportation and disposal of hazardous waste and incinerator emissions or wastewater discharges to surrounding environment.** Several criteria in the *puskesmas* Accreditation System regulate these aspects, such as Standard 8. 5. 2 has included the availability of the packaging system of medical waste, colour coding and symbol system to prevent people coming into contact with medical waste on route to the final disposal area or at the waste facilities. A thorough manifest system regulated in Appendix IV of the PemenLH 56/2015 also serves to prevent the potential adverse impact to public during transportation and is part of the accreditation system for *puskesmas* that always being endorsed by Local Environmental Agency in cooperation with Local Health Agency. No sub-national government has a licensed hazardous waste landfill facility for accepting medical waste that cannot be treated at medical facilities (combustion residues, toxic chemicals etc.). Indonesia has only one final disposal facility at PT PPLI Cileungsi Bogor, operated by Waste Management International since 1994 and now is owned by a Japanese company and MOEF. Nonetheless, the MOEF Regulation no 56/2015 allows the disposal of incinerator residue (e.g. fly ash and bottom ash) to be disposed at municipal sanitary landfill, provided that pretreatment e.g. immobilization by solidification using cement or encapsulation with bitumen has been done in advance, and the toxicity characteristic leaching procedure (TCLP) test result of the treated residue meets the stipulated standard. Several criteria in the *puskesmas* Accreditation System regulate these aspects. It is necessary also that members of the public receive adequate information regarding potential infection hazards within the facility, and at associated waste disposal sites (e. g. landfills). Ministry of Environment Decree no 16/2012 about *AMDAL* Document preparation has specific provisions about Public Health and Safety consideration (Appendix II and III). Further, the government sets the emission and effluent standards for incinerators and wastewater to protect the environment and people within the area of influence of a project. Potential program impact that fall outside healthcare facilities from the above aspects are possible and the facilitator of the accreditation program shall be made aware of the 'cradle to grave' responsibility of the healthcare providers. Life and fire safety is also applicable to buildings that are accessible to the public such as healthcare facilities. Visitors' health and safety is also important as part of public safety. Emergency preparedness and response procedure and disease prevention are intended for staff, patient and visitors of the healthcare facilities.

51. **Emphasis should be given to standardizing solid and liquid waste management practices among HCFs participating in the Program through strengthening the accreditation process and implementation.** Different provinces in Indonesia whereby the total number of 4223 *puskesmas* had been accredited as of date. Only 20 *puskesmas* did not manage to pass the basic grade after final accreditation process. Based on the National QSDS Report (2016), facilities performed well in terms of final disposal of sharps-related wastes. More than half of the *puskesmas* and three fourths of the private sector clinics used the services of a third party professional waste management agency for final disposal of sharps-related waste. About 11% of the *puskesmas* buried their discarded sharps in a pit or covered ground. However, the use of third party services for non-sharp medical waste was much less with only about a third of the *puskesmas* and just over half the private sector facilities using the same. The facilities that did not use these services appear to dispose of the waste in the ground, with about one-fifth of the *puskesmas* not even

covering the ground or pit that contained these medical wastes. (National QSDS, 2016). The relevant national regulation is the MOEF *Regulation no 56/2015 on Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities*. The Decree is very comprehensive and provides guidelines managing hazardous medical waste and the segregation of medical waste based on category for hospitals and *puskesmas*. Based on field assessment one not surveyed/not accredited *puskesmas* the facility provides very basic services and lacks a full-time doctor. Most of the patients are outpatient. They do not have proper/well equipped equipment/instruments and appear to dispose of medical waste in the ground, by covering the ground or pit, and by burning medical wastes such as expired drugs and used syringes. Some of the reasons were the lack of training for medical staffs (e. g nurses), no guidelines or SOPs, poor awareness among medical staffs and lack of budget to implement the necessary measures such as accreditation for the *puskesmas*

52. **Only about a quarter of the facilities (26% private clinics and 29% *puskesmas*) met all the criteria regarding infection prevention and waste disposal (National QSDS, 2016).** Infection prevention is key to patient and health worker safety, in terms of avoiding nosocomial (health facility acquired) infections. The gaps in both *puskesmas* and private facilities in terms of infection prevention and waste management equipment, systems and supplies could be minimized though staff training, (and also accreditation facilitators and surveyors), good quality hospital management system and hygiene protocols being introduced and implemented. At least one instrument for sterilizing medical equipment was available in 87% and 64% of the *puskesmas* and private sector facilities, respectively. (National QSDS Report, December 2017). The most common equipment in both these places was the electric dry heat steriliser, while the electric autoclave, that uses both heat and pressure to sterilise equipment, and is considered the best of all sterilization equipment, was rarely seen in the sampled facilities. The various supplies required for direct patient care such as running water and soap (or disinfectant) to clean hands, latex gloves, or disposable syringes were generally available in over 80% of the facilities. However, even this seemingly small gap is a cause of concern as lack of infection control can lead to adverse and even fatal patient outcomes. The *puskesmas* were slightly better off than the private sector for these supplies. (National QSDS, 2016).

53. **Healthcare facilities operations may have adverse effects on medical staff, healthcare providers, housekeeping personnel, workers involved in waste management handling, storage, treatment and disposal.** The potential hazards are generally from exposure to infectious materials (sharps/needles, blood-borne pathogens, pathological waste) and exposures to radiation and other hazardous materials and waste such as toxic chemicals, pharmaceuticals and cytotoxic waste, used clothes/dressings, equipment etc. There is also the risk of fire due to storage, handling of chemicals, pressurised gas and other flammable substrates). Indonesia country systems have a comprehensive set of regulations to govern this aspect such as the MOEF Regulation no 56/SetDitjen/2015 on Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities (*Fasyankes*) including appendix VII on Personnel Safety, MOH Decree No 1204/Menkes/SK/X/2004 on Provision of Hospital Environmental Sanitation and higher level regulations that govern Occupational Health and Safety such as The Indonesian Law No. 36/2009 on Health (section XII) promulgates that PHOs/DHOs are required to oversee and ensure occupational health and safety for health workers and provide them with preventive, treatment, and rehabilitation services and also Government Regulation (PP) No. 50/2012 on Practice of Health and Safety Management in general. However, implementation on the ground is still a challenge, indicated by the recent QSDS survey that found low adherence to the regulation on medical waste management from *puskesmas* operations across Indonesia.

54. **The basic elements of HCF facilities such as the location of the facility, building standards, ancillary facilities (laboratory, blood banks, temporary waste storage), disinfection and sterilization of equipment, sanitation services, staff competency and monitoring and evaluation are important to ensure the health and safety of patients, especially to prevent nosocomial infections at the facility.** Appendixes I to X of the MOH Decree no 75/2014 about *puskesmas* covers all key important aspects above.

Appendix III of MOEF Decree no 56/2015 about Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities regulates the requirement for hazardous storage location to protect patient safety and visitors. Also, specific design requirements for health care building standards, ventilation, pest management and decontamination are regulated in the MOH Decree no 1204/2004 about the Provision of Hospital Environmental Sanitation. And lastly, specific criteria of *puskesmas* Accreditation has been created, i. e. about patient safety (Chapter 9), as per regulated by MOH Decree no 46/2015. Based on field assessment of one not surveyed/not accredited *puskesmas* in Central Maluku, no wastewater treatment facilities (*IPAL*) such as septic tanks or no proper procedure on how to handle medical waste such as expired medicines and syringes were available. There was an old safety box marked as biohazard for used syringes was found in the medical room. However, it is not being utilized instead medical waste was burnt and buried in the ground or pit behind the *puskesmas*. Awareness for the facilitator and surveyor of accreditation program on the potential health impact from this poor practice is needed.

55. **Patients and healthcare workers, including medical staff in *puskesmas,* are vulnerable in case of a fire and emergency situations caused by natural disasters.** The accreditation standards and processes require implementation of an emergency strategy for *puskesmas* healthcare workers. The standard requirement for building permits, sprinklers, alarm and detection systems and staff training work should be standardized in all the *puskesmas* in the country to ensure that patients can be safely and adequately protected if there are fire or natural disaster incidents. *puskesmas* were significantly more likely to have the technical guidelines available in the facilities compared to the private sector. The probable reason is because the government publishes these guidelines and is mandated to share those with the *puskesmas*. (National QSDS, 2016). Technical guidelines are one way of ensuring quality of services as they list down standard management protocols that use the most recent evidence. The more *puskesmas* that are accredited – and the higher level of accreditation they achieve - will ensure that these guidelines are available, healthcare workers are trained and follow the management and quality assurance systems set up by GOI. Based on field assessment of one not surveyed/not accredited *puskesmas* in Central Maluku, it is staffed by a doctor (on rotational schedule as there is a shortage of doctors) and few full-time nurse staffs but most of the time, they will visit their patients at their home especially for maternity patients. Their main primary care services included providing maternal and child health care, general outpatient curative and preventative health care services, immunization and community preventive health awareness program. The *puskesmas* did not have emergency response plan or any fire extinguisher was not sighted during field visit. Due to lack of full time doctor, it is rarely open after mid-day or every day.

56. **Based on the field assessment of one not surveyed/not accredited *puskesmas* in October 2017, has all necessary valid licenses to operate.** However, improvement is needed to improve patient health and safety providing medical support facilities (e. g. patient beds, sterilization equipment, wastewater treatment including septic tanks and sufficient drug supplies to treat patients with different ailments), increasing number of medical specialists in referral hospitals and hiring adequate medical staffs for *puskesmas*. The allocated fund for improvement health services in *puskesmas* is adequate but the process for liquidation of the fund is slow due to bureaucracy system. This will affect the services provided by the *puskesmas* to ensure patient health and safety.

57. **Institutional Capacity for Environmental Performance Management of Directorate of Environmental Health (MOH):** The Directorate manages the Dashboard Environmental Health as a system to collecting data and information on waste management generated by health service facility which includes primary health facilities (*Puskesmas*) based on Government Regulation No. 101 of 2014 on the Management of Hazardous and Toxic Wastes and Decree of the Minister of Health No. 1204 of 2004 on Hospital Health Requirements. There are 6 main components that fulfils the quality for the Environment Health (*PKKL*). There are: 1) implementation of Community Based Total Sanitation / Sanitasi Total Berbasis Masyarakat (*STBM*), 2) Monitoring quality of clean water / *Pengawasan Kualitas Air Minum* (*PKAM*), 3) Fulfilment of s health requirements / Memenuhi Syarat *Kesehatan*; 4) Medical Waste

Management / *Pengelolaan Limbah Medis* (*PLM*); 5) Food sanitation meets health requirement / *Memenuhi Syarat Kesehatan*; 6) Health area indicator / *Tatanan Kawasan Sehat* (*TKS*). Every year, there will training on managing waste management procedures and protocol conducted by their own instructors to different healthcare facilities including primary health facilities (*Puskesmas*). It is conducted in Bogor, Central Java in two batches. Each batch is around 150 people. The budget is from the national budget (*APBN*). Medical waste management is a priority training for the directorate. There are two types of monitoring processes depending on the type of waste. For medical waste that is hazardous and toxic, it will be monitored/enforced by the Ministry of Environment and Forestry under Ditgen Waste (Local Environment Agency, *BLHD*) in provinces and cities. For normal and domestic waste from the primary health facilities, it will be managed and discarded to the final disposal area which is managed by local governments.

58. **Institutional Capacity for Environmental Performance Management of Directorate Quality and Accreditation of Health Services (MOH):** All surveyors managed by the Accreditation commission have been trained to identify potential risks in relation to the patient safety and environmental health through a 3-day training program dedicated to this aspect. The revised and improved module for this training was introduced in late 2016 for new surveyors and also for the existing surveyors. However, specific training for environmental and social risk beyond patient safety is still not available. For this year 2018, MOH is planning to improve the guidelines for the surveyor on the accreditation system and this will be a good opportunity to introduce better environmental and social management aspect into the guidelines of the accreditation standards. For example, strengthening the guidelines in technical and legal aspects of HCF waste management facilities (as currently the standard is only to appraise the physical existence of the waste water treatment facility as part of administrative survey review without the analysis of the workability of the system and its compliance with the effluent standard), and also the assurance of the third part contractors' performance and its legal status in waste handling as the responsibility of the HCF does not end with the contractor.

D.2 Social Considerations

59. **Social effects to be assessed were informed by the I-SPHERE program objective of supporting systems towards strengthening provision of essential health care to be made universally accessible to individuals and acceptable to them, through full participation and at a cost that can be afforded.** The social considerations were: patient and community participation specifically focused on consent processes, patient rights including complaint and feedback handling and level and types of support provided to enable patients and families to understand health care needs and participate in an informed manner.

60. ***Puskesmas* are the backbone of the Indonesian health system. They play a key role in engaging communities and promoting health care, largely through *posyandu* in remote and rural areas.** This includes monthly check-ups and primary health care services as well as immunization and vitamin distribution, usually for pregnant mothers, infants and the elderly. Both *puskesmas* and private clinics provide information and counselling services about childhood nutrition (breastfeeding and complementary breastfeeding) and vaccines (including potential side effects and management of follow-up schedules and doses). However, according to the QSDS[16] only a fraction of the private clinics surveyed (less than 15%) provided such services. This underscores the key role of *puskesmas* and *posyandu* for engaging

[16] Indonesia Qualitative Service Delivery Survey (QSDS) (2016). This survey examined health care facilities and services of both private clinics and puskesmas, focusing on nutrition, maternal and child health, communicable diseases (particularly, HIV and AIDS, tuberculosis, and malaria), and non-communicable diseases (NCDs). The survey covered 268 puskesmas and 289 private clinics across 22 districts, including sample districts in Eastern Indonesia.

communities, providing information, and promoting the delivery of public goods, such as vitamins, food supplements, and immunizations.

61. **Primary-care accreditation standards call for participatory assessments of community health needs as well as services.** However, efforts to foster alignment of health priorities between *puskesmas* and villages constrained by a lack of coordination. Factors that limit local engagement and/or complementary support and funding for health services include:[17]

a. The Plan of Action (POA) for *puskesmas*, including annual work plans, are out of sync with the timeframe for village planning and budgeting processes (also known as *Musrenbangdes*). Village planning takes place toward the end of each year, and POA formulation occurs at the beginning of each year.
b. Communication with *puskesmas* often rests with external facilitators, instead of village cadres and village government officials, particularly for districts receiving national programs (e.g., *Generasi Sehat Cerdas* which is implemented by the Ministry of Villages to support village planning processes). This creates the impression that village-level health interventions, including those supported/financed by village funds, are still associated with national programs.
c. Regulations and accounting procedures for *puskesmas* operational funds, including National Health Insurance Program (*JKN*) funding caps[18] and operational support funds (*BOK*), are restrictive and may inadvertently limit funds in order to avoid overlaps with village-supported health intiatives.

62. **The primary health care facility should obtain patient consent through a defined process and carried out by trained staff.** This includes:

a. A list of categories or types of treatments and procedures requiring consent;
b. Provision of adequate information, in an accessible and understandable form, about the illness, proposed treatment and care providers so that patients and, as appropriate, families, can make informed decisions and provide informed consent; and
c. Obtaining informed consent prior to decision-making.

63. **Obtaining consent from patients and families is a standard requirement (standard 7. 4 for *puskesmas* and 2. 4 for private clinics) for health practitioners before initiating any procedures and/or medication.** However, enforcement of consent procedures and patients' awareness to demand consent likely varies across facilities. In order for consent to be exercised, information regarding illness, treatment, prognosis, and alternative treatments should be made available and accessible to patients and families regardless information requests. *puskesmas* and private clinics particularly in rural areas likely limit their services to basic health care treatments where consent processes may be weakly exercised since requirements for consent are considered needed for serious and high-risk treatments. From site visits undertaken to facilities in Maluku Province the processes for consent varied from facility to facility. Most of the information is conveyed verbally and often written records of this process are not kept.

64. **The primary health care facility should be responsible for providing processes that support patient and family rights during care.** This includes:

a. Understanding of patient and family rights and responsibilities;

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[17] Scoping Assessment, Social Safeguards Team (2017).

[18] puskesmas registered to BPJS-Health is eligible for JKN funds up to IDR6,000 per-member, with a possible increase up to IDR10,000 for lagging, remote, and border areas. The total amount calculated is based on the population registered by BPJS for each puskesmas' catchment area.

b. Identification and understanding of the cultural context of the population it services and how this might influence how the patients exert their rights and responsibilities;
c. How patients and families are informed about the process to receive and act on complaints, conflicts, and differences in opinion about patient care the patient's right to participate in that process;
d. Ensuring that all patients are informed about their rights in a manner they can understand.

65. **Indonesia is equipped with a legal framework for the protection of patients' rights and the accreditations standards sufficiently cover the rights of patients and families.** Citizens have the rights to choose services, to be treated without prejudice and discrimination, to have their record and treatments kept confidential, to receive information about treatment and costs as well as seek a second opinion (Law No. 29/2004 on Medical Practice, Article 52 and the Health Act, the Hospital Act and the Medical Practice Act). Citizens have the right to choose services, to be treated without prejudice and discrimination, to have access to information regarding services, to be heard and complain, as well as to access to litigation (Law No. 8 of 1999 on Consumer Protection). Access to health services for people with special needs is also protected by law, with health providers being required to ensure their facilities are accessible and services are non-discriminatory.

66. **Patient confidentiality is another concern. [19] The QSDS (2016) reports that only one-fourth of the *puskesmas* and half of private clinics surveyed were equipped with chambers or rooms that provided auditory and visual privacy.** This can adversely affect patients seeking access to information and services, especially in facilities offering HIV counselling and testing services where disclosure could have social and economic implications because of associated stigmas. [20] This is reportedly more severe for women with HIV and AIDS, who may face double burdens of ostracism by their families and communities (as reported in Papua). [21]

67. **There is no centralised system addressing patient feedback and complaints.**

a. At the national level, the MOH operates *"Halo Kemkes"* or they can be contacted by email both of which are not specifically designed functions as a grievance mechanism by health care clients but rather feedback on overall health administration.
b. Most patient care related complaints are handled at the facility level. Existing MOH, DHO and PHO mechanisms to address complaints may be loosely linked with improvements in the overall health system since issues are likely to be underreported at the central level. This prevents understanding of systemic issues in health-care provisions at all levels.
c. In the case of Accreditation Commission again there are several systems with no central system that captures feedback or complaints: it has a hotline; feedback and complaints and can be provided through the website or directly to individuals including facilitators.

68. **Education supports patient and family *participation* in care decisions and care processes. This includes:**

a. Education methods consider the patient's and family's values and preferences and allow for that learning to occur;
b. Education related to a patient's immediate and long-term health needs are recorded and the methods to be used and the provision of the education to be recorded.

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[19] QSDS (2016).
[20] The QSDS survey reported that only one-fourth of puskesmas and one-half of the private clinics surveyed were equipped with a chamber for both auditory and visual privacy.
[21] Butt (2013).

Engagement in Maluku suggested that this is very much dependent on the capacity of individual health practitioners. Findings from the QSDS (2016) *puskesmas* suggest that staff have greater access to professional development included behavioural change communication (BCC) compared to private clinics.

69. **Communication remains a challenge for *puskesmas* and private clinics in rural and remote catchment areas.** Many clinics and health posts lack mobile phones and/or short-wave radio capacity, which reduces options for readily communicating with communities. The use of mobile phones in *puskesmas* is lower than the use of landline phones, which tend to be relatively costly to administer. [22] Improved telecommunication technology and connectivity, particularly for mobile phones, present an opportunity to strengthen communication, increase access to information and improve health services responsiveness.

70. **On affordability, a survey by the National Institute of Health Research and Development (2007) revealed a high number of incorrect diagnosis every year.** Households, especially the poor, bear a large part of this burden in unwarranted out-of-pocket payments; over 50% of the time people are paying to be treated for health problems they do not require. This observation was supported by the QSDS survey which found that only about half of healthcare workers responded correctly to standard questions about procedures. There is also a high rate of absenteeism among Indonesia's health workers, with doctors "moonlighting" at private practices during afternoon and evening hours. Engagement Maluku highlighted that doctors work both at public and private health care facilities and there is no regulation on hours worked.

71. **Engagement in Maluku highlighted the need and importance of infrastructure such as roads, transportation, electricity, for health provisioning and communication particularly in remote locations.** Health service availability (and access) is challenging at all levels, due the national geography which spans 6,000 inhabited islands and a skewed distribution of skilled health care providers. Accessibility to health care varies across the country, with disparities between regions as well as in urban, peri-urban, and rural locations. These differences are evident in overall health outcomes, especially for the Eastern Provinces (which tend to be worse than other regions), as well as in rural and remote areas. [23]

72. **Health services in Indonesia are delivered through public and private providers, with the public sector more predominant in rural areas and for secondary levels of care. Differences in access to services can be measured, in part, by the distance to a health facility.** On average, 18. 5% and 12. 4% of households take more than 60 minutes to reach a government hospital or a private hospital, respectively. [24] However, for more than 40% of households in Maluku, West Sulawesi, and West Kalimantan it takes more than one hour to reach a health facility. In terms of kilometres, the average distance to a health facility

[22] QSDS (2016).

[23] Child mortality rates in the Eastern Provinces (particularly Papua, West Papua, North Maluku and Maluku), are between 2.5 and 6.5 times higher than the most Western Provinces (such as, Java and Sumatera). Some differences between urban and peri-urban and socio-economic characteristics can also be observed, with rural areas and households in the lowest wealth quintile experiencing worse health outcomes. The maternal mortality ratio (MMR) in Eastern Indonesia is highest in Indonesia at above 200 per 100,000 live births, compared to the national average of 126 per 100,000 which is considered high for middle-income countries. Malaria remains endemic in some regions, particularly Papua, West-Papua, NTT, Maluku and North Maluku. Almost 70% of malaria cases come from these provinces, even though containing only 8% of the country's population (QSDS 2017).

[24] National Institute of Health Research and Development (2013). Riset Kesehatan Dasar, Riskesdas 2013 Jakarta: National Institute of Health Research and Development.

in West Papua, Papua and Maluku is more than 30 kilometres, which compares unfavourably with an overall average in Indonesia of only 5 kilometres.

73. **The availability of services found in health facilities across Indonesia vary significantly. The 2011 Health Facility Census (*Rifaskes*) measured the provision of basic services by assessing outcomes for 38 indicators across five domains: basic amenities, basic equipment, standard precautions for infection prevention, diagnostic capacity, and essential medicines.** At that time, no *puskesmas* could meet the minimum standards for readiness across all 38 indicators (World Bank, 2014). More than 80% of the 38 indicators were met by *puskesmas* in DI Yogyakarta, East Java, and Central Java on average, but only about half of *puskesmas* in Papua and Maluku reached this level. While challenges were noted across key program areas[25] throughout Indonesia, the situation is most acute in eastern Indonesia.

74. **The number of *puskesmas* have kept up with population growth, and tend to be more accessible than both public and private hospitals.** Nationally, only 2% of the population takes more than one hour to reach a *puskesmas*, but the proportion of the population facing this travel time is much higher in Papua (27. 9%), East Nusa Tenggara (10. 9%), and West Kalimantan (10. 9%). [26] *puskesmas* and other primary health care facilities are important for public health and referral services, particularly in the context of the JKN program.

75. **There are wide variations in the numbers of people served by different *puskesmas*.** The numbers of patients range from 70 up to 28,000, impacting the level of attention and care that can be provided. On average, rural areas serve approximately half of the population as compared with urban areas. However, rural *puskesmas* are harder to reach and require more time and resources to access both for patients and health workers. [27] The selection of *puskesmas* location needs to be weighed against access indicators, such as the size of population in the catchment area as well as the distance, time, and costs for accessing care. Furthermore, innovations such as mobile clinics should be considered to expand outreach services, particularly in remote sparsely-populated. This would maximize access and increase health worker productivity.

76. **People in very remote areas, Indigenous Peoples, and those who are not formally registered or transient populations (including nomadic, seafaring, farming communities, temporary and migrant workers) often lack access to health services.** Unregistered individuals may not be formally recognized as residents, and therefore not proposed for social assistance programs and JKN. In addition, because of the non-permanent nature of their residence and/or civil status, they not be included in censuses/surveys and outreach activities by *puskesmas*. Article 15 of the Law No. 23/2006 on Population Administration stipulates that any individual who leaves his/her original place of residence must obtain a transfer letter from the village head or authorized officials in order to be registered in his/her new place of residence. Family and/or ID cards can only be amended upon obtaining the transfer letter. This presents challenges for individuals who may not be aware of the procedures or who are unable to obtain this letter because of costs or other considerations.

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[25] These include: capacity of health facilities to provide interventions in key program areas of family planning, antenatal care, basic obstetric care, routine childhood immunization, malaria, tuberculosis, diabetes, basic surgery, blood transfusion, and comprehensive surgery (WHO 2017).

[26] BAPPENAS (2014). Supply side readiness: Indonesia health sector review. Jakarta: Ministry of National Development Planning of the Republic of Indonesia/Bappenas.

[27] The puskesmas surveyed in the QSDS study indicates that the average time to reach care in puskesmas was 15 minutes, and it could be five times higher for rural puskesmas.

77. **Human rights violations against sexual and gender minorities, often referred to by the acronym LGBT (lesbian, gay, bisexual, and transgender) also includes concerns about social exclusion and discrimination in accessing health care.** Indonesian national laws are largely silent with respect to LGBT people, and neither explicitly criminalize them nor protect them. However, at the local level, there are provinces, cities, and regencies that explicitly criminalize LGBT people. A recent report (2017) notes that public opinion studies suggest that acceptance of LGBT people is very low and has changed little over the last decade, and that media coverage is generally negative. [28] It also offers that studies in Indonesia (and elsewhere) indicate that stigma related to being LGBT reduces access to condoms, testing, and treatment of HIV. Studies also show high rates of HIV prevalence, suicidal ideation, and risky health practices for LGBT people, which are linked to stigma and minority stress. Barriers to accessing health care, include difficulties with ID cards, fear of having their sexual orientation or gender identity disclosed, fear of harassment by health care providers, and lack of funding for LGBT-related care.

[28] Badgett, M., A. Hasenbush and W. Luhur (2017). "LGBT Exclusion in Indonesia and Its Economic Effects." Los Angeles: The Williams Institute, UCLA School of Law.

E ENVIRONMENTAL AND SOCIAL ACTIONS.

78. **The measures (on the following page) were discussed during a consultation workshop on the draft ESSA that was undertaken on March 15, 2018, inviting 10 puskesmas with various level of accreditation and provincial health office of DKI Jakarta.** The draft ESSA report was circulated prior to the meeting and a summary in Bahasa (Annex 3) was also shared.

79. **The lack of a KTP represents a barrier to gaining health care services including primary health care for certain individuals and groups.** Addressing this risk falls outside of the program boundary and therefore an action has not been developed. The barrier is governed by a procedure for accessing JKN and therefore should be addressed so as to exclude persons or groups from accessing health care as a right provided in various legislation including the Constitution.

Table 6: Environmental and Social Actions.

Action Description	DLI	Responsibility	Recurrent	Frequency	Due date	Completion Measurement
Strengthen DHO's oversight and require primary care providers to report patient-care related complaints and feedback and publish them (Result Area 1)	DLI 1	MOH and DHOs	Yes	On-going	On-going	Records of patient-care related feedback and complaints in the dashboards (including the status of resolution)
Strengthen facilitator and surveyor capacity through sustained professional development and mentoring in the following areas: - Assessment and technical recommendations on compliance of safe-handling of medical waste including its chain of custody system, environmental sanitation, emergency response and waste reduction consisted with government regulation. - Develop necessary work instructions[29] (simple SOP as mentioned in the accreditation system standards) to improve the existing Guidelines for surveyors and for environmental sanitation officers on proper management of medical waste management (including waste reduction efforts, emergency preparedness and response for fire, infectious control, radiation safety and abnormal condition by providing contact numbers of alternate licenced-waste transporters from MoEF)	DLI 5	Accreditation Commission	Yes	On-going	On-going	Training and workshops conducted Surveyor's performance evaluation Guidelines improvement -specific SOPs and Work Instructions for waste management.

[29] Note: example of work instructions (or SOP-as mentioned in the accreditation system standards) that can be developed by Accreditation Commissions/MOH HQ as a template.

- Work instructions for waste reduction and emergency preparedness and response for fire, infectious control, radiation safety and abnormal condition by providing contact numbers of alternate lisenced-waste transporters from MoEF.
- Work instructions for burial technique of solid hazardous waste as per MOEF Regulation 56/2015 article 25 for the area with no access to waste transporter.
- Work instructions for providing, replacing and decommissioning safety equipment to medical workers and the hospital unit in charge for environmental sanitation to ensure that they always have access to all necessary equipment in good operational condition.
- Work instruction to handle potential non-compliance, grievances and complaints (e.g.if effluent of the waste water to environment and emission from incinerator is not meeting the effluent standard or if the transportation of hazardous waste materials creating an apparent hazard to public health and safety event though the permit has been granted).
- Work Instructions for regular auditing the performance of pollution abatement control equipment with guidance and supervision from competent expertise including the plan for spare parts or equipment replacement (including incinerators operation, burial pit for solid waste, septic tank design and maintenance).

Action Description	DLI	Responsibility	Recurrent	Frequency	Due date	Completion Measurement
- Assessment and technical recommendations on management of complaints and grievances, consent processes, patient's rights and working with vulnerable groups and Indigenous Peoples.						

F ENVIRONMENTAL AND SOCIAL RISK RATING

80. **Based on the assessment findings and draft mitigation and improvement measures the environmental and social risk is moderate.** At project concept stage the overall risk was considered to be substantial. With the vertical hospitals and accreditation of referral hospitals now not forming part of the result areas the nature and extent of the environmental and social risks are considerably different. With the revised framework the focus of the assessment of environmental and social risks has been on the supporting processes for the accreditation systems for *puskesmas* and private clinics. The risks identified relate to lack of capacity, commitment and processes and/or implementation of the processes in place. Risk areas of concern include safe-handling of medical waste, health service providers' health and safety, patient and public safety and poor consent processes and inadequate grievance systems. Indigenous Peoples are expected to benefit from the Program through enhanced community engagement and improved service delivery of primary health care. With varying capacity of health providers to manage such risks, careful management is required with agreed actions to be mainstreamed in the I-SPHERE PforR's Program Action Plan. Annex 6 provides further information against the policy elements of the Bank Policy Program-for-Results Financing (December 2017).

G INPUTS TO THE PROGRAM IMPLEMENTATION SUPPORT PLAN

81. To support MOH in strengthening of DHO's oversight and the requirement of primary care providers to report patient-care related complaints and feedback and publish them in the district-level performance dashboard, technical assistance will be needed for:

a. Workshops to build awareness and understanding at district level of managing grievances through the dashboard;
b. Development of materials for communicating grievance procedure suitable for operationalising at the facility level; and
c. Development of and piloting of procedures for documenting grievances via the dashboard.

82. Inputs to strengthen facilitator and surveyor capacity through sustained professional development and mentoring in the following areas in the assessment and technical recommendations on compliance of safe-handling of medical waste including its chain of custody system, environmental sanitation, emergency response consisted with government regulation:

a. Guideline for surveyor and facilitator of the HCF accreditation needs to include medical waste chain of custody system as stipulated in MOEF Regulation no 56/2015. Coordination, both at inter-ministries level (i. e. MOH and MOEF) and inter agencies at provincial and city/district level (i. e. *Dinas Kesehatan* and *Dinas Lingkungan Hidup*) needs to be developed to ensure role and responsibility of each party in safe handling of medical waste from HCF.
b. Regular workshop for the HCF staff in charge for environmental sanitation and accreditation surveyor and facilitator (including annual refresher) with regards to the manifest system of medical waste handling needs to be developed by PCU. This is to ensure full comprehension of the principle "cradle to grave" in medical waste handling. In addition, the waste generator needs to be aware of its responsibility and be prepared for emergency response handling.

83. To support MOH in strengthening surveyor capacity through sustained professional development and mentoring in the assessment and technical recommendations on management of complaints and grievances, consent processes and patient's rights, through technical assistance on:

a. capacity building of district accreditation facilitation teams to assist facilities to improve their performance prior and post-accreditation (as part of sustained improvements);
b. review of the current training modules and if relevant addressing any gaps;
c. capacity building of surveyors to assess performance on complaint handling and to in turn provide practical advice to facilities.

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ANNEXES

Annex 1: Program Results Framework

PDO Indicators by Objectives / Outcomes	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets (IT)				End Target
					Y1	Y2	Y3	Y4	
Strengthening performance monitoring for increased local government and facility accountability									
Districts covered in MoH's published performance dashboard	DLI 1		Text	0. 00	Performance dashboard designed and guidelines issued	5 %	30 %	60 %	90 %
Improving implementation of national standards for greater local government and facility performance									
Puskesmas that have received higher levels of accreditation	DLI 3		Number	496. 00	600. 00	900. 00	1,200. 00	1,500. 00	1,996. 00
Pregnant women delivering at a health care facility			Percentage	78. 00	80. 00	82. 00	84. 00	87. 00	90. 00
Enhancing performance orientation of health financing for better local service delivery									
Primary care providers that are implementing performance based JKN capitation	DLI 8		Text	0. 00			Joint MOH-BPJS agreement (on JKN performance based capitation) signed	40 %	60 %
Districts showing an improvement on at least half of the performance indicators in the enhanced DAK non-fisik	DLI 9		Text	0. 00	Enhanced performance based DAK non-fisik designed	Enhanced DAK non-fisik baseline data collected	DAK non-fisik allocated based on performance	25 %	60 %

Intermediate Results Indicators by Results Areas	DLI	CRI	Unit of Measure	Baseline	Intermediate Targets (IT)				End Target
					Y1	Y2	Y3	Y4	
Strengthening performance monitoring for increased local government and facility accountability									
Puskesmas using electronic data reporting systems with complete and compliant data in accordance with MoH's data dictionary			Text	0.00	Enhanced data dictionary published	20%	40%	60%	80%
Puskesmas using mHealth application to support enhanced PIS-PK	DLI 2		Text	0.00	mHealth plan for PIS-PK completed	mHealth for PIS-PK designed and field tested	25.00	250.00	1,500.00
Improving implementation of national standards for greater local government and facility performance									
Puskesmas that have been accredited (for basic levels) in Eastern Indonesia	DLI 4		Number	66	100.00	175.00	250.00	350.00	466.00
Primary care accreditation body (KAFKTP) functioning as an independent commission	DLI 5		Text	No	Roadmap for independent commission produced	Costed business plan and by-laws submitted	Decree issued establishing independent commission	75 % of commission staff appointed	Accreditation commission operating in accordance with its by-laws
Lagging districts that have produced an improved annual plan and budget	DLI 6		Text	0. 00	Upgraded training modules designed	10. 00	25. 00	50. 00	120.00
Special health worker teams deployed	DLI 7		Number	439. 00	539. 00	639. 00	739. 00	839. 00	1,039. 00
Provinces that are using an integrated referral information system (IRIS)	DLI 10		Text	0.00	Integrated referral information system (IRIS) designed	Software application for IRIS completed	1.00	3.00	5.00

Annex 2: Environmental and Social Risks and Impacts Screening Matrix

Environmental Considerations

Results Areas	Activities	Potential Risks and/or Impacts	Primary Receptors	Level of Concern	Systems and Capacity to be Reviewed
Result Area 1 Strengthening performance monitoring for increased local government and facility accountability	- Dashboards: publish performance dashboards to benchmark facilities and districts - Data: improve quality of reported data.	Environmental risk: None.			
Result Area 2 Improving implementation of national standards for greater local government and facility performance	Type of activities: - Primary care accreditation capacity: strengthen credibility (independence, transparency, validity of results) and capacity of accreditation commission - Improved facility managerial and clinical processes: increase accreditation of *puskesmas* and private providers, including in Eastern Indonesia	Positive: Improve environment protection towards managing medical solid waste within healthcare facilities (HCF) to ensure the proper standard operating procedures based on the accreditation standards are followed and implemented. Build capacity of healthcare workers to manage medical facilities and ensure good technical support in implementing effective waste management system. Negative: Poor implementation of the accreditation system and lack of ownership from the management of the medical healthcare facilities to carry out the procedures and	Patients and families, medical workers directly handling waste, communities within/near the facility premises	Moderate: Overall for this component in Result Area 2, the level of risk is assessed based on the failure of compliance and possible not achieving the level of accreditation needed to mitigate the risks from the operation of *puskesmas*.	Accreditation system and the training capacity of the accreditation implementers and surveyors are important to ensure that the standards and the quality assurance of the standards are not being compromised or diluted due to lack of training capacity, quality of surveyors or enforcement. Central level (MOH) capacity in developing adequate guidelines (Directorate of Environmental Health) and Directorate Health Service Facility (laboratories etc.) correspond to the MOEF regulation and standards. Infrastructure, resources and management system in place (P,D,C,A) and monitoring and

Results Areas	Activities	Potential Risks and/or Impacts	Primary Receptors	Level of Concern	Systems and Capacity to be Reviewed
	- Human resources: ensure availability in remote areas - Local government capacity: Build capacity for planning, budgeting and management of health services	protocols as planned in the accreditation system. Other potential negative risk could arise from the failure to implement or follow the standards of the accreditation systems as listed below:			evaluation system to support the objectives.
		a) Medical solid waste management within healthcare facilities (HCF). It is expected that visitors to primary healthcare facilities will increase. While composition of the primary healthcare's medical solid waste will not change substantially, the quantity will likely increase. Poor handling of medical solid waste in its chain of custody system (poor storage, handling and disposal system at HCF or illegal dumping/storage beyond the facility) will also pose potential adverse impacts to the staff, visitors and the surrounding environment and community	Patients and families, medical workers directly handling waste, communities within/near the facility premises, visitors or public along the waste' chain of custody.	Moderate: With guided procedures, medical waste generated in HCF is collected and packaged by authorized medical workers and temporarily stored at designated places. A special unit is responsible for providing technical guidance and day-to-day oversight. However, enforcement is often compromised due to lack of awareness or technical knowledge, inadequate equipment and storage capacity and/facility, as well as lack of supervision from the hospital management.	Waste management systems in primary healthcare providers (both private and public) including regulatory frameworks on bio-medical waste, facility operational licenses, medical waste categorization systems and management plans, hazardous material/waste labelling system, training programs (where they exist), and governance instrument (i. e. accreditation and sanctions, Grievance Redress Mechanisms/Complaint Handling Systems) will be reviewed. Provincial and district health agencies (PHO and DHO respectively) will be engaged.
		b) Medical wastewater. The amount of wastewater at primary healthcare will likely increase due to increased	Patients and families, medical workers directly handling waste,	Moderate: At primary healthcare (*Puskesmas*), wastewater treatment facilities should	Guidelines for *puskesmas* in handling its wastewater and the competency of the

Results Areas	Activities	Potential Risks and/or Impacts	Primary Receptors	Level of Concern	Systems and Capacity to be Reviewed
		demand. If not properly treated and managed (spill over, plant capacity overloaded and poor operational control), potential pollution from poor quality effluent to surrounding environment and human health is likely.	communities within/near the facility premises.	be designed to anticipate increase of visitors.	operator and management support.
		c) Radiation waste. Without good procedures, the disposal of old medical imaging or radiotherapy equipment in facilities may lead to radiation exposure and leakages if not well managed or properly decommissioned.	Patients, health workers and communities in *puskesmas* that has the radioactive equipment.	Low: Without accreditation system and no proper implementation of the waste management system, old medical imaging and radiotherapy equipment have a very low possibility of leaking but still can lead to radiation exposure and/or radiation contaminated materials (including liquids, faeces, paper and medical gloves).	Accreditation system includes evaluation on the management of radio diagnostic equipment. Others included licensing, procedures, management (safe use, work-site detection, maintenance, emergency response, decommissioning, etc.) and capacity of facilities to manage radiation risks.
		d) Radiation risks. In addition, there could also be risks related to occupational radiation exposure to equipment emitting X-rays and gamma rays (e. g. CT, PET scanners), radiotherapy machines and wastes contaminated by radiation.	Patients, health workers and communities in *puskesmas* that has the radioactive equipment.	Moderate: If not well managed or protected, new and advanced medical imaging and radiotherapy equipment can lead to radiation exposure and/or radiation contaminated materials (including liquids, faeces, paper and medical gloves).	Licensing, procedures, management (safe use, work-site detection, maintenance, emergency response, decommissioning, etc.) and capacity of facilities to manage radiation risks
		e) Facilities storage. This includes transportation and disposal of medical solid	Communities living in medical waste disposal	Moderate: For primary care facilities without solid waste treatment	Licensing, procedures and standards for disposal facilities (Government

Results Areas	Activities	Potential Risks and/or Impacts	Primary Receptors	Level of Concern	Systems and Capacity to be Reviewed
		wastes. The operation of the HCF will generate medical solid waste requiring proper transportation and disposal. The disposal centres' operation may produce air emissions (bottom slag and fly ashes) and wastewater during operation. The transportation of the medical solid waste may cause secondary pollution. The total amount and composition of the medical solid waste in each province are envisaged to increase, so the designed capacity of the disposal facilities needs to be adjusted when implementing the Program. Health care workers may be exposed to hazardous materials and wastes, including expired chemicals/medicines, glutaraldehyde (toxic chemical used to sterilize heat sensitive medical equipment), ethylene oxide gas (for medical equipment sterilization), formaldehyde, chemotherapy and antineoplastic chemicals, solvents, and photographic chemicals, among others.	areas and transporters.	facilities, the collection, transportation and disposal of medical wastes generated are expected to be carried out by a third party with a valid license to manage such wastes. However, many primary healthcare facilities are in remote areas and may not have access to such third-party services. Consequently, risks of mismanagement are greater for these facilities. Effects may be site-specific and could be mitigated through development of SOPs, capacity, the provision of protective gear and training on safe handling of hazardous materials and wastes and supervision.	Regulation No. 101/2014), verification/manifest tracking systems for the transportation fleets certified according to the domestic requirements, as well as procurement of vendors (listed in the National Public Procurement Agency E-Catalogue). Guidelines for labelling and storage of hazardous materials and hazardous waste. Operator competency and training.

Results Areas	Activities	Potential Risks and/or Impacts	Primary Receptors	Level of Concern	Systems and Capacity to be Reviewed
		f) Public health and safety – exposure to infections and diseases. Health care providers and personnel may be exposed to general infections, blood-borne pathogens, and other potential infectious materials during care and treatment, as well as during collection, handling, storage, treatment, and disposal of health care waste.	Patients and visitors, health workers and facility staff, and communities in the facility premises and along the chain of custody of the medical waste.	Moderate: Since the activities supported by the PforR are expected to enhance quality service capacity of HCFs across levels, the quantity of medical waste and types of diseases to be treated will likely become more complex and therefore may present greater risks of infections and diseases for both health workers, other patients and visitors as well as communities nearby. Impacts to public health and safety are likely to result from poor enforcement of accreditation procedures and lack of procedures and/or their implementation by health providers and/or vendors.	Facility policies, procedures and protocols (including SOPs), and awareness on infection control policies, supervision and management of disease outbreaks and handling of infectious materials and wastes (e. g. blood). The accreditation process will continue the improvement to ensure the standardization of necessary procedures and protocols (SOPs) in all *puskesmas* will be carried out and accredited to safeguard the quality of health of the patient.
		g) Fire safety: Risk of fire in health care facilities due to poor storage facilities, handling and presence of chemicals, pressurized gases, boards, plastics and other flammable substrates.	Patients and visitors, health workers and facility staff, and communities in the facility premises.	Moderate: Potential effects are site-specific and moderate. Good design of the structures in line with technical specifications (building code) for fire prevention (e. g. sprinklers, fire alarm and detection systems) and regular drilling of firefighting	Licensing and accreditation requirements for facility safety, SOPs and enforcement capacity.

Results Areas	Activities	Potential Risks and/or Impacts	Primary Receptors	Level of Concern	Systems and Capacity to be Reviewed
				plans could address fire risks.	
Results Area 3: Enhancing performance orientation of health financing for better local service delivery	Type of activities: Performance oriented "*DAK*- Non fisik": enhance indicators and allocation processes Performance oriented *JKN*: link primary health care capitation to performance	Environmental risk: None.			

Social Considerations

Results Areas	Activities	Potential Risks and/or Impacts	Primary Receptors	Level of Concern	Systems and Capacity to be Reviewed
Result Area 1 Strengthening performance monitoring for increased local government and facility accountability	- Dashboards: publish performance dashboards to benchmark facilities and districts - Data: improve quality of reported data	No social risks or impacts			
Result Area 2 Improving implementation of national standards for greater local government and facility performance	- Primary care accreditation capacity: strengthen credibility (independence, transparency, validity of results) and capacity of accreditation commission - Improved facility managerial and clinical processes: increase accreditation of *puskesmas* and private providers, including in Eastern Indonesia - Human resources: ensure availability in remote areas	No social risks or impacts envisioned. The program is expected to generate opportunities to enhance social outcomes through accreditation processes (pre, during and post-accreditation). The whole cycle of the accreditation process, including pre- and post-accreditation facilitation by DHOs is expected to improve service readiness and quality of primary care services over the long term. By requiring primary care facilities to meet certain standards in public health and community relations, primary care accreditation is expected to promote community engagement, outreach, access		While the Program is not expected to introduce new risks with regards to community engagement, consent and consultations, system capacity to handle these aspects will likely vary across facilities and therefore, would require further measures to understand improvements in social outcomes (partially addressed through upgrades in accreditation status and facilitation processes).	Elements of community engagement, patient care and safety, consultation and consent procedures and handling of complaints in the accreditation standards for primary care facilities

Results Areas	Activities	Potential Risks and/or Impacts	Primary Receptors	Level of Concern	Systems and Capacity to be Reviewed
	- Local government capacity: Build capacity for planning, budgeting and management of health services	to information about health services and treatments, privacy and confidentiality, exercise of more stringent patient consultations and free, prior and informed consent prior to undertaking any treatments.			
		Primary facility performance with regards to complaints handling is expected to improve by requiring these facilities to establish a mechanism to handle and document complaints and feedback, including a procedure to follow-up complaints that could not be resolved at the facility level (i. e. *JKN* enrolment)	N/A	Moderate: accreditation is expected to improve procedures for complaints handling at the facility level. However, since complaints are mostly handled at the facility level, system capacity, including documentation, follow-up and resolution procedures would greatly vary and therefore, require further attention with regards to MOH's capacity in ensuring that there are improvements in this area.	Complaints handling procedures within the overall health system (to be partially addressed in the accreditation system assessment)
		Understanding benefits and impacts relating to access, inclusion, vulnerable groups and peoples are key to ensuring the key objectives of the Program are met. The I-SPHERE Program includes a focus on the three Eastern Indonesia provinces with poor health outcomes and access to healthcare. It will address some of the inequalities of access and	Social exclusion would particularly affect those living in remote areas, stateless individuals (without ownership of recognized IDs), Indigenous Peoples, transient populations and nomadic groups,	Moderate: Exclusion factors to health care services are multi-layered and may not solely be influenced by availability of services, but also personal preference, social sanctions and norms as well as lack of awareness. Efforts to promote social inclusion are expected to be promoted through the	Health service delivery systems including access to health services (i. e. financing, availability, equity, outreach), patients' rights, and grievance redress mechanisms/complaint handling systems.

Results Areas	Activities	Potential Risks and/or Impacts	Primary Receptors	Level of Concern	Systems and Capacity to be Reviewed
		reaching out to vulnerable and marginalised groups, including those living in remote areas. Incremental improvements to ensure that barriers to access are overcome, while addressing the quality of healthcare delivery through strengthening accreditation systems, will enable appropriate services for those who do not or have limited access to quality healthcare. Improved community level outreach has the potential to further improve outcomes at the household level. Improved social and environmental performance will contribute to ensuring that the services to these groups are undertaken is a safe and socially and culturally appropriate manner.	people with disabilities and certain illnesses (e. g. HIV and AIDS) and sexual and gender minorities.	PforR operations through support to improved access and quality of primary health service and referral care (supply-side readiness) and Human Resources for Health (HRH)	
Results Area 3: Enhancing performance orientation of health financing for better local service delivery	- Performance oriented *DAK*: enhance indicators and allocation processes - Performance oriented *JKN*: link primary health care capitation to performance	No social risks or impacts envisioned.			

Annex 3: Stakeholder Engagement and Validation Workshop

Table 7: Consultations undertaken for supporting preparation of the I-SPHERE Program.

Date	Location	Stakeholders Consulted	Topic
16 Nov, 2015	Jakarta	*PKLN, HSS-CU, Dit Bina Gizi, Dit BUK Dasar*, Rorenggar MOH, *Rokeu & BMN, Dit Bina Kes. Anak, Pusat Perencanaan and Pendayagunaan SDMK, Kemenkes, PPJK Kemenkes, PKLN Kemkes*	Discussion on I-SPHERE.
10 Dec, 2015	Jakarta	*HSS – CU, TU Bukr Kemenkes, PI - Setdijen BUK, Roren Kemenkes, nkl / HRS CU, Set Badan Litbangkes, PI Gizi KIA, Dit Ibu, Balitbangkes, BUK, Dit Bina Gizi, Dit. ngm, Pudatin Kemenkes, Pusat Promkes, BUKD, BUMD, kemenkes rokeu & BMN, BUK, Gizi, Kemenkes, BUKR Kemenkes*	I-SPHERE Project Design discussion; including project cycle; project design (objectives, results, components); choice of districts; implementing agency; causal chain; and project financing.
2 Oct, 2017	Jakarta	Ministry of Health Building, Kuningan DG *Fasyankes* (Planning Unit)	Field visit preparation to Maluku; I-SPHERE Project Design discussion, including project cycle, project design (objectives, results, components); accreditation system; and medical waste management.
6 Oct, 2017	Jakarta	*Fasyankes* and Planning Bureau Director of *Fasyankes*	DAK and how BOK (operational funds support to *puskesmas*) to be more performance oriented; and introduce ESSA.
9 Oct, 2017	Jakarta	Ministry of Health	Land acquisition process in Ambon; future land acquisition process in *NTT* and Papua; "DAK *Fisik"* for facility rehabilitation/ renovation; responsibilities and risk management for land acquisition/donation.
11 Oct, 2017	Ambon, Maluku	*RSUD* Haulussy Ambon	Health service management and accreditation; planning and budgeting; human resources; *DAK* allocation; financial reporting; procurement; waste management; complaint process and consent process.
	Ambon, Maluku	National Social Health Agency (*BPJS*) Center, *RSUD* Haulussy Ambon	Process for managing of insurance claims.
	Ambon, Maluku	*Puskesmas* Karang Panjang	Human resources; national health insurance; financing and allocation planning; and information systems.
12 Oct, 2017	Ambon, Maluku	District Planning Agency (*BAPPEDA*) Maluku Province	Challenges for medical services and health providers working in remote areas; land acquisition for hospitals; sanitary land fill; complaints process; and human resources for training medical staff.

Date	Location	Stakeholders Consulted	Topic
	Ambon, Maluku	Land Agency (*BPN*) Maluku Province	Land acquisition processes; complaints process; and engagement and consultation.
	Ambon, Maluku	Ministry of Health	Site visit of proposed vertical hospital; and land acquisition.
	Ambon, Maluku	Local *dinas kesehatan* staff, *RSUD* Haulussy, Ambon	Debrief and information requirements.
13 Oct, 2017	Masohi, Maluku Tengah	District health officer, *RSUD* Masohi	Waste management, health infrastructure; human resources; financing; accreditation process; *DAK* planning process; *WKDS* program; and recruitment and placement.
	Masohi, Maluku Tengah	District Health Officer, District Dinas Kesehatan	Human resources; health issues in district; complaints procedure; medical waste management; and wastewater equipment and incinerator for *puskesmas*.
	Masohi, Maluku Tengah	Maluku Tengah Deputy of District	Medical service challenges in Maluku Tengah, introduction on I-SPHERE program, lack of infrastructure hindering access to health facilities.
14 Oct, 2017	Masohi, Maluku Tengah District	*Puskesmas* Amahai	Health issues; accreditation process; waste management; complaint process; consent process; and financing.
	Maluku Tengah District	*Posyandu* Amahai	Waste management; cultural preferences related to delivering at home vs health facilities; and observed weighing and vaccinations.
16 Nov, 2017	Jakarta	Ministry of Health relevant units related to I-SPHERE Program	PforR Workshop with OPCS, MOH and I-SPHERE Task Team.
16 Jan, 2018	Jakarta	*Set. Ditjen Pelayanan Kesehatan*	MOH policy on complaint handling on health services in health facilities (Hospital, Primary Health Care).
17 Jan, 2018	Jakarta	*Pusdatin*	Performance Dashboard for Local Government (*Pemda*).
	Jakarta	*P2JK* *Dit Pelayanan Kesehatan Primer* *Rorengar*	Discussion on *KBK* and potential of using MSS indicators.
22 Jan, 2018	Jakarta	*Pusrengun* *Rorengar*	*Nusantara Sehat* and *Wajib Kerja Dokter Spesialis* (*WKDS*). Discussion on the target as indicators, challenges in recruitment, and target of placement of *Nusantara Sehat* and *WKDS*.
	Jakarta	*Ses. ltjen*	*Sistem Pengendalian lnternal (Proses Pengadaan dan Laporan Keuangan Pemerintah).*
23 Jan, 2018	Jakarta	Directorate Primary Health Care *Pusat Analisis Determinan Kesehatan – PADK.*	*PIS-PK* and potential to use of mHealth in reporting and recording of data.

Date	Location	Stakeholders Consulted	Topic
	Jakarta	Directorate Quality and Accreditation of Health Services (Ministry of Health) Chairman of FKTP Accreditation Commission	Preparation process for accreditation and post accreditation; continuous quality improvement post accreditation; quality assurance process during accreditation and quality of the assessors; identification of TA for *Komisi Akreditasi*; and field visit plan.
24 Jan, 2018	Jakarta	*Rorenggar* *Set. Ditjen Kesmas* *Dit. Fasyankes*	Performance Based *DAK*, Capacity building *Pemda*, I-SPHERE implementation arrangements, DLI verification; planning meeting with *BPKP*; and confirm results framework and DLI.
15 Mar, 2018	Jakarta	*Puskesmas from DKi Jakarta*	ESSA consultations and validation

Validation Workshop Participant List

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Attendance List
Indonesia - Supporting Primary Healthcare Reform (P164277)
Environmental and Social Systems Assessment Workshop
JS Luwansa Hotel, March 15, 2018

NO.	NAME	ORGANIZATION
1.	dr. Nisma [illegible], SH MH	Puskesmas [illegible]
2.	Jumadi, [illegible]	Puskesmas Kec. Tg. Pri
3.	dr. Murniasi Hutapea	Puskesmas Grogol Petamburan
4.	Marzuanta, SKM	Puskesmas Kebon jeruk
5.	Faja Djahi	WB
6.	ALKA PATEL	WB
7.	dr. Hilda	Puskesmas Tebet
8.	Puti Marzoeki	Bank Dunia
9.	Dyah Prabaningrum	Dit. Kesling, Kesmas, Kemenkes
10.	Mujaddid	DJA. Penyehatan
11.	KIAN SIONG	WB

NO.	NAME	ORGANIZATION
12.	A. Dzulkarnain	HSS - CCA
13.	Edwin Kurniawan	PI - Kesmas
14.	Budiman Budiman	PI - Kesmas
15.	dr. Manyati R	PKM. Pasar Rebo
16.	Bayu Teja Muliawan	Kanreg
17.	Drg Lindawati Mkes	PKM. Kemayoran
18.	Drg. I.G.A. Rusmala Dewi	PKM Gambir
19.	VIKRAM RAJAN	World Bank
20.	NICHOLAS MENZIES	" "
21.	Novita K Asta	WB
22.	Amy Chua	WB

NO.	NAME	ORGANIZATION
23.	Dewi Mulyani	Dit Kesling, Ditjen Kesmas
24.	M. Baliankr	PKM Keb. Baru
25.	Nurdiana	PKM Keb. Baru
26.	Indri Yogyaswari	PI Yankes
27.	Debbie Valonton	Dinas Kesehatan DKI
28.	Choirul R021	pkm kec Menteng

Validation Workshop Minutes

Aspects	Inputs/Concerns from Participants
Participation and awareness	- No participants from *Puskesmas* outside Jakarta areas and therefore contextual views and experiences could only reflect the running of primary care services in Jakarta, which is an urban, well-served setting. Inputs are strongly encouraged from representatives from remote *Puskesmas*; - Access to information about the project and ESSA was not readily available for participants prior to the consultation. - The status of the *Puskesmas* where the participants mainly are from had achieved *Utama (Advanced)* and *Paripurna (Full)* accreditation. - The participants had focused their inputs based on their experience to handle *Puskesmas*, the challenges and the benefits of accreditation process. - The participants had high understanding on the chapters of the accreditation process. They know which chapters that is hard to be implemented and also those needs a collaboration with inter-agency (e. g. MOEF and local agencies) to able to achieve the target of the standards.
Project design	- The inter-linkages of activities supported by the I-SPHERE with the broader SDG goals would need better clarity. - Accreditation may not necessarily capture and guarantee improvements in certain practices since the requirements are mostly around the existence of SOPs and documentation. Enforcement and practices are oftentimes overlooked. However, there are opportunities to strengthen the accreditation system as a check and balance process at the facility level by investing in the supporting the enabling environments, such as the M&E and reporting platform, personnel; - The I-SPHERE program covers only parts of the broader GoI's healthy Indonesia program implemented by MoH and BPJS-K. There is an expectation that the PforR is supporting other areas beyond what it is currently being covered, in particular with regards to government's program on stunting, environmental health (e. g. ODF) and handling of medical wastes. These interventions are currently managed or being planned in parallel with other initiatives, both through the existing government programs and other new operations, such as Investing in Nutrition and Early Years (INEY) PforR, also supported by the WB. - The current accreditation system and requirements are mostly focused on services for individual health (*Upaya Kesehatan Perorangan*) and less on community health (*Upaya Kesehatan Masyarakat*). The latter would require inter-agency collaboration, particularly in the provision of water, sanitation and environmental hygiene. - Currently there is no inter-agency program and currently there is a program for environmental health in the MOH (i. e. STBM, community based for total sanitation), yet implementation is still challenging. It would be the role of Bappenas to improve the inter-agency collaboration or platform. It is also important to involve the local government in different province to be also responsible for the management of the medical waste in their area. - Data integration still remains an issue and although there have been efforts to synergize data and MIS, there are still requirements for separate reporting for

Aspects	Inputs/Concerns from Participants
	individual programs. M-health is not yet connected to the *Puskesma*s Information System. - The benefit of accreditation process is to improve primary health care services and maintaining the status of the *Puskemas*. The appreciation of the society on the improvement services has been very motivational for the staffs of the *Puskesmas* to continuing to improve health care systems to the community.
Environmental risks considered under the ESSA	- Addressing issues with regards to the handling of medical wastes would require an inter-sectoral collaboration, notably with the Ministry of Environment and Forestry (MOEF) as the main license provider for medical waste management. MOEF is expected to be more transparent with regards to license/permit granting processes as well as the list of licensed waste management providers and their track-records and validity of licenses. There were perceptions that the M&E by MOEF with regards to the performance of license holders has not been fully enforced. - Infringements around the handling of medical wastes are usually attributed to third-party medical waste service providers (i. e. medical waste transporter and receiver) and hence, there is a limited role that *Puskesmas* can play to ensure proper enforcement of codes of practices as it falls outside their responsibility. Such an inter-sectoral nature of medical waste management presents constraints to the extent the program is equipped with a mechanism to address the issues as the MOEF is currently outside the program boundaries; - Complexities and possibilities of medical waste leakages emerge when the third-party service providers no longer provide such services due to various factors (e. g. suspension of permits and lack of final disposal or treatment facilities) and at the same time, *Puskesmas* are no longer allowed to store such wastes beyond a certain period. Existing incinerators at *Puskesma*s are currently not operational due to absence of licenses, hence creating bottlenecks. In addition, the current regulation also limits *Puskesmas* ability to take medical wastes from private clinics unless the *Puskesmas* has temporary hazardous and toxic waste storage permit. Private clinics are expected to manage such wastes on their own. This has increased the likelihood for leakages. - Establishing medical waste temporary storage could be expensive and may not be affordable for *Puskesmas* outside Java and remote areas. The MOEF regulation on management of waste from health care facilities allows practices to bury such wastes with certain procedures for remote areas with limited access. There could be a demand for the introduction of alternative safe handling of medical wastes which should be introduced to facilities with limited access to third party service providers. - As for the hospital accreditation, the PROPER status (on environmental compliance) is not fully taken into account in the accreditation scoring/weighting. There is a possibility that facilities with low compliance are still accredited, thus calling further synergy and/or data sharing. - As part of strengthening the accreditation system, the surveyors' capacity and responsibilities must be expanded to also track the chain of custody (known locally as "manifest") and practices of medical waste management. In addition,

Aspects	Inputs/Concerns from Participants
	the accreditation scoring system should take into more account compliance with medical waste management. - The use of the manifest for tracking hazardous and toxic waste is very good to ensure the security of the disposal of the medical waste. However this needs the support particularly from MOEF in law enforcement and ensuring the third party transporters and receivers are being monitored. - The type of hazardous waste that is generated by *Puskesmas* are mostly kept in the yellow container bags (infectious waste) and black bags. The black bags are for non-medical solid waste or domestic waste. - In conclusion, strengthening medical waste management would require stronger involvement of key agencies responsible for the handling of such wastes, particularly the MOEF in law enforcement responsibilities. In addition, there is also a need to strengthen collaboration with the sub-national governments to ensure that codes of practices in medical waste handling and supervision to third party service providers are in place.
Social risks considered under the ESSA	- Overall the practice of written consent has been followed in *Puskesmas* in Jakarta areas, particularly with regards to vaccination and serious medical procedures. However, it is also acknowledged that such practice may not necessarily be enforced in remote areas with personnel capacity constraints; - Accreditation, especially the advanced status e. g. *Paripurna*, could serve as a moral pressure to deliver better services and accountability as usually the status is publicly known; - Ensuring confidentiality, by providing tailored services and facilities at the *Puskesmas* level will be challenging to be addressed due to resource constraints;

Validation Workshop Bahasa Summary

Ringkasan Kajian Sistem Lingkungan dan Sosial (ESSA) untuk
INDONESIA-MENDUKUNG REFORMASI KESEHATAN PRIMER (I-SPHERE)
PROGRAM BERBASIS HASIL (PforR)

A. PforR I-SPHERE dan ESSA

1. **Ruang lingkup proses ESSA meliputi penilaian terhadap:**

   a) potensi risiko dan manfaat lingkungan dan sosial;
   b) sistem lingkungan dan sosial yang berlaku untuk program;
   c) pengalaman dan kapasitas implementasi program;
   d) apakah sistem dan kinerja konsisten dengan prinsip-prinsip utama; dan
   e) langkah yang harus diambil untuk memperbaiki ruang lingkup sistem atau kapasitas pengelolaan.

2. **Tujuan Pengembangan Program (PDO) PforR I-SPHERE yang diusulkan adalah untuk:** "Memperkuat kinerja sistem layanan kesehatan primer di Indonesia. Program ini diharapkan dapat meningkatkan kinerja melalui penguatan akuntabilitas, peningkatan pengelolaan pelayanan kesehatan, dan meningkatkan pembiayaan berbasis kinerja.

3. **Fokus PforR I-SPHERE adalah mendukung Program Indonesia Sehat (Healthy Indonesia Program/HIP) yang dicanangkan oleh Pemerintah Indonesia,** dalam meningkatkan kinerja layanan kesehatan primer di seluruh Indonesia, termasuk tiga provinsi tertinggal di Nusa Tenggara Timur (NTT), Maluku dan Papua. HIP dibangun berdasarkan serangkaian intervensi dengan tujuan untuk memperbaiki status kesehatan dan gizi masyarakat melalui upaya pemberdayaan kesehatan masyarakat, didukung oleh pemerataan layanan kesehatan dan perlindungan finansial, khususnya bagi masyarakat miskin dan rentan.

4. **PforR I-SPHERE mencakup tiga Results Area (RA) yang terkoordinasi dan berkaitan:**

   a) RA 1: Memperkuat pemantauan kinerja untuk meningkatkan akuntabilitas pemerintah daerah dan fasilitas kesehatan.
   b) RA 2: Meningkatkan implementasi standar nasional bagi kinerja pemerintah daerah dan fasilitas kesehatan yang lebih baik.
   c) RA 3: Meningkatkan orientasi kinerja pembiayaan kesehatan untuk pelayanan kesehatan yang lebih baik di tingkat lokal.

5. **PforR I-SPHERE akan diimplementasikan oleh Kementerian Kesehatan (Kemenkes[30])**. Berbagai unit yang terkait dengan pengelolaan aspek lingkungan dan sosial PforR I-SPHERE di tingkat pusat termasuk: Direktorat Pelayanan Kesehatan Primer, Direktorat Kesehatan Lingkungan, Direktorat Mutu dan Akreditasi Fasilitas Kesehatan, dan Komisi Akreditasi Fasilitas Pelayanan Kesehatan Primer; sedangkan di tingkat daerah termasuk Dinas Kesehatan Provinsi dan Dinas Kesehatan Kabupaten/Kota) dan penyedia layanan kesehatan primer (puskesmas dan klinik swasta).

B. SISTEM LINGKUNGAN DAN SOSIAL

6. **Karena PforR I-SPHERE mencakup berbagai program pemerintah di bawah payung HIP, sistem lingkungan dan sosial menyeluruh yang relevan bagi ESSA tidak tersedia.** Proses ESSA mengkaji ulang berbagai sistem, mencakup sistem akreditasi pelayanan kesehatan primer untuk puskesmas dan klinik swasta maupun sistem lainnya di luar sistem akreditasi. Pemilihan sistem yang dinilai dalam proses ESSA, bergantung

[30] Pengaturan Kelembagaan dan Pelaksanaan: Komite Pengarah Program Nasional (PSC) akan terdiri dari Kemenkes, BPJS, Kemenkeu, Bappenas dan Kemendagri dan akan memberikan panduan kebijakan, pengawasan pelaksanaan dan memastikan koordinasi lintas kementerian dan subnasional

pada relevansinya dalam pengelolaan potensi risiko dan dampak lingkungan dan sosial dari PforR I-SPHERE. Utamanya, fokus dari proses ESSA adalah pada sistem yang mengatasi risiko pelayanan kesehatan primer yang terkait dengan:

a) Pertimbangan lingkungan: pengelolaan limbah; kesehatan pekerja dan masyarakat serta keselamatan yang berfokus pada tanggap darurat; tanggap darurat keselamatan pasien; dan
b) Pertimbangan sosial: partisipasi pasien dan masyarakat, khususnya difokuskan pada proses persetujuan, hak pasien (termasuk penanganan keluhan dan umpan balik), dan tingkat dan jenis dukungan yang diberikan untuk memungkinkan pasien dan keluarga memahami kebutuhan pelayanan kesehatan dan berpartisipasi dengan cara yang benar.

7. **Ruang lingkup ESSA difokuskan pada proses yang mendukung sistem akreditasi untuk puskesmas dan klinik swasta**. Akreditasi berfungsi sebagai platform untuk mempromosikan praktik yang baik dalam pengelolaan lingkungan dan sosial dari fasilitas perawatan kesehatan. Sistem nasional lainnya yang mengatur pengelolaan limbah dan keselamatan dan kesehatan masyarakat dan pekerja, yang terkait dengan risiko lingkungan, juga dinilai. Proses penilaian dilaksanakan melalui kajian informasi, sertan konsultasi dan kunjungan ke berbagai fasilitas di Provinsi Maluku. ESSA untuk PforR I-SPHERE ini disusun antara lain berdasarkan informasi yang diperoleh dari Unit terkait di tingkat pusat dan Dinas terkait di Provinsi Maluku, masyarakat yang terkena dampak/masyarakat penerima manfaat, penyedia layanan kesehatan, dan petugas pelayanan kesehatan.

C. PERTIMBANGAN DAN RISIKO LINGKUNGAN DAN SOSIAL

8. **Potensi risiko lingkungan dan sosial kemungkinan diakibatkan oleh kurangnya kapasitas, komitmen dan proses dan / atau pelaksanaan proses yang ada**. Pertimbangan dan risiko utama dari lingkungan dan sosial meliputi:

a) **Penanganan limbah medis yang aman**: Pengangkutan dan pembuangan limbah berbahaya dan emisi insinerator atau pembuangan air limbah ke daerah sekitarnya adalah dampak Program yang berpotensi jatuh di luar fasilitas pelayanan kesehatan. Hanya sekitar seperempat dari fasilitas (26% klinik swasta dan 29% puskesmas) memenuhi semua kriteria mengenai pencegahan infeksi dan pembuangan limbah (QSDS Nasional, 2016). Pencegahan infeksi adalah kunci keselamatan pasien dan petugas kesehatan, dalam hal menghindari infeksi nosokomial (infeksi yang didapat dari fasilitas kesehatan). Perlu adanya penekanan terhadap standarisasi praktek pengelolaan limbah padat dan cair di fasilitas pelayanan kesehatan yang turut serta dalam Program ini melalui penguatan proses dan pelaksanaan akreditasi. Kesenjangan antara puskesmas dan fasilitas swasta dalam hal peralatan dan sistem penanganan pencegahan infeksi, sistem dan persediaan, dapat diminimalkan melalui pelatihan staf, (dan juga fasilitator dan surveyor akreditasi), sistem manajemen rumah sakit yang berkualitas, dan diperkenalkan serta dilaksanakannya protokol kebersihan.
b) **Kesehatan dan keselamatan penyedia layanan kesehatan**: Kegiatan fasilitas pelayanan kesehatan mungkin memiliki dampak buruk pada staf fasilitas kesehatan, penyedia layanan kesehatan, personil kebersihan, pekerja yang terlibat dalam pengelolaan, penyimpanan, penanganan dan pembuangan limbah. Bahaya potensial meliputi pemaparan terhadap bahan infeksi (benda tajam / jarum suntik, patogen yang terbawa darah, limbah patologis) dan juga paparan radiasi dan bahan berbahaya lainnya dan limbah seperti bahan kimia beracun, obat-obatan dan limbah sitotoksik, pakaian / kain bekas, peralatan, dll.) Ada juga risiko kebakaran akibat dari penyimpanan, penanganan bahan kimia, gas bertekanan dan substrat yang mudah terbakar lainnya). Pemerintah Indonesia memiliki berbagai peraturan yang komprehensif untuk mengatur aspek ini[31]. Namun, penerapan di lapangan masih menjadi tantangan, seperti ditunjukkan oleh survei QSDS baru-baru ini yang menemukan rendahnya kepatuhan terhadap peraturan pengelolaan limbah medis di

[31] Keputusan Kementrian Lingkungan Hidup no 56 / SetDitjen / 2015 tentang Tata Cara dan Persyaratan Teknis Penanganan Limbah Berbahaya dari Fasilitas Pelayanan Kesehatan (Fasyankes) termasuk Lampiran VII tentang Keselamatan Personel, Keputusan Menteri Kesehatan Nomor 1204 / Menkes / SK / X / 2004 tentang Penyediaan Sanitasi Lingkungan Rumah Sakit dan peraturan tingkat tinggi yang mengatur Keselamatan dan Kesehatan Kerja seperti Undang-Undang No. 36/2009 tentang Kesehatan (bagian XII) menetapkan bahwa PHO / DKK diminta untuk mengawasi dan menjamin keselamatan dan kesehatan kerja bagi petugas kesehatan dan memberi mereka layanan pencegahan, perawatan, dan rehabilitasi serta Peraturan Pemerintah (PP) No. 50/2012 tentang Praktek Pengelolaan Kesehatan dan Keselamatan pada umumnya

Puskesmas di seluruh Indonesia. Unsur dasar fasilitas perawatan kesehatan seperti lokasi fasilitas, standar bangunan, fasilitas tambahan (laboratorium, bank darah, tempat penyimpanan limbah sementara), desinfeksi dan sterilisasi peralatan, layanan sanitasi, kompetensi staf dan pemantauan dan evaluasi penting untuk memastikan kesehatan dan keselamatan pasien, terutama untuk mencegah infeksi nosokomial di fasilitas.

c) **Keselamatan pasien dan publik**: Selain risiko terpapar infeksi nosokomial, pasien dan petugas layanan kesehatan, termasuk staf medis di puskesmas, rentan dalam hal terjadinya kebakaran dan situasi darurat yang disebabkan oleh bencana alam. Standar dan proses akreditasi memerlukan penerapan strategi darurat untuk petugas kesehatan di puskesmas. Petunjuk teknis adalah salah satu cara untuk memastikan kualitas layanan karena terdapat protokol manajemen standar yang menggunakan bukti terbaru. Puskesmas secara signifikan cenderung memiliki panduan teknis yang tersedia di fasilitas dibandingkan dengan sektor swasta. Semakin banyak puskesmas yang terakreditasi - dan semakin tinggi tingkat akreditasi yang mereka capai - memastikan bahwa pedoman ini tersedia, dan petugas layanan kesehatan dilatih dan mengikuti sistem manajemen dan penjaminan mutu yang ditetapkan oleh Pemerintah Indonesia.

d) **Persyaratan persetujuan**: Mendapatkan persetujuan dari pasien dan keluarga adalah persyaratan standar akreditasi fasilitas pelayanan kesehatan primer (standar 7. 4 untuk puskesmas dan 2. 4 untuk klinik swasta) untuk praktisi kesehatan sebelum memulai prosedur dan / atau pengobatan apa pun. Namun, penegakan prosedur persetujuan dan kesadaran pasien untuk menuntut persetujuan kemungkinan bervariasi di seluruh fasilitas. Dari kunjungan lapangan yang dilakukan ke fasilitas di Provinsi Maluku proses persetujuan bervariasi dari satu fasilitas ke fasilitas lainnya. Sebagian besar informasi disampaikan secara lisan dan catatan tertulis terkait hal ini tidak disimpan. Agar persetujuan atas tindakan dapat dilaksanakan, informasi mengenai penyakit, perawatan, prognosis, dan perawatan alternatif harus tersedia dan dapat diakses oleh pasien dan keluarga bahkan tanpa perlu meminta informasi apapun.

e) **Hak pasien termasuk umpan balik dan penanganan pengaduan**: Tidak ada sistem terpusat yang menangani umpan balik dan keluhan pasien. Di tingkat nasional, Kementrian Kesehatan mengoperasikan "Halo Kemkes". Namun, ini tidak secara khusus digunakan sebagai mekanisme pengaduan oleh klien pelayanan kesehatan, namun lebih pada umpan balik mengenai administrasi kesehatan secara keseluruhan. Sebagai gantinya, sebagian besar keluhan terkait pelayanan pasien ditangani di tingkat fasilitas, yang membatasi pemahaman akan masalah sistemik dalam ketentuan layanan kesehatan di semua tingkat. Indonesia dilengkapi dengan kerangka hukum untuk perlindungan hak pasien dan standar akreditasi yang mencakup hak pasien dan keluarga. Fasilitas pelayanan kesehatan primer harus bertanggung jawab untuk menyediakan proses yang mendukung hak pasien dan keluarga selama pelayanan. Kerahasiaan pasien adalah kekhawatiran lain[32]. QSDS (2016) melaporkan bahwa hanya seperempat puskesmas dan setengah dari klinik swasta yang disurvei dilengkapi dengan kamar atau ruangan yang menyediakan privasi pendengaran dan visual. Hal ini dapat mempengaruhi pasien yang mencari akses terhadap informasi dan layanan, terutama di fasilitas yang menawarkan layanan konseling dan tes HIV di mana pengungkapan dapat memiliki implikasi sosial dan ekonomi karena stigma terkait.

f) **Akses dan penyertaan**: orang-orang di daerah yang sangat terpencil dan mereka yang tidak terdaftar secara formal atau populasi sementara (termasuk masyarakat nomaden, masyarakat Adat, masyarakat pelaut, masyarakat petani, pekerja sementara dan pekerja migran) seringkali kekurangan akses terhadap layanan kesehatan. Individu yang tidak terdaftar mungkin tidak diakui secara formal sebagai penghuni, dan oleh karena itu tidak mengajukan program bantuan sosial dan Program Jaminan Kesehatan Nasional (JKN atau Jaminan Kesehatan Nasional). Persyaratan dokumen identitas legal, seperti KTP atau Kartu Tanda Penduduk memberikan tantangan bagi individu yang mungkin tidak mengetahui prosedur yang harus diikuti atau yang tidak dapat memperoleh dokumen tersebut karena biaya atau pertimbangan lainnya. Perhatian khusus juga muncul sehubungan dengan akses terhadap layanan kesehatan kepada kelompok minoritas gender dan seksual, yang sering disebut dengan singkatan LGBT (lesbian, gay, biseksual, dan transgender). Sebuah laporan baru-baru ini (2017) mencatat bahwa opini publik menunjukkan bahwa penerimaan orang LGBT sangat rendah dan hanyasedikit berubah dalam dekade terakhir, dan liputan media pada umumnya negatif[33]. Ini juga mengindikasi bahwa penelitian di Indonesia (dan di tempat lain) menunjukkan bahwa stigma yang terkait dengan LGBT mengurangi akses terhadap kondom, pengujian, dan pengobatan HIV.

[32] QSDS (2016)

[33] Badgett, M., A. Hasenbush dan W. Luhur (2017). "LGBT Exclusion in Indonesia and Its Economic Effects." Los Angeles: The Williams Institute, UCLA School of Law

9. **Diperkirakan bahwa PforR I-SPHERE tidak akan mendukung investasi infrastruktur dan /atau instrumen pembiayaan infrastruktur untuk pembangunan dan rehabilitasi fasilitas pelayanan kesehatan.** Oleh karenanya tidak diantisipasi dampak buruk terhadap habitat alami, kekayaan budaya fisik, sumber daya alam, atau aset atau penghidupan orang berdasarkan aktivitas yang didukung oleh PforR I-SPHERE. Penilaian sistem yang berkaitan dengan risiko lingkungan dan sosial dan dampak manajemen yang muncul dari pembebasan lahan, konversi lahan dan kegiatan infrastruktur juga tidak diantisipasi, dan oleh karenanya tidak termasuk dalam lingkup ESSA.

10. **Masyarakat Adat tidak terpengaruh secara merugikan dari kegiatan yang didukung oleh PforR I-SPHERE**. Proses pendukung sistem akreditasi untuk puskesmas dan klinik swasta tidak melakukan diskriminasi terhadap suatu kelompok atau individu. Namun demikian, memperkuat sistem penjangkauan untuk menjadi lebih baik, meningkatkan keterlibatan masyarakat, dan layanan kesehatan primer yang disesuaikan akan menghasilkan hasil yang lebih baik.

D. PENILAIAN SISTEM DAN TINDAKAN YANG DIREKOMENDASIKAN

11. **Sistem akreditasi untuk pelayanan kesehatan primer cukup memadai terkait dengan cakupan aspek sosial yang relevan dengan program: keterlibatan dan konsultasi masyarakat, termasuk akses terhadap informasi; proses persetujuan; hak pasien termasuk penanganan pengaduan; dan akses dan kepesertaan**. Setiap fasilitas kesehatan bertanggung jawab atas penerapan ketentuan dalam standar akreditasi, dengan kapasitas yang berbeda dan menghasilkan praktek yang bervariasi. Rencana Aksi Program (Program Action Plan) serta Results Area 2 dari PforR I-SPHERE bertujuan untuk mendukung peningkatan kinerja klinis dan manajerial fasilitas pelayanan kesehatan primermelalui dukungan terhadap proses akreditasi. Jika dikelola dengan baik, langkah-langkah tersebut akan mencakup kinerja sosial terkait masalah yang diidentifikasi dalam ESSA.

12. **Kombinasi sistem perundang-undangan nasional yang ada di Indonesia dan sistem akreditasi untuk perawatan kesehatan primer telah secara memadai mencakup aspek lingkungan yang sesuai dengan program: penanganan limbah medis; lisensi untuk beroperasi; Kesehatan dan Keselamatan Kerja; keselamatan pasien dan kesehatan dan keselamatan masyarakat.** Namun, kapasitas pengelolaan puskesmas dan klinik swasta untuk menerapkan ketentuan dalam standar akreditasi bergantung pada kapasitas orang yang kompeten dalam mengelola masalah kesehatan lingkungan. Kapasitas fasilitas pelayanan kesehatan masih rendah untuk mengelola dampak lingkungan yang potensial terutama berkaitan dengan pengoperasian insinerator (untuk fasilitas pelayanan kesehatan yang memiliki insinerator), penanganan limbah berbahaya, bahan kimia berbahaya, termasuk teknik penguburan, pengolahan limbah cair, laboratorium limbah dan radiasi. Oleh karena itu, Rencana Aksi Program dan Results Area 2 PforR I-SPHERE bertujuan untuk meminimalkan risiko dan meningkatkan peningkatan kinerja klinis dan manajerial fasilitas kesehatan primer (terutama terkaitpengelolaan kesehatan lingkungan.

13. **Memperhatikan terdapatnya perbedaan kapasitas penyedia layanan kesehatan dalam mengelola risiko utama, dibutuhkan manajemen kehati-hatian dan pengarus-utamaan dalam Rencana Aksi Program PforR I-SPHERE.** Telah dikembangkan suatu rencana aksi lingkungan dan sosial yang perlu disepakati bersama pemangku kepentingan eksternal yang relevan. Rencana Aksi tersebut meliputi:

    a) Memperkuat pengawasan di tingkat kabupaten, dan mewajibkan penyedia pelayanan kesehatan untuk melaporkan keluhan dan umpan balik mengenai pelayanan pasien yang bersangkutan (dipublikasikan di dashboard kinerja kabupaten); dan
    b) Memperkuat kapasitas fasilitator dan surveyor akreditasi melalui pengembangan profesional dan pendampingan yang berkelanjutan dalam bidang:
        - Penanganan limbah medis yang aman, termasuk sistem rantai penelusuran, sanitasi lingkungan, tanggap darurat dan pengurangan limbah sesuai dengan peraturan pemerintah.
        - Aduan dan keluhan, proses persetujuan dan hak pasien.

E. PENINGKATAN RISIKO LINGKUNGAN DAN SOSIAL

14. **Berdasarkan temuan ESSA dan rancangan mitigasi dan perbaikan, risiko lingkungan dan sosial PforR I-SPHERE dianggap <u>sedang</u>,** risiko lingkungan pada khususnya, memerlukan tindakan lebih lanjut.

F. PUBLIKASI ESSA

15. **Setelah diskusi dan kesepakatan mengenai rencana aksi lingkungan dan sosial dan masukan terhadap rencana dukungan pelaksanaan program, draf dokumen ESSA akan difinalisasi untuk dipublikasikan**. Rancangan ESSA telah dibagikan sebelum lokakarya dilakukan di tingkat nasional dengan peserta dari kelompok pemangku kepentingan yang relevan dari tingkat pusat dan daerah.

G. MEKANISME DAN PROSEDUR KELUHAN

16. **Masyarakat dan individu yang percaya bahwa mereka terkena dampak negatif akibat dukungan Bank Dunia dalam operasi PforR I-SPHERE, sebagaimana ditentukan oleh kebijakan dan prosedur yang berlaku, dapat mengajukan keluhan kepada program pengaduan yang ada atau Layanan Pengaduan Keluhan Bank Dunia (GRS).** GRS memastikan bahwa pengaduan yang diterima segera ditinjau untuk mengatasi masalah yang bersangkutan. Komunitas dan individu yang terkena dampak dapat mengajukan keluhan mereka ke Panel Inspeksi independen Bank Dunia yang akan menentukan apakah dampak negatiiftelah terjadi atau dapat terjadi, sebagai akibat dari ketidakpatuhan Bank Dunia terhadap kebijakan dan prosedur nya sendiri. Keluhan dapat diajukan setiap saat, setelah kekhawatiran diajukan langsung ke Bank Dunia, dan Manajemen Bank Dunia telah diberikan kesempatan untuk meresponsnya. Untuk informasi tentang cara mengajukan keluhan ke Layanan Pengaduan Keluhan Bank Dunia (GRS), silakan kunjungi http://www. worldbank. org/GRS. Untuk informasi tentang cara mengajukan keluhan ke Panel Inspeksi Bank Dunia, silakan kunjungi www. inspectionpanel. org.

Annex 4: Community Participation

Community engagement, including consultations and access to information

Puskesmas (community health clinics) are the backbone of the Indonesian health system. They play a key role in engaging communities and promoting health care, largely through *posyandu* (village health posts) in remote and rural areas. This includes monthly check-ups and primary health care services as well as immunization and vitamin distribution, usually for pregnant mothers, infants and the elderly. Both *puskesmas* and private clinics provide information and counselling services about childhood nutrition (breastfeeding and complementary breastfeeding) and vaccines (including potential side effects and management of follow-up schedules and doses). However, according to the QSDS[34] only a fraction of the private clinics surveyed (less than 15%) provided such services. This underscores the key role of *puskesmas* and *posyandu* for engaging communities, providing information, and promoting the delivery of public goods, such as vitamins, food supplements, and immunizations.

Primary-care accreditation standards call for participatory assessments of community health needs as well as services. However, efforts to foster alignment of health priorities between *puskesmas* and villages constrained by a lack of coordination. Factors that limit local engagement and/or complementary support and funding for health services include:[35]

- The Plan of Action (POA) for *puskesmas*, including annual work plans, are out of sync with the timeframe for village planning and budgeting processes (also known as *Musrenbangdes*). Village planning takes place toward the end of each year, and POA formulation occurs at the beginning of each year.
- Communication with *puskesmas* often rests with external facilitators, instead of village cadres and village government officials, particularly for districts receiving national programs (e.g. , *Generasi Sehat Cerdas* which is implemented by the Ministry of Villages to support village planning processes). This creates the impression that village-level health interventions, including those supported/financed by village funds, are still associated with national programs.
- Regulations and accounting procedures for *puskesmas* operational funds, including National Health Insurance Program (*JKN*) funding caps[36] and operational support funds (*BOK*), are restrictive and may inadvertently limit funds in order to avoid overlaps with village-supported health intiatives.

Communication remains a challenge for *puskesmas* and private clinics in rural and remote catchment areas. Many clinics and health posts lack mobile phones and/or short-wave radio capacity, which reduces options for readily communicating with communities. The use of mobile phones in *puskesmas* is lower than the use of landline phones, which tend to be relatively costly to administer. [37] Improved telecommunication

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[34] Indonesia Qualitative Service Delivery Survey (QSDS) (2016). This survey examined health care facilities and services of both private clinics and puskesmas, focusing on nutrition, maternal and child health, communicable diseases (particularly, HIV and AIDS, tuberculosis, and malaria), and non-communicable diseases (NCDs). The survey covered 268 puskesmas and 289 private clinics across 22 districts, including sample districts in Eastern Indonesia.

[35] Scoping Assessment, Social Safeguards Team (2017).

[36] puskesmas registered to BPJS-Health is eligible for *JKN* funds up to IDR6,000 per-member, with a possible increase up to IDR10,000 for lagging, remote, and border areas. The total amount calculated is based on the population registered by BPJS for each puskesmas' catchment area.

[37] QSDS (2016).

technology and connectivity, particularly for mobile phones, present an opportunity to strengthen communication, increase access to information and improve health services responsiveness.

Patient confidentiality is another concern. [38] The QSDS (2016) reports that only one-fourth of the *puskesmas* and half of private clinics surveyed were equipped with chambers or rooms that provided auditory and visual privacy. This can adversely affect patients seeking access to information and services, especially in facilities offering HIV counselling and testing services where disclosure could have social and economic implications because of associated stigmas. [39] This is reportedly more severe for women with HIV and AIDS, who may face double burdens of ostracism by their families and communities (as reported in Papua). [40]

Consent processes

Procedures and patients' awareness of their right to demand consent varies across health service facilities. By law, health providers are mandated to provide patients and families with information about treatments, side effects, and possible consequences as well as alternative options. However, consent procedures are sometimes weakly enforced. *puskesmas* and private clinics in rural areas tend to provide only basic health care treatments and services, and consent processes or procedures are widely perceived as unnecessary except for very serious and high-risk treatments.

Patient rights and grievance handling

Grievance redress mechanisms are loosely linked with improvements in the overall health systems. MOH tends to address grievances on an ad-hoc basis and there is a lack of systematic reporting to the central level. Complaints and patient-care issues are mostly handled at the facility level. At the central level, the Health Services Directorate is responsible for managing grievances associated with health care services provided in *puskesmas* and private clinics. However, in 2017, only 70 complaints were logged with the MOH. Further analysis of these reveals that the majority of complaints were not related to health care services, but rather to *JKN* which is not within the domain of health care providers to resolve or address. The current operating GRM platform[41] is designed to respond to health administration issues, not grievances. As a result, it is difficult to effectively track or correlate health care issues or concerns per health care facilities or providers, unless recurrent patterns or specific are investigated by the media and made public.

In cases of medical negligence, rules of conduct for medical professionals apply the principles of "*lex specialis derogate generali*". [42] As a result, negligence cases are subject to the Medical Practice Act, Hospital Act and Health Act Indonesia (Indonesia Health System Review 2017). Therefore, it is difficult to charge medical professionals under the criminal code (*Kitab Undang-Undang Hukum Pidana*) despite any neglect and/or malpractices leading to injury, disabilities or even deaths. Under these circumstances, the use of civil code (*Kitab Undang-Undang Hukum Perdata*) may be pursued and complaints may be settled through financial compensations for improper services. Medical professionals who are subject to litigation are punishable through disciplinary sanctions (by the Indonesia Medical Disciplinary Board - *MKDKI*)

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[38] QSDS (2016).

[39] The QSDS survey reported that only one-fourth of puskesmas and one-half of the private clinics surveyed were equipped with a chamber for both auditory and visual privacy.

[40] Butt (2013).

[41] Specifically, Halo Kemkes 1500-567, SMS 081281562620, fax (021)5223002, 52921669 and/or kontak@kemkes.go.id

[42] This means that when two laws govern the same situation, the more specific law overrides the more general law in application.

and/or the civil court (paying compensations). This provides limited avenues of redress for aggrieved patients and their families.

Access and Inclusion

To achieve access and inclusion, health services need to be accessible, affordable, and appropriate. This includes the quality and availability of health care services as well as the removal of barriers stemming from language, physical disabilities, and sociocultural factors, especially as pertain to the poor and vulnerable. For the purposes of the ESSA, access is understood as people's ability to receive health services at an affordable rate when they need it, especially the poor and vulnerable. Access and inclusion are examined in the following subsections in terms of: (1) Affordability and access to health financing; (2) Availability of health services; and (3) Quality and service appropriateness.

Affordability and access to health financing

Access to healthcare services has expanded significantly through the National Health Insurance Program (*JKN*). The program was introduced by the GOI in response to persistently high out-of-pocket expenditures (OOPE) per capita per total health expenditures (THE). [43] Since 2004, the percentage of the population covered under *JKN* has increased from 27% to more than 73%. *JKN* is making health services provided by hospitals and primary care providers increasingly affordable and providing greater protection in securing health care for the poor and vulnerable. However, discrepancies remain. The most recent DHS (2012) highlights that concerns about getting money for medical treatment are highest among women in Papua (57. 8%), West Papua (39. 9%), and West Sulawesi (37. 9%). This may be, in part, influenced by distance to a health facility, which is also highest among women in Papua (50. 5%), West Sulawesi (32. 9%), and West Papua (27. 3%). In addition, a recent World Bank (2017) report highlights continuing inequities in health care because many poor and remote rural populations are not covered by *JKN* or are unable to utilize these benefits due to distance to health facilities. [44]

The GOI has set a target of Universal Health Coverage (UHC) for at least 95% of the population by 2019. To achieve UHC a three pronged-approach has been adopted, which incorporates: (1) regional health insurance schemes (*JAMKESDA*) that operate at the district level; (2) health insurance programs provided by employers; and, (3) informal sector workers. The GOI acknowledges that achieving UHC is a long-term commitment. This is backed by global experiences, which offer that UHC is best accomplished incrementally and that it is often the informal sector and those above the poverty line which are hardest to reach. [45]

[43] Although there has been a steady increase in public health spending, the government share of total health expenditure remains low at 39% with OOPE at 60%. By law, the central government should spend 5% of its national budget on health (excluding salary payments) and provincial and district levels should spend at least 10% of their budget on health care (Government Regulation No. 36/2009).

[44] World Bank (2014) "Indonesia Economic Quarterly – December 2014: Delivering Change." Jakarta: World Bank; and World Bank (2014). "The Production, Distribution, and Performance of Physicians, Nurses, and Midwives in Indonesia: An Update." Jakarta: World Bank.

[45] Global experience with transitions to universal health care offer that this can take a long time. For example, Japan (40 years), Korea (29 years), and Thailand (20 years).

Indonesia's economy and labour market are dominated by the informal sector. Over 62% (68 million) of those classified as having work (114 million) can be found in the informal sector. [46] A large number of those who work in the informal sector and poor people are not registered in JKN. To help address these concerns and bridge this gap, *JKN* is being administered to cover poor and vulnerable participants registered as Premium Assistance Beneficiaries (PBI) as identified and listed in the Unified Database (UDB),[47] and non-Premium Assistance Beneficiaries (non-PBI) per a contribution-based scheme for wage earners, civil servants, military, informal workers, and other groups not classified as being poor or vulnerable. Advancing a differentiated strategy to increase inclusion of informal sector workers and low-income people will be necessary. Informal sector workers are more vulnerable due to the lack of income predictability and regularity, and people tend to drop out because they are unable to consistently pay-in contributions to non-PBI schemes. Moreover, administrative costs for premium collections tend to be higher, offsetting potential revenues to be collected since these workers are often outside the tax system.

Availability of health services

Health service availability (and access) is challenging at all levels, due the national geography which spans 6,000 inhabited islands and a skewed distribution of skilled health care providers. Accessibility to health care varies across the country, with disparities between regions as well as in urban, peri-urban, and rural locations. These differences are evident in overall health outcomes, especially for the Eastern Provinces (which tend to be worse than other regions), as well as in rural and remote areas. [48]

Health services in Indonesia are delivered through public and private providers, with the public sector more predominant in rural areas and for secondary levels of care. Differences in access to services can be measured, in part, by the distance to a health facility. On average, 18. 5% and 12. 4% of households take more than 60 minutes to reach a government hospital or a private hospital, respectively. [49] However, for more than 40% of households in Maluku, West Sulawesi, and West Kalimantan it takes more than one hour to reach a health facility. In terms of kilometres, the average distance to a health facility in West Papua, Papua and Maluku is more than 30 kilometres, which compares unfavourably with an overall average in Indonesia of only 5 kilometres.

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[46] The National Labour Force Survey/*SAKERNAS* (2012) offers that among informal sector workers 20 million (28.3%) are unpaid family workers, 35.6 million (31.5%) work for less than 35 hours/nearly jobless, 55.5 million (49.2%) did not pass elementary school, and the average income is only IDR1.5 million per month.

[47] The UDB for social protection programs consists of social, economic, and demographic information. This covers around 24.5 million of the poorest households or 96 million people. Data were collected by *BPS* (Central Bureau of Statistics), with the most recent updates in 2015. The database contains information on economic and social indicators of household members (name, gender, date of birth, age, disabilities, chronic diseases, marital status, ownership of identity cards, education and economic activities of household members) as well as welfare (housing, assets owned, access to schooling, health, and sanitation).

[48] Child mortality rates in the Eastern Provinces (particularly Papua, West Papua, North Maluku and Maluku), are between 2.5 and 6.5 times higher than the most Western Provinces (such as, Java and Sumatera). Some differences between urban and peri-urban and socio-economic characteristics can also be observed, with rural areas and households in the lowest wealth quintile experiencing worse health outcomes. The maternal mortality ratio (MMR) in Eastern Indonesia is highest in Indonesia at above 200 per 100,000 live births, compared to the national average of 126 per 100,000 which is considered high for middle-income countries. Malaria remains endemic in some regions, particularly Papua, West-Papua, *NTT*, Maluku and North Maluku. Almost 70% of malaria cases come from these provinces, even though containing only 8% of the country's population (QSDS 2017).

[49] National Institute of Health Research and Development (2013). *Riset Kesehatan Dasar, Riskesdas* 2013 Jakarta: National Institute of Health Research and Development.

The availability of services found in health facilities across Indonesia vary significantly. The 2011 Health Facility Census (*Rifaskes*) measured the provision of basic services by assessing outcomes for 38 indicators across five domains: basic amenities, basic equipment, standard precautions for infection prevention, diagnostic capacity, and essential medicines. At that time, no *puskesmas* was able to meet the minimum standards for readiness across all 38 indicators (World Bank, 2014). More than 80% of the 38 indicators were met by *puskesmas* in DI Yogyakarta, East Java, and Central Java on average, but only about half of *puskesmas* in Papua and Maluku reached this level. While challenges were noted across key program areas[50] throughout Indonesia, the situation is most acute in eastern Indonesia. Specific gaps identified by the 2011 Health Facility Census and the 2014 Indonesia Family Life Survey include:

- Less than 60% of *puskesmas* in North Sulawesi, Maluku, and Papua were able to diagnose anemia with hemoglobin testing.
- Urine tests were almost completely unavailable in Gorontalo, North Sulawesi, and Maluku.
- Less than 80% of *puskesmas* in eastern provinces of Papua, West Papua and Maluku reported the availability of the measles, DPT, polio and BCG vaccines.
- Most of the 380 *puskesmas* (4. 2%) that do not have any physician in place are located in Papua, *NTT*, Papua Barat, Maluku, and Sulawesi Tenggara.
- Only 4. 6% of the total number of doctors reside in *NTT*, Maluku and Papua, serving 41. 4% of the population and 28. 8% of the land mass, and amounting to a 0. 03 ratio of doctors to 1000 population. [51]
- The majority of the 430 subdistricts (6. 3%) without a *puskesmas* are located in Papua and Papua Barat.
- Most of the *puskesmas* without electricity are in Papua, Sulawesi Tenggara, *NTT* and North Sumatra). [52]

The number of *puskesmas* have kept up with population growth, and tend to be more accessible than both public and private hospitals. Nationally, only 2% of the population takes more than one hour to reach a *puskesmas*, but the proportion of the population facing this travel time is much higher in Papua (27. 9%), East Nusa Tenggara (10. 9%), and West Kalimantan (10. 9%). [53] *puskesmas* and other primary health care facilities are important for public health and referral services, particularly in the context of the *JKN* program.

There are wide variations in the numbers of people served by different *puskesmas*. The numbers of patients range from 70 up to 28,000, impacting the level of attention and care that can be provided. On average, rural areas serve approximately half of the population as compared with urban areas. However, rural *puskesmas* are harder to reach and require more time and resources to access both for patients and health workers. [54] The selection of *puskesmas* location needs to be weighed against access indicators, such as the size of population in the catchment area as well as the distance, time, and costs for accessing care. Furthermore,

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[50] These include: capacity of health facilities to provide interventions in key program areas of family planning, antenatal care, basic obstetric care, routine childhood immunization, malaria, tuberculosis, diabetes, basic surgery, blood transfusion, and comprehensive surgery (WHO 2017).

[51] In contrast, over half of Indonesian doctors (57.4%) are located on the islands of Java and Bali, serving 36.7% of the population and 6.9% of the total area of Indonesia, with a doctor to 1000 population ratio of 0.39 (WHO 2017).

[52] Sparrow R, and M. Vothknecht (2012). PODES Infrastructure Census 2011. Report on infrastructure supply readiness in Indonesia – Achievements and remaining gaps.

[53] *BAPPENAS* (2014). Supply side readiness: Indonesia health sector review. Jakarta: Ministry of National Development Planning of the Republic of Indonesia/*Bappenas*.

[54] The puskesmas surveyed in the QSDS study indicates that the average time to reach care in puskesmas was 15 minutes, and it could be five times higher for rural puskesmas.

innovations such as mobile clinics should be considered to expand outreach services, particularly in remote sparsely-populated. This would maximize access and increase health worker productivity.

Discrepancies in *puskesmas* and the Human Resources for Health (HRH) to population ratio has a significant impact on health care service availability. A relatively low number of health facilities have met compliance standards for quality health care services, in part due to shortages of available specialists, nurses, and para-medical staff and a lack of equipment. [55] Shortages of nurses and physicians are particularly acute in rural areas and in private clinics providing primary health care (Indonesia Health Profile 2016). Out of Indonesia's 33 provinces, 29 do not have the GOI's target (and WHO recommended ratio) of 1 physician per 1,000 people. Despite increases in the numbers of graduating physicians (trained largely through private medical schools) and financial incentives to work in remote areas, substantial staffing gaps persist. This suggests that other factors need to be considered to motivate recruitment, including non-monetary incentives. [56]

Progress has been made in achieving targets for midwives. *posyandu* activities are spearheaded by midwives and village cadres together with *puskesmas* outreach workers. Cadres are usually female community members, who work on a voluntary basis in collaboration with *puskesmas* staff. Midwives generally work on a special assignment basis (up to two years) to fill gaps in the health care workforce, particularly in remote, lagging, or border areas. They are recruited either by DHO and *Program Nusantara Sehat* (Healthy Indonesia Program)[57] or locally by village governments. They tend to be temporary workers with no civil servant status or benefits, which impacts rates of attrition and the continuity of services. [58] However, there are reports that the recruitment of new cadres is waning as young people are "not interested" in the positions. Most of existing cadres have served for more than 10 years, following their appointment during the *PNPM* (National Program for Community Empowerment). Some of the new cadres were recruited by village heads, and their rotation tends to follow election cycles which raises concerns around sustainability.

The GOI has made sustained efforts to revamp quality assurance systems for health professional schools through internship schemes for medical school graduates, which is also expected to improve health worker distribution. However, some gaps persist. Income sources for physicians are fragmented with no substantial increase from service reimbursements, particularly for midwives. Government oversight of the private sector is limited despite the growing number of private providers. Furthermore, shortages of health workers

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55 *Rifaskes* (2011) and QDQS (2016).

56 Physicians working in remote areas receive significantly larger than the salaries of their civil servant counterparts in urban areas. A World Bank study (2014) reported that physicians in remote areas receive between USD 485 and 715, compared to physicians in urban areas who receive approximately USD 205 from the central government's budget. Additional monetary incentives are also received from local government budgets. However, other non-monetary factors seem to affect willingness to be posted in remote areas, including perceived opportunity costs for training, self-development and promotion, as well as limited education options and security issues for family members.

57 Following the discontinuation of the PTT program which provided temporary deployment of doctors, midwives, and dentists, the Ministry of Health (MOH) launched the *Nusantara Sehat Program* in 2016 to fill health workforce gaps through special assignments (two years on a rolling basis) in targeted puskesmas locations (i.e., remote, lagging or border areas as well as those with the four priority health issues of the NSP). The NSP deploys team-based and individual special assignments, depending on local needs.

58 A World Bank (2017) study on Community Health Workers (CHW) noted a high attrition rate for *Posyandu* cadres (Consultant's Report, 2017).

are not being prudently addressed through prioritizing and allocating resources to meet the greatest needs. [59]

In the context of the proposed operation, primary health accreditation status should reflect improved services in availability and quality. Technical interventions and standard practices differ from one facility to another, including the management of postpartum haemorrhage, chronic respiratory diseases, and HIV-related services. [60] Moreover, future staffing will need to adapt to changing epidemiological profiles to address the rise in non-communicable diseases (NCDs) caused by sociodemographic and lifestyle changes. [61] Almost 70% of the disease burden is due to NCDs, and this is expected to grow in the coming years. Periodic reviews following accreditation will help to target and monitor gradual improvements within the overall system.

1.1 Quality and Appropriateness of Services

A survey by the National Institute of Health Research and Development (2007) revealed a high number of incorrect diagnosis every year. Households, especially the poor, bear a large part of this burden in unwarranted out-of-pocket payments; over 50% of the time people are paying to be treated for health problems they do not require. This observation was supported by the QSDS survey which found that only about half of healthcare workers responded correctly to standard questions about procedures. There is also a high rate of absenteeism among Indonesia's health workers, with doctors "moonlighting" at private practices during afternoon and evening hours.

The burden of family planning and curbing HIV and AIDS or other sexually transmitted diseases is gender-biased, with women taking greater precautions than men. Family planning services and contraceptives are generally available in *puskesmas*. Contraceptive use (e. g. , pills, injectable, and implants) is particularly high amongst women, although not among men. The QSDS reports that HIV prevention of mother to child transmission (PMTC) related services are limited in both *puskesmas* and private clinics, with only slightly more than half of *puskesmas* and one-fifth of private clinics surveyed providing these services. Available PMTC services usually include laboratory testing and anti-retroviral therapy/ARV, and the lack of PMTC provisions tends to be associated with limited infrastructure, equipment, and ARV supplies as well as trained staff. The study also cited a lack of demand from HIV-positive mothers, which may partially be attributed to lack of awareness of appropriate PMTC procedures. This increases the risk of HIV contraction to newly born infants.

Puskesmas tend to be better equipped than their private counterparts, particularly single-run private clinics (QSDS 2017 – draft). Emergency transport vehicles are more readily available in *puskesmas* than private primary health facilities. The same also applies to immunization and administration of care (diagnosis and management) for communicable diseases such as malaria, TB, and HIV, although new vaccines are likely more available in private clinics at a personal expense (QSDS 2017). However, if these services are available

[59] A proxy analysis was made for immunization where there is a negative correlation reported between immunization coverage and midwife and nurse density, suggesting that scare resources are not allocated to meet the greatest needs.

[60] Of all primary health services surveyed, only two-thirds of puskesmas and one-quarter of the private clinics provided HIV counselling and testing services. Availability of Anti-Retroviral Therapy (ART) is dismally low in the public sector and almost non-existent in private primary care facilities.

[61] Indonesia's population is ageing with a growing number of people falling into the 50 to 74 age brackets. Stroke, TB, maternal-related complications, road injury are some of the leading causes of pre-mature deaths.

in private clinics, the quality of care is usually not consistent and may not meet MOB prescribed standards (e.g., in the diagnosis of TB which often relies on clinical symptoms instead of microscopy procedures).

Outreach activities for preventative and promotional programs, including immunizations are primarily organized through *puskesmas* and *posyandu*. *puskesmas* staff are more likely to receive various trainings and have broader access to technical guidelines than their private sector counterparts, although access to professional development tends to be inconsistent overall. In the absence of formal training, self-learning or peer-mentoring are encouraged – often at the expense of quality.

The launch of the *KBK* (*Kapitasi Berbasis Komitmen*)[62] is creating new opportunities to access capitation payment for primary health facilities, with links to an agreed set of performance indicators. [63] As of 2016, *KBK* has been implemented in 97% of all districts in 34 provinces around the country (Technical Assessment draft 2017). Three performance indicators are currently being used: (1) contact rate of registered *JKN* participants (to measure coverage), (2) ratio of avoidable specialist care, and (3) chronic disease management program. Each district will have different standards, as the extent of applicability of these indicators will be agreed by participating districts on the basis of their commitments and readiness. The capitation payments for primary health providers empanelled by *BPJS* are adjusted based on the achievement of indicators, with full payment if all indicators are satisfied (safe zone) and incremental payment (reductions to 90%) depending on the level of achievement. Since its launch, *KBK* has been increasingly used as a quality control and cost-containment measure as well as an incentive mechanism for improving service availability.

With the right model for implementation, *KBK* could also incentivize primary healthcare facilities to improve the quality of their services (such as, patient safety, and preventative and promotional interventions). However, at present *KBK* implementation focuses on the use of relevant indicators to adjust capitation payment and tends to be limited to cost-containment measures instead of quality improvement. Furthermore, it is unclear whether a relatively small reduction in payment (5 to 10%) would sufficiently incentivize health providers to move beyond business as usual. In terms of supply side readiness, such as the availability of doctors, laboratory services, and equipment present challenges for *KBK* to be fully operational. [64] In areas with severe supply-side challenges, such as remote areas, reducing the amounts of capitation received due to failing to meet *KBK* performance indicators could negatively affect capacity to provide services.

Social Inclusion

Social inclusion can be enhanced through empowerment of health workers, including village midwives, nurses, and cadres. They are critical to service delivery because of their placement at the village level and their familiarity and rapport with the communities they serve. Their services are more accessible than physicians who are mainly based in *puskesmas* and located in sub-district capitals.

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62 Efforts to expand health coverage under the *JKN* are not accompanied with improvements in quality of care and consistencies in the availability of the basic benefits package. Supply-side financing is not linked to incentivizing local governments to improve supply-side readiness, with the majority of inter-governmental transfers being unconditional and having weak performance orientation (National QSDS report – draft 2017).

63 *NTT* and Papua are awaiting a response from MOH for their earlier request for exemption from the *KBK*

64 As reported in the technical assessment, the exchange of *KBK*'s performance monitoring and reporting data as captured in the P-Care (Primary Care Information System) by BPJS is not automatic between MOH and *BPJS* and the former needs to submit a request to access this data.

Targeting specific groups tends to be more reliable through these frontline health workers who usually collect data from *posyandu* and other village-based activities. This places them in a better position for village-level targeting and understanding of vulnerability and poverty. Cadres are in closer communication with families and usually report cases of malnutrition or high-risk pregnancy to midwives and *puskesmas* staff. This information is generally more accurate and up-to-date than the UDB,[65] as it is provided by community members on a more regular basis. However, in terms of targeting specific health issues, there could be a limit with regards to what extent and types of information could be generated. This suggests the need for further capacity building for cadres and *puskesmas* staff, including the development of simple measurement tools/methods and monitoring protocols.

People in very remote areas and those who are not formally registered or transient populations (including nomadic, seafaring, farming communities, temporary and migrant workers) often lack access to health services. Unregistered individuals may not be formally recognized as residents, and therefore not proposed for social assistance programs and *JKN*. In addition, because of the non-permanent nature of their residence and/or civil status, they not be included in censuses/surveys and outreach activities by *puskesmas*. Article 15 of the Law No. 23/2006 on Population Administration stipulates that any individual who leaves his/her original place of residence must obtain a transfer letter from the village head or authorized officials in order to be registered in his/her new place of residence. Family and/or ID cards can only be amended upon obtaining the transfer letter. This presents challenges for individuals who may not be aware of the procedures or who are unable to obtain this letter because of costs or other considerations.

Human rights violations against sexual and gender minorities, often referred to by the acronym LGBT (lesbian, gay, bisexual, and transgender) also includes concerns about social exclusion and discrimination in accessing health care. Indonesian national laws are largely silent with respect to LGBT people, and neither explicitly criminalize them nor protect them. However, at the local level, there are provinces, cities, and regencies that explicitly criminalize LGBT people. A recent report (2017) notes that public opinion studies suggest that acceptance of LGBT people is very low and has changed little over the last decade, and that media coverage is generally negative. [66] It also offers that studies in Indonesia (and elsewhere) indicate that stigma related to being LGBT reduces access to condoms, testing, and treatment of HIV. Studies also show high rates of HIV prevalence, suicidal ideation, and risky health practices for LGBT people, which are linked to stigma and minority stress. Barriers to accessing health care, include difficulties with ID cards, fear of having their sexual orientation or gender identity disclosed, fear of harassment by health care providers, and lack of funding for LGBT-related care.

Further analysis of a typology of exclusion is presented in Table 8. Since legal identity falls within the purview of the Ministry of Home Affair and not the MOH, additional analysis of these areas is outside the scope of the ESSA.

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[65] The Unified Database (UDB) is an electronic data system containing social, economic and demographic information. Welfare status is ranked using household welfare information obtained during *PPLS* (Data Collection for Social Protection Programs) Survey 2011 conducted by the Central Bureau of Statistics (*BPS*) using proxy means testing (PMT) models to determine the relative poverty of households for each district/municipality. The PMT models predicted household income, by collecting simple information about the assets they own, tailored to each district and municipality to accommodate variable differences (*TNP2K* 2015). The consumption index generated by the PMT models is used to rank households based on their welfare status. To date, the UDB is considered to be the most comprehensive targeting database in the country.

[66] Badgett, M., A. Hasenbush and W. Luhur (2017). "LGBT Exclusion in Indonesia and Its Economic Effects." Los Angeles: The Williams Institute, UCLA School of Law.

Table 8: Typology of Exclusion.

Who get excluded?	Reasons for exclusion
People who are not recognized by village administrations	Not involved in village development deliberation processes, unable to access health and educational services, some of the barriers would be: 1) administrative requirements i. e. lack legal identity 2) living in remote areas (geographical access, costs).
People living in very remote, hard to reach areas	Access to basic health services is limited, poor health service quality, high costs for non-health care related expenditures (e. g. transportation, accommodation, etc.).
Enrolled in *JKN* but registered outside catchment area of the *puskesmas* or not having legal identity	There are limitations with regards to *JKN*, particularly for in-patient services. Although *BPJS* can be accessed by those not resident of *puskesmas* catchment areas, in-patient services are limited for those enrolled outside the catchment areas. Such services may be available provided that patients have: 1) recommendation from village heads, 2) *BPJS* card from their original residence. Those who cannot provide will have to pay at their own expenses. *JAMPERSAL* (health insurance for pregnant mothers) is but to obtain the insurance, families have to provide: 1) ID cards, 2) family certificate, and recommendation letter from village heads. This suggests that stateless people, or transient populations with no formal registration in particular village administrative jurisdictions have a greater chance of being excluded. *JKN* cannot cover transportation costs and accommodation in cases where referral is needed.
Beneficiaries of other programs managed by central ministries	One possible exclusion could also be the fact that cadres and *puskesmas* staff would avoid families/households having benefitted from other programs to ensure fairness and avoid overlaps/double-counting/jealousy. For instance, households already receiving *PKH* (Conditional Cash Transfers) may get a more limited access to other social assistance programs administered by DHOs and/or village governments.
People with disabilities	Exclusion can sometimes start from home, with parents and family members feeling ashamed or feeling concerned that their family members with disabilities will be stigmatized.
Nomadic/non-permanent residents	May not have a legal identity and could be categorized as stateless particularly in border areas; Are characterized as being highly mobile, and sometimes, not having permanent residence; Have a higher likelihood for missing out on surveys and therefore are not registered; May not have access to basic services.
Marginalized groups	Exclusion against these groups will be further assessed, including level of stigmatization against certain groups (e. g. LGBT, certain ethnic groups, people with HIV and AIDS).
People who are perceived to be well-off	Targeting of specific programs, especially around nutrition and maternal health may skip households who are considered to be wealthy/well-off and there are issues around mobilization of village resources to support this groups (especially in the case of stunting) due to social status barriers, and social justice principles (i. e. priorities are for the poor).

Annex 5: Description of Accreditation System with Environmental and Social Considerations

Accreditation serves as a platform to promote good practices in environmental and social management of healthcare facilities. Independent accreditation systems aim to promote greater accountability, synchronization, and standardization of health services both provided by public and private healthcare providers in addition direct oversight by relevant health offices. In Indonesia, there are three levels of government with roles and responsibilities for health care and hospital regulations. The national government (MOH) is responsible for regulations and oversight at central hospitals (Vertical Hospitals), the Provincial Government for provincial hospitals (both public and private), and the District Government for district hospitals (both public and private). Delivery of primary healthcare is provided through a chain of services, with a network of *puskesmas* spearheading basic health services at the community level as well as through private clinics of doctors and midwives. Accreditation systems for both hospitals and *puskesmas* are currently in place, with the latter being relatively new.

Accreditation in being increasingly used in Indonesia as a platform to monitor, maintain and improve the quality and safety performance of healthcare services by primary healthcare facilities (*Puskesmas/*PHC). MOH through the Directorate of Primary Health (*BUK*) has undertaken a process to develop PHC accreditation since 2011. The Norms, Standards, Procedures and Criteria (*NSPK*) were developed in 2014 and an accreditation commission, currently under the purview of MOH, was also established in the same year (MOH Decree No: HK. 02. 02/MKES/59/015). The RPJMN (the National Medium-Term Plan) sets out annual targets for PHC accreditation over the period between 2015 – 2019[67] with an exponential increase by 100% each year. By 2017, around 2037 PHCs have been accredited out of an accumulative target of 2450 PHCs (MOH report 2017).

Periodic reviews and accreditation renewal every three years provides for the maintenance and improvement of services. Government oversight is performed by the MOH, and provincial and district health offices (PHOs and DHOs). The following sub-sections will discuss in greater detail each of the accreditation systems in view of environmental and social management relevant to the program.

Primary Health Care Accreditation

Primary care accreditation, both public/*Puskesmas* and private, is still currently under development. The accreditation system was established in 2015 with the enactment of MOH regulation No. 46/2015 which includes accreditation standards for public and private facilities. An interim accreditation commission for primary care facilities (*KAFKTP*) was established by MOH with mandates to carry out accreditation surveys before a fully independent accreditation body is established within four years following the issuance of MOH regulation on primary care accreditation. Support to the establishment of this independent body is one of the main areas under the RA 2 in the Program's Result Framework (DLI # TBD).

Although accreditation processes and decisions are reported to be independent from the MOH, the interim accreditation commission relies on funding from MOH for salaries and operating costs which raises concerns around conflict of interest[68] (Technical Assessment Notes). The commission is yet to prepare a road-map to transform into a fully independent institution with a robust business plan. To achieve a certain level of credibility, the commission is also expected to obtain ISQua (International Society for Quality in

67 The *RPJMN* sets out PHC annual accreditation targets from 2015 – 2019 i.e. 2015: 350 PHCs, 2016: 700 PHCs, 2017: 1400 PHCs, 2018: 2800 PHCs, 2019: 5,600 PHCs.

68 Potential conflict of interest may stem from MOH's target to achieve their *RENSTRA* (*Rencana Strategis*/Strategic Plan) milestones which could put pressure to the accreditation commission to assist MOH in achieving their targets (Technical Assessment Note)

Healthcare) accreditation. [69] The independence of the commission is one of the results of the Program, with the production of the road map one of the interim targets.

Primary care accreditation is envisioned to serve as a regulatory platform to standardize and improve quality of frontline healthcare services. There are opportunities to enhance environmental and social outcomes if accreditation standards are met and continuously improved and maintained. In the process of being accredited, primary healthcare facilities are required to meet management, outreach and clinical service standards as specified in MOH's regulation No. 75/2014. Several mechanisms exist to enable these facilities to be accredited. *DAK Akreditasi* covers the costs of district facilitators. The MOH covers the costs of the accreditation surveyors from *APBN*. *puskesmas* can access financing for infrastructure improvements from "*DAK Fisik"* (Special Allocation Funds for Physical Investments). [70]

Financial incentives are created to encourage primary healthcare facilities to achieve at least basic accreditation. By 2021, MOH will place accreditation as a pre-requisite for empanelment by *BPJS-Health* as a *JKN* (National Health Insurance) provider and therefore, remain eligible to receive JKN capitation funds, which is a significant source for financing for primary care facilities. [71] Plans for accreditation for primary healthcare facilities include a staged approach, with at least 5600 facilities being accredited by 2019. As reported by MOH, approximately 2,400 *puskesmas* (of a total 9,767) have received accreditation by August 2017, of which 30. 2% have received basic accreditation, 58. 5% intermediate and the remainder the top two levels. Although accreditation has covered 320 districts/cities and 34 provinces across Indonesia, the number of accredited *puskesmas* is much lower in Eastern Indonesian provinces particularly Papua, Maluku and North Maluku.

Although accreditation is technically available for both *puskesmas* and private clinics, a formal request for accreditation is required for the latter. In addition, the provisions in the accreditation standards including the composition of the surveyor team, are less comprehensive for the private clinics compared to *puskesmas*. As a public facility, community-oriented and public-health aspects remain central in *puskesmas* accreditation, including among others: access to health services, outreach, community engagement, participatory assessments of health needs and services. These standards are not required for private clinics.

Required expertise for the accreditation survey team includes public health management, medical specialization, and nursing services, whereas environmental-related expertise such as waste, pollution and resource management remains optional. Each surveyor team is comprised of at least three surveyors, including: 1) management surveyor with expertise in public health management, 2) medical surveyor with expertise in medical specialization, and 3) nurse surveyor with expertise in nursing services. Additional surveyors with specific expertise may be called upon depending on needs and the composition and number of each accreditation team may vary depending on the size of the hospital to be accredited.

Mirroring the hospital accreditation, four-tiered accreditation levels, including *dasar* (basic), *madya* (intermediate), *utama* (advanced), and *paripurna* (full) are envisioned to encourage primary healthcare facilities to achieve higher levels of accreditation. Each level serves as a proxy for managerial and service quality and hence, upgrades in accreditation levels may indicate quality improvements.

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69 ISQua (International Society for Quality in Healthcare) is an international accreditor to ensure that accreditation standards, surveyor training programs, and external evaluator entities meet international good practices.

70 Private facilities are expected to cover some of the accreditation costs including facilitator fees, pre-accreditation assessments, and post-accreditation improvements. The accreditation survey is covered by the MOH.

71 MOH policy is to make accreditation of hospitals and PHC facilities a prerequisite for empanelment by *BPJS-Health* as a *JKN* provider; by 2018 for hospitals and by 2021 for PHC facilities. The target for accreditation is at least one accredited puskesmas per sub-district (5,600) and at least one accredited government hospital per district by 2019.

Table 9: Surveyor Team Composition.

Management and Administration	Medical	Public Health
Minimum a Bachelor's Degree in Health Science	Medical professions with a valid license to operate	Minimum a Bachelor's degree in Health Science
Minimum 3 years of experience working in *puskesmas* and/or managing primary healthcare facilities	Minimum 1 year of experience working in *puskesmas* and/or clinics	Minimum 3 years of experience working in *puskesmas* and/or managing primary healthcare facilities
Having attended a surveyor training and possessing a valid certificate of completion issued by an independent accreditation commission	Having attended a surveyor training and possessing a valid certificate of completion issued by an independent accreditation commission	Having attended a surveyor training and possessing a valid certificate of completion issued by an independent accreditation commission

With the four-tiered system, accreditation processes are not expected to cease upon achieving a certain accreditation status. Hence, the whole cycle of accreditation provides an opportunity to strengthen the roles of key government agencies, particularly MOH and DHOs in improving service readiness and quality of primary care services over the long term. The accreditation cycle consists of pre-accreditation facilitation, accreditation survey (followed by determination of accreditation status) and post-accreditation facilitation. Technical facilitation (both prior and post-accreditation) represents an important window of opportunity to strengthen investments in capacity building for staff and management environmental and social-related aspects, including safe-handling of medical waste, outreach and community engagement by DHOs to primary care facilities in their respective jurisdictions. Each is described as follows:

a. **Pre-accreditation:** DHOs are responsible to assess *puskesmas* readiness and nominate facilities to be accredited. For private clinics, a formal proposal for accreditation is to be submitted to DHOs who are responsible to follow up with PHOs and the accreditation commission for further assessments. Following the nomination and prior to accreditation, DHOs are responsible to provide technical facilitation to facilities in the accreditation pipeline to meet minimum accreditation requirements. A facilitation team, comprised of facilitators with health administration and management, public health and medical backgrounds (see Table 10), is established by DHOs to provide capacity building and mentorship support to *puskesmas* and private clinics. This team will also carry out a mock accreditation survey prior to the actual survey to ensure that key requirements are met.

Table 10: Facilitation Team Composition.

Management and Administration	Medical	Public Health
Minimum a Diploma 3 in Health Science	Medical professions with a valid license to operate	Minimum a Bachelor's degree in Health Science
Minimum 2 years of experience working in *puskesmas* and/or managing primary healthcare facilities	Minimum 1 year of experience working in *puskesmas* and/or clinics	Minimum 2 years of experience working in *puskesmas* and/or managing primary healthcare facilities
Having attended a surveyor training and possessing a valid certificate of completion issued by an accredited training institution	Having attended a surveyor training and possessing a valid certificate of completion issued by an accredited training institution	Having attended a surveyor training and possessing a valid certificate of completion issued by an accredited training institution

b. **Accreditation survey**: following a pre-accreditation assessment, a team of surveyors from *KAFKTP* will assess and score facilities against a set of managerial and clinical standards. In the events that gaps are identified, the surveyor team will list key actions for further improvements that should be noted by

the facilitation team during their post-accreditation facilitation processes. A provisional accreditation status, subject to completion of corrective actions and re-assessment, might be issued by the *KAFKTP*;

c. **Post-accreditation:** Accredited facilities are entitled to receive post-accreditation facilitation and mentorship from their respective DHOs. This stage is envisioned to address deficiencies identified in the previous accreditation, maintain and improve the current performance to achieve a higher accreditation level in the subsequent re-accreditation process (every three years).

Prevailing accreditation standards for primary healthcare facilities require *puskesmas* to meet basic requirements for patient safety, hazardous waste management, building and equipment safety, and community relations and engagement, including management of grievances. Various mechanisms exist within the standards to screen *puskesmas* in view of environmental and social aspects and ensure that those accredited have at least these requirements are met:

a. Compliance with districts' spatial plans and prevailing environmental requirements (for new construction);
b. Construction of *puskesmas* must consider the ratio of population and available health services to ensure access to health services
c. Conformity to building codes;
d. Construction/layout of the *puskesmas* must be accessible for people with special needs, children, senior citizens as well as safe for its staff;
e. Adequacy of space, facilities and equipment to deliver available health services and protect patients' privacy and confidentiality;
f. Equipment to deliver available services is available, functioning and regularly calibrated;
g. Human resources are available and personnel meet minimum academic and professional qualifications regulated by the prevailing law; and
h. Waste treatment facilities are operational and rules and procedures exist to manage hazardous waste.

Unless the *puskesmas* achieves high scores for all applicable standards[72] (advanced and upper-advanced), the scoring system does not necessarily guarantee that the *puskesmas* has met adequate environmental standards, particularly around environmental management, including treatment of hazardous wastes. As per-the accreditation standards issued by MOH, management of environmental safety is regulated under Chapter 8 on Clinical Diagnostic Support Management. Under the current scoring system, the minimum thresholds for this chapter is at least 20 percent, indicating that *puskesmas* can still obtain basic accreditation despite the lack or absence of environmental management systems. Although accreditation may serve as an entry point to enhancing environmental management for primary healthcare facilities, there is no guarantee that such systems will be enforced as far as the scoring system does not require *puskesmas* to achieve certain environmental standards to be accredited. Table 11 outlines the scoring matrix for *puskesmas* accreditation.

72 There are nine chapters under the puskesmas accreditation standards, divided into three groups with three chapters for each group. Group one on Management of Administration, includes chapters on: C.1. puskesmas Services (C.1), puskesmas Leadership and Management (C.2), puskesmas Quality Improvement (C.3). Group two on Community Health, includes Target Oriented Community Health (C.4), Community Health Leadership and Management (C.5), Community Health Performance Targets (C.6). Group three on Individual Health, includes chapters on Patient Oriented Clinical Services (C.7), Clinical Diagnostic Support Management (C.8), Clinical Quality Improvement and Patient Safety (C.9).

Table 11: Accreditation Scoring Matrix.

	Not accredited	*Dasar* (Basic)	*Madya* (Intermediate)	*Utama* (Advanced)	*Paripurna* (Upper-advanced)
***Puskesmas* accreditation chapters**	Chapters 1, 2, 3 less than 75%	Chapters 1, 2, 3 ≥ 75%	Chapters 1,2,3,4,5 ≥ 75%	Chapters 1,2,3,4,5,6,7 ≥ 75%	Chapters 1,2,3,4,5,6,7,8,9 ≥ 75%
	Chapters 4,5,6 <60%	Chapters 4,5,6 ≥ 60%	Chapters 6, 7 ≥ 60%	Chapters 8,9 ≥ 60%	
	Chapters 7,8,9 less than 20%	Chapters 7,8,9 ≥ 20%	Chapters 8, 9 ≥ 20%		

An increasing demand for accreditation may undermine quality service improvement processes for various possible reasons. As dictated in the MOH's Strategic Plan for 2015-2019, at least 5,600 sub-districts are expected to have at least one accredited *puskesmas*. This may present a number of risks:

a. An increased target may stretch the capacity of the accreditation commission, particularly the quality of surveyor teams and quality of assessment and technical facilitation prior to accreditation. Achieving accreditation to thousands will require a large number of qualified surveyors[73] to be deployed and training programs to be rolled-out. As per-MOH's regulation No. 46/2015, each surveyor team should consist of three surveyors with qualifications in *puskesmas* management, public health and medical specialists and minimum education backgrounds of Diploma-3 in health. Similar to the hospital accreditation, there are no mandatory skill requirements particularly in the areas of medical waste management and environmental-related aspects. Such skills will likely be subsumed within the required skill-sets for surveyor teams and therefore, training materials and modules need to ensure that key elements of environmental management at *puskesmas* can be mainstreamed.
b. Focus on aggregate targets may distort efforts by districts to prioritize ready-to-be accredited *puskesmas* rather than quality improvements in hard-to-access *puskesmas*. As of 2017, a total 2037 sub-district *puskesmas* have been accredited since 2015 (discussion with MOH). This represents a significant achievement for MOH since the system is still relatively new. However, the figure does not necessarily capture geographic distribution and equity. As reported in the technical assessment note, the number of accredited *puskesmas* is much lower in eastern provinces such as Papua, Maluku, and North Maluku. NTT is an exception as the province is among the top ten provinces with the highest number of accredited *puskesmas*;
c. There could be a potential conflict of interest due to pressures to deliver targets by the accreditation commission which is currently reliant on MOH for funding.

73 The technical assessment note reported that there were 114 surveyor teams (three surveyors per-team) as of 2016. Each province is also reported to have at least one team of trainers of district accreditation facilitators and at least one accreditation surveyor team.

Annex 6: Analysis Against Key Policy Elements of Bank Policy Program-for-Results Financing

Policy Element a) Program systems promote environmental and social sustainability in the PforR Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts.			
Key Attributes related to Core Principles	**Relevance to Program**	**Provisions in System**	**Practice**
Operate within an adequate legal and regulatory framework to guide environmental and social impact assessments at the Program level.	Relevant	A complete set of regulatory and legal framework related to Primary Health Care facilities is presented in Table 4. Also, a clear distinction between national, provincial and district level jurisdiction for permitting system of Medical waste management handling at HCF level is available (MOEF Decree 56/2014). And also for the permitting system for wastewater effluent and emission. A complete assessment of the accreditation system as regulated by *Permenkes* 46/2015 as the key legal and regulatory framework for Primary Health care facilities' accreditation is presented in Table 4.	Permit documents are found at HFCs in the field also all necessary equipment for waste handling such as dedicated bins for sharps, infectious waste and all personnel wear PPEs. However, the main challenge is to maintain the same level of performance 2-3 year after the permit granted for keeping the practice/equipment running well. A management system for periodic evaluation, training, annual refresher and work instructions development for task with high environmental and social risk is needed that could take the form as a Health Care Facilities Waste Management System (HWMS). The capacity of Local Environmental Agency is still low in regulation implementation, monitoring and advice provision.
Incorporate recognized elements of environmental and social assessment good practices	Relevant	Covered by various standards as part of accreditation system.	
(a) early screening of potential effects;	Not relevant	*Permenkes* 75/2015- Appendix 1- regulates the requirement of the location of the *puskesmas* that must be free from natural hazards such as hurricanes, floods, earthquake (faults), steep slope, tsunami, at riverbank area (erosion potential) etc.	Manageable. Ministry of Public Works or Local contractors has adequate information related to screen out the potential natural hazard in the area in addition to information from local communities.

Policy Element a) Program systems promote environmental and social sustainability in the PforR Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts.			
Key Attributes related to Core Principles	**Relevance to Program**	**Provisions in System**	**Practice**
		Element Criteria 2. 1. 1 of *Permenkes* 46/2014 about accreditation. *Puskesmas* have the necessary valid building permits and in accordance with the spatial layout of the district/cities.	
(b) consideration of strategic, technical, and site alternatives (including the "no action" alternative);	Relevant	*Permenkes* 75/2014 about *puskesmas* location and building permit system.	Manageable. See above.
(c) explicit assessment of potential induced, cumulative, and trans-boundary impacts;	Relevant	Accreditation system for waste management storage and transport. And also the permitting system for wastewater effluent and emission and the manifest system from MOEF	Manageable, in term of the comprehension that the potential induced impacts must be taken care of in the regulation. It has been explicitly assessed and regulated. The challenge is in ensuring the chain of custody system for medical waste that need attention from primary care providers staff and also accreditation facilitator and surveyor.
(d) identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized;	Relevant	Accreditation system and provisions and also national regulatory system as it applies to environment.	No significant gap, the measures for mitigation has been regulated.
(e) clear articulation of institutional responsibilities and resources to support implementation of plans	Relevant	A clear distinction between national, provincial and district level jurisdiction for permitting system of Medical waste management handling at HCF level is available (MOEF Decree 56/2014). *Permenkes* 1204/2004 also regulates the required competency for environment sanitation staff of the HCF.	Cleary articulated.

Policy Element a) Program systems promote environmental and social sustainability in the PforR Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the PforR Program's environmental and social impacts.			
Key Attributes related to Core Principles	**Relevance to Program**	**Provisions in System**	**Practice**
(f) responsiveness and accountability through stakeholder consultation, timely dissemination of Program information, and responsive grievance redress measures.	The focus of the program is to strengthen existing systems to improve primary healthcare performance. Environment may want to add.	Law No. 8/1999 on Consumer Protection Patients file a law suit to the court or to appeal to the Indonesian *MKDKI*. Medical negligence and litigation implicating medical professionals (doctors and dentists) is investigated by the Indonesian Medical Disciplinary Board (*Majelis Kehormatan Disiplin Kedokteran Indonesia/MKDKI*). The accreditation system for *puskesmas* and private clinics.	No one centralized mechanism for addressing feedback or complaints. Many complaints or feedback systems at various administrative levels and at institutional level including at each health facility.

Policy Element b) Program systems avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the PforR Program.			
Key Attributes related to Core Principles	**Relevance to Program**	**Provisions in System**	**Practice**
Includes appropriate measures for early identification and screening of potentially important biodiversity and cultural resource areas.	No adverse impacts to important biodiversity of physical cultural heritage.	*Permenkes* 75/2014 about *puskesmas* location and Permit Requirement for HCF establishment by respective jurisdiction.	The location of *puskesmas* is always designed to be close/nearby human settlement area for easy access and is not located at protected or sensitive area (Appendix I. 1. b of *Permenkes* 75/2014).
Supports and promotes the conservation, maintenance, and rehabilitation of natural habitats; avoids the significant conversion or degradation of critical natural habitats, and if avoiding the significant conversion of natural habitats is not technically feasible, includes measures to mitigate or offset impacts or program activities.	Not relevant.	Not relevant.	Same as above.
Takes into account potential adverse impacts on physical cultural property and, as warranted, provides adequate measures to avoid, minimize, or mitigate such effects.	Not relevant.	*Permenkes* 75/2014 Appendix 1 - about *puskesmas* location.	The construction of *puskesmas* facility often involved local community leaders and "*gotong royong*" system (in-kind, or working together) so that necessary information related to physical cultural resources is always taken into account.

Policy Element c) Program systems protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the PforR Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the PforR Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
Promotes community, individual, and worker safety through the safe design, construction, operation, and maintenance of physical infrastructure, or in carrying out activities that may be dependent on such infrastructure with safety measures, inspections, or remedial works incorporated as needed.	Relevant.	Accreditation system for *puskesmas* and private clinics (see Table 4 for detail assessment related to worker and patient safety and public health during the operations of the HCF and its waste management handling). Similar assessment for national regulatory/policy framework is in Table 4.	In general, the promotion of health and safety in HCF operations is meeting the standard for some areas in western part of Indonesia (Sumatera, Bali, Jawa) but need attention for eastern part of Indonesia.
Promotes the use of recognized good practice in the production, management, storage, transport, and disposal of hazardous materials generated through Program construction or operations; and promotes the use of integrated pest management practices to manage or reduce pests or disease vectors; and provides training for workers involved in the production, procurement, storage, transport, use, and disposal of hazardous biological wastes in accordance with GIIP.	Relevant	Accreditation system for *puskesmas* and private clinics. National laws and regulations that governs the following: (see Table 4). Law No. 32/2009 on The Protection and Environmental Management, requires management of materials and wastes that are classified as dangerous and/or poisonous or B3 (*Bahan Berbahaya dan Beracun*) Government Regulation No. 74/2001 on Management of Hazardous Materials), Government Regulation No. 101/2014 on Management of Toxic and Hazardous	For the national laws and regulations: No significant gaps with regards to policy and law and regulations. As part of *puskesmas* Accreditation requirements, HCFs are required to develop Standard Operating Procedures (SOPs) or Work Instructions in the handling of both medical solid and liquid wastes and also expired chemicals/reagents/medicines and radioactive waste. The requirements in MOEF Regulation no 56/2015 are equivalent to the WBG EHS Guidelines for Healthcare Facilities as they cover GIIP such as labelling and symbols for hazardous materials and waste, waste reduction, segregation, storage, transportation (manifest), treatment and

Policy Element c) Program systems protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the PforR Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the PforR Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
		Waste, Government Regulation No. 27/2012 on Environmental Permit). MOEF Decree no 56/2015 on Procedures and Technical Requirement of Hazardous Waste Management from Health Care Facilities or *FASYANKES* and *Kepbappedal* No 03/*Bapedal*/09/1995 on Emission standards from Incinerators. **Medical Solid Wastes**: As regulated in the MOEF Regulation No 56/2015 above and MOH Decree No 1204/*Menkes*/SK/X/2004 on Provision of Hospital Environmental Sanitation. PP 101/2014 and MOH Decree no 1204/*Menkes*/SK/X/2004 on Provision of Hospital Environmental Sanitation specifies incinerator requirements and outlines requirements for safe-handling of hazardous waste materials. MOH Decree no 1204/*Menkes*/SK/X/2004 provides specific treatment for each type of medical wastes. **Medical Liquid Wastes** The MOH Decree no 1204/Menkes/SK/X/2004 (aligned with WHO's guidelines) require HCFs to apply	handling (with autoclave, incineration), health workers' occupational health and safety and public health and safety. From the field visit to Riau, Java, Bali from other projects related to health care system (*DAK*, *RIDF*), permit documents are found in the field also all necessary equipment for waste handling such as dedicated bins for sharps, infectious waste and all personnel wear PPEs. However, this is not be the case for Eastern part of Indonesia as the capacity and the comprehension of the staff at HCF and government agencies are still low. A specific intervention might be needed for this region. Nation-wide, strengthening the accreditation system is required in creating a management system for periodic evaluation, training, (including annual refresher and drill, also for the facilitator and surveyor), and work instructions (SOP) development for task with high environmental and social risk, as well as handling the chain of custody of medical waste. This could take the form as a Health Care Facilities Waste Management System (HWMS).

Policy Element c) Program systems protect public and worker safety against the potential risks associated with: (i) construction and/or operations of facilities or other operational practices under the PforR Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the PforR Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
		the following measures in the handling of medical liquid wastes. MoE Decree No 58/1995 on Hospital Effluent Discharge Standard includes pH, BOD, COD, Temperature, NH3, PO4, Microbiology (e-Coli) and Radioactive (11 elements, 12 isotopes). MOH Regulation No 37/2012 about Laboratory Management for *puskesmas* covers provisions about liquid and hazardous waste from hospital laboratory.	No significant gaps between the policy and procedures for handling the wastewater. The GOI system has also the effluent standard that specifically regulate hospital's effluent similar and to the WBG EHS Guidelines for Health Care Facilities (Performance Monitoring), even for specific parameter it is stricter, for example 100 mg/L for COD (Indonesia) and 250 mg/L (WBG Guidelines). The main challenge now is to strengthen the accreditation system by developing a standardized work instruction or SOP on how to evaluate the performance of the treatment system for wastewater and understanding the mechanism for identification and troubleshooting of the abnormal condition (excedance, equipment malfunction etc.).
Includes measures to avoid, minimize, or mitigate community, individual, and worker risks when Program activities are located within areas prone to natural hazards such as floods, hurricanes, earthquakes, or other severe weather or climate events.	Relevant	*Permenkes* 75/2015- Appendix 1- regulates the requirement of the location of the *puskesmas* that must be free from natural hazards such as hurricanes, floods, earthquake (faults), steep slope, tsunami, at river bank area (erosion potential) etc. Also the provision of the community participation approach as required in the accreditation system	No significant gaps between regulation and implementation as the construction of *puskesmas* facility often involved local community leaders and "g*otong royong*" system (in-kind, or working together) so that necessary information related to natural hazards is always taken into account.

Policy Element d) Program systems manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist the affected people in improving, or at the minimum restoring, their livelihoods and living standards.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
Avoids or minimizes land acquisition and related adverse impacts;	No land acquisition as a result of program.	Not relevant.	Not relevant.
Identifies and addresses economic and social impacts caused by land acquisition or loss of access to natural resources, including those affecting people who may lack full legal rights to assets or resources they use or occupy;	No adverse social impacts or to livelihoods.	Not relevant.	Not relevant.
Provides compensation sufficient to purchase replacement assets of equivalent value and to meet any necessary transitional expenses, paid prior to taking of land or restricting access;	Not relevant.	Not relevant.	Not relevant.
Provides supplemental livelihood improvement or restoration measures if taking of land causes loss of income-generating opportunity (e.g., loss of crop production or employment);	Not relevant.	Not relevant.	Not relevant,
Restores or replaces public infrastructure and community services that may be adversely affected.	Not relevant.	Not relevant.	Not relevant.

Policy Element e) Program systems give due consideration to the cultural appropriateness of, and equitable access to, PforR Program benefits, giving special attention to the rights and interests of the Indigenous Peoples and to the needs or concerns of vulnerable groups.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
Undertakes free, prior, and informed consultations if Indigenous Peoples are potentially affected (positively or negatively) to determine whether there is broad community support for the program.	The I-SPHERE PforR is expected to enhance inclusion of Indigenous Peoples and vulnerable groups by strengthening delivery of primary healthcare services through improved community engagement, patient care and safety, cultural appropriateness of service delivery as well as consultation and concent procedures, including the handling of complaints. The Program will focus on system strengthening to ensure that practices of inform consent could be improved and there is a mechanism to monitior such practices at the facility level. Key measures supported by the Program include: *first*, enhancing the capacity of surveyors commissioned by the accreditation commission and	The requirements and supporting processes for accreditation systems for *puskesmas* and private clinics do not discriminate against groups or individuals. Furthermore, strengthening the system for better outreach, improved community engagement, and tailored primary health care services will translate to better outcomes.	The ESSA found that practices for informed consent for delivery of medical treatments greatly varies across primary health facilities, with potentially negatice attiudes and stigma, especially against those with HIV/AIDS being reported in the highland Papua (Butt et.al 2010). This has been considered as a major concern that needs addressing. With regards to consultations and consent, the assessment found no significant gaps in terms of accreditation provisions and international good practices as set out in standards by the International Society for Quality in Healthcare (ISQua). However, the surveyor capacity to assess consent practices is likely affected by their lack of engagement with the communities served by the health facilities and their ability to assess such practices adequately due to time and resource constraints. Each surveyor team is provided with three days to assess the whole indicators, which are heavy in documentation and SOPs.

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Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
	facilitation teams established by DHOs in assessing procedures and practices of consultations and consent. *Second*, improving citizens' awareness of their rights for informed consent with regards to medical practices.		
Ensures that Indigenous Peoples can participate in devising opportunities to benefit from exploitation of customary resources or indigenous knowledge, the latter (indigenous knowledge) to include the consent of the Indigenous Peoples.	Not relevant.	Not relevant.	Not relevant.
Gives attention to groups vulnerable to hardship or disadvantage, including as relevant the poor, the disabled, women and children, the elderly, or marginalized ethnic groups. If necessary, special measures are taken to promote equitable access to program benefits.	Relevant. The program focus is to strengthen primary health care performance nationally with focus on Eastern Indonesia. One of the key primary care accreditation provisions supported by the PforR include community outreach, access to healthcare and appropriateness of services through improved engagement and community participation.	Provisions in the primary care accreditation system. Law No. 29/2004 on Medical Practice, Article 52 and the Health Act, the Hospital Act and the Medical Practice Act. Citizens have the rights to choose services, to be treated without prejudice and discrimination, to have their record and treatments kept confidential, to receive information about treatment and costs as well as seek for second opinion. Law No. 8 of 1999 on Consumer Protection	Although the key regulations contain provisions for community outreach as well as improvements in access and appropriateness of health care services, efforts to achieve equal health outcomes especially for people in Eastern provinces in Indonesia have been constrained by limited connectivity due to geographical barriers (islands, mountainous terrains), unequal distribution of health workers and availability of the right skills to address specific health needs (e. g. non-communicable diseases, HIV and AIDS), legal identity to access *JKN* and

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Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
	The accreditation processes will serve as a check and balance tool for DHOs and MOH to assess to what extent social acceptance and accessibility have improved over time. An additional measure proposed by the Program to enhance citizens' engagement, by expanding access and documentation of feedback and grievances is expected to improve primary healthcare facilities' accountability both to the citizens they serve as well as the oversight entities.	Citizens have the right to choose services, to be treated without prejudice and discrimination, to have access to information regarding services, to be heard and complaint as well as legal access to litigation. Procedures governing access to *JKN* require the possession of an ID Card (*Kartu Tanda Penduduk or KTP*) which then impacts on people being able to access healthcare. Access to health services for people with special needs is also protected by law, with health providers being required to ensure their facilities are accessible and services are non-discriminatory. The accreditation system for *puskesmas* and private clinics.	other social assistance programs), social and cultural factors (e. g. stigma, cultural practices and preferences)

Policy Element f) Program systems avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.			
Key Attributes Related to Policy Element	**Relevance to Program**	**Provisions in System**	**Practice**
Considers conflict risks, including distributional equity and cultural sensitivities.	Not of immediate relevance to Program. Equity and cultural aspects can be addressed through examination of accreditation system and analysis of data on and for equity in *JKN*.	Not relevant.	Not relevant.