MAKING SERVICES WORK FOR THE POOR IN INDONESIA

CASE STUDY 2:
VOUCHERS FOR MIDWIFE SERVICES
IN PEMALANG DISTRICT, CENTRAL JAVA PROVINCE

ABSTRACT

In 1998, as part of the World Bank-funded Safe Motherhood Project, the Targeted-Performance-Based Contracts for Midwives (TPC) pilot project was launched in ten districts of Indonesia, including Pemalang in Central Java province. The TPC pilot objective was to strengthen the sustainability of maternal health services at the village level. In addition, central Ministry of Health staff thought that it was intended to assist in eventual privatization of the midwives. All poor pregnant women in villages with midwives contracted under the TPC pilot were to receive booklets with pre-paid vouchers for specific maternal health services such as delivery, motivating them to seek care. TPC midwives were only paid upon submission of vouchers, motivating them, in turn, to seek out poor clients. In 2002 the government tacitly abandoned its goal of midwife privatization by allowing unlimited contract renewals for many government-funded midwives. The TPC pilot ended in 2003 but the district continued the voucher system with some of its own funding. In November 2004, however, the central government enabled TPC midwives to transfer to a PTT midwife contract which requires no district funding, and the voucher system was discontinued. Overall, the TPC pilot increased the access of poor pregnant women to higher quality maternal health care. Success was due to two main factors: first, the voucher enabled the poor to get midwife services, and second, the voucher system was quite effective in holding midwives accountable for delivery of their services to the poor. During the project’s implementation period, there was an improvement in the district’s maternal mortality rate from 51 per 1,000 live births in 1997 to 32 in 2003. This improvement is likely not due to the project, however, but at least in part to an increase in quality of midwives’ services as a result of training provided to all midwives by the central government. Project impact was limited by difficulties in identifying and reaching the target group, insufficient dissemination of project information, inadequate collection and analysis of project data, and ineffective project management, as well as by conflicts stemming from its overlap with the health card program.
INTRODUCTION

THE STUDY SITE: PEMALANG DISTRICT

Pemalang district (kabupaten) is one of 35 districts and cities in Central Java province. The district’s population of nearly 1.3 million is all of Javanese ethnicity.\(^1\) Flat terrain means all 14 sub-districts and most villages are accessible by road. Forty-eight out of the 222 villages in the district, however, are classed as “remote”, with difficulties in transportation. The region is relatively poor with a poverty rate of almost 40 percent in some sub-districts (compared to the national rate of 17 percent); the main income source is paddy rice. The district’s illiteracy rate, 13 percent, is the same as the national rate.\(^2\) The local language is the widely spoken Javanese; most elderly villagers do not speak Indonesian.

MATERNAL HEALTH SERVICES IN PEMALANG DISTRICT

Maternal health services are the responsibility of the Ministry of Health via Province and District Health Bureaus (dinast kesehatan), and are available to all Indonesian women from both public and private providers. Public providers include government-paid midwives, either contracted (pegawai tidak tetap bidan di desa or BdD PTT) or appointed as civil servants (pegawai negeri sipil bidan di desa or PNS Bdd) at sub-district health centers (puskesmas) and their associated village midwife stations (polindes) and health centers (puskesmas pembantu or pustu). Private providers, who work from their homes, include government-paid midwives who work for themselves after government working hours, as well as women who are solely private. A key group of private providers is the traditional birth attendants, or dukun, who are still used to assist in most village births whether a midwife delivers the child or not. In villages without subsidized midwives, dukun still deliver most babies of poor women. According to Parker and Roestam (2002), this is because their services are cheaper and more conveniently located, they are more likely to have children themselves, and they offer additional valued non-clinical services following childbirth, including cleaning the placenta, washing the baby, and providing massage for baby and sometimes mother. The dukun have no formal midwife training, are usually older women with low education levels (elementary school or lower) and usually rely on traditional methods. Since the 1990s, the government of Indonesia has asked the puskesmas to arrange small training sessions for the dukun by government midwives. In Pemalang all dukun have received this training. The dukun are, however, still not trained in how to deal with complications in delivery. With the increasing number of trained and licensed midwives, the government’s view is that the use of the dukun for deliveries should be stopped.

The current health care network in the district includes 31 doctors, 22 sub-district health centers, 49 village health centers and 161 village midwife stations with 244 midwives (115 contracted and 129 civil servants). Only a few of the 222 villages are still without a midwife.\(^3\) There are about 300 dukun working in the district (at least one per village). In addition, there are about 26,000 volunteer village health workers, or kader, in the district. The majority are women. Hospitals play a very minor role in village maternal health care: TPC midwives refer between 30 and 50 pregnant women (or much less than one-tenth of one percent of all Pemalang deliveries annually) to the hospital for childbirth-related care a year.\(^4\)

\(^1\) District Health Bureau DinKes (2004)
\(^2\) World Development Indicators Indonesia: 17 percent of women aged 15 and above and 8 percent of men aged 15 and above are illiterate.
\(^3\) District Health Bureau.
\(^4\) Source: District Health Bureau (2000-2004).
MATERNAL HEALTH SERVICE REFORM

Despite overall improvement since 1997, key maternal and child health indicators remain higher in Indonesia than in other countries in the region. For instance, the infant mortality rate is 47 per 1,000 life births (2003 statistics) in Indonesia as compared with 32 in the East Asia and Pacific region.\(^5\)

In the early 1990s, Indonesia launched a Safe Motherhood Strategy in response to the 1987 Nairobi Safe Motherhood Conference. The first program launched nationally as part of the Safe Motherhood Strategy was the Temporary Contract Midwife (pegawai tidak tetap bidan di desa or PTT BdD) Program. Under this program, the government planned to place 56,000 midwives nationwide (as of early 2005, it has placed approximately 50,000). Supplying enough midwives to meet demand in Indonesia was one problem, but another was to find a sustainable solution. The government was already aware of the burden that financing the new midwives would place on the central budget, and strengthened sustainability through privatizing the PTT midwives was an unwritten program objective from the start.\(^6\) But the newly graduated midwives had many problems promoting their services and attracted few clients, which made privatization following the expiration of their contracts very unlikely.\(^7\)

In 1997, the World Bank in cooperation with the Ministry of Health (MOH) designed the Safe Motherhood Project: A Partnership and Family Approach to support the government’s strategy. The project aimed to improve maternal health status in selected districts of East and Central Java by: (1) improving the demand for and utilization of quality maternal health services; (2) strengthening the sustainability of maternal health services at the village level; (3) improving the quality of family planning services; and (4) preparing adolescents to lead a healthy reproductive life.\(^8\)

Under PTT rules, initial contracts were for a three-year period with one optional renewal. The first group of PTT midwives in Pemalang district was hired in 1994, and the second—a group of 50—in 1995. When the contracts of the second group were due to expire in 1998, though, there was confusion about whether the contracts would indeed be renewed. The launch of a new pilot project for maternal health services that year presented an opportunity for these midwives to regain some stability in their work, as well as for the District Health Bureau to maintain and increase access to midwifery services.

The pilot project, launched as a key component of the Safe Motherhood Project, was called Targeted-Performance-Based Contracts for Midwives (TPC). It was implemented from 1998 to end-2003. The main objective of the TPC pilot was to strengthen the sustainability of maternal health services at the village level.\(^9\) It “was designed to be more equitable [than the existing PTT contracts system] for the BDD [midwives], ...[and] more equitable for the villagers; [in addition it] would be performance-based and therefore encourage greater efficiency.” It was intended that the TPC pilot would “save the MOH a substantial amount of money over time...as the proportion of the population who are poor continues to decline with future development... Accordingly, the TPC provides an ‘exit strategy’ for MOH’s support to the BDD [midwives], who will be assisted to become (eventually) self-sustaining private providers.”\(^10\)

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\(^6\) Source: Parker and Roestam 2002.
\(^7\) Source: heads of sub-district health centers.
The TPC pilot project consisted of three elements: contracting and training of midwives,\(^{11}\) a demand-driven voucher system for midwives' services; and target-based evaluation of midwives' work. In theory, issuing pre-paid vouchers for specific maternal health services would ensure that people of all incomes could afford midwifery services. The requirement that TPC midwives submit the actual vouchers for payment gave the midwives an incentive to look for poor patients and convince them of the need for their services. Ministry of Health officials envisioned that through the voucher system, demand for midwife services would increase sufficiently to permit privatization of TPC midwives’ services.

Complicating the story further, in 1997, the government had implemented Social Safety Net (SSN) Programs to reduce the negative impact of the economic crisis on the poor. One of the SSN programs, the JPS-BK (Jaring Pengaman Sosial Bidang Kesehatan, or Social Safety Net on Health), aimed to increase access to health services for lower-income families through the provision of health cards. The health card program was introduced nationwide the same year that the TPC pilot project was launched in ten districts. The health card covers not only some maternal health services (delivery, ante- and post-natal care) but many other health care services as well, in both health centers and hospitals.

**RESEARCH QUESTIONS**

The objective of this case study was to examine the impact of the voucher system on quality and utilization of midwife services, with a focus on utilization by the poor. Three hypotheses were tested during the fieldwork:

1. As a result of the voucher system, utilization of TPC midwives’ services by the poor increased.
2. Specifically, the voucher system caused this increase in utilization because: (a) it became financially possible for the poor to use TPC midwives’ services; (b) TPC midwives had a financial incentive to encourage the poor to use their services; and (c) there was a greater understanding on the part of poor pregnant women of the need for, and higher quality of, TPC midwives’ services.
3. The use of targets for evaluation of TPC midwives increased their motivation, and thus the quality of their services.

**METHODOLOGY**

Fieldwork was carried out in March 2005 for a period of 11 days. Three villages in two sub-districts were visited: Peguyangan village in Bantar Bolang sub-district, and Ampelgading and Ujunggede villages in Ampelgading sub-district. The criteria for selection were location (one sub-district is fairly remote while the other is near the main coastal road) and number of TPC midwives (sub-districts and villages with a relatively high number were selected).

The primary research tools were semi-structured interviews and focus group discussions. Two sub-district health centers (puskesmas) and one village health center (posyandu) were visited. About fifty people were interviewed, including the head and staff of the District Health Bureau, eight sub-district health center staff, eight PTT midwives, of whom six are former TPC midwives, two midwives with civil servant status (PNS BdD), eight kader, the Safe Motherhood Project facilitator,\(^{12}\) the head of the Social Sub-Department of the District Planning Bureau (Bappeda Kasubid, or Badan Perencanaan Daerah Kepala Sub Bidang Social), one village head, ten voucher patients, and eight poor families. The voucher patients interviewed were invited by the midwives and are mothers who used vouchers for giving

\(^{11}\) Training was not a part of the TPC project *per se*, but TPC midwives were prioritized in the new national midwife training program.

\(^{12}\) Because the project involved so many organizations, the central government decided to hire district-level facilitators to avoid overlapping activities.
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Poor families interviewed were chosen with the help of kader or just by strolling through the villages and rice paddies.

All TPC project data from 1999 and earlier was lost in a fire in the District Health Bureau in 2000, complicating analysis somewhat.

THE LIFE AND DEATH OF TPC

HOW TPC WORKED

The TPC midwives. Pemalang District contracted 30 midwives under the TPC pilot project in October 1998. Any midwife was eligible to apply for the TPC positions, but as it turned out, all midwives who were hired under TPC had previously been PTT midwives, hired in 1995, and uncertain in 1998 whether their PTT contracts would be renewed.

TPC contracts were seen as desirable for a number of reasons. First, initial TPC contracts, at five years, were longer than initial PTT contracts (just three years). Second, TPC income was expected to be higher than PTT income. Not only was there a TPC contract-signing bonus of Rp. 500,000 (~US$56), but income from services provided to low-income pregnant women was higher per service, and the number of reimbursable maternal health services was higher for the voucher project (six) than for the health card program (three). Third, TPC midwives, unlike PTT midwives, were allowed to choose where to practice. Fourth, there were rumors of additional benefits of being a TPC midwife, such as being eligible for civil servant status following contract expiration, and being able to buy a motorbike on credit. Finally, through the dissemination of information about the program, for which the TPC midwives were responsible, TPC midwives got the chance to promote their own services. This was especially important for the still fairly inexperienced midwives who had problems winning the trust of the villagers.

Approximately 20 of the 30 midwives contracted under TPC simply switched from PTT to TPC status in the same village. In a few cases, TPC midwives chose either villages that had never had midwives, or villages in which a PTT midwife had been working but had already left.

TPC midwives had a three-part income, including a monthly base wage for assisting in village health centers (posyandu) a few days a month, fees from vouchers paid by low-income pregnant women, and private practice income.

TPC midwives’ work was evaluated by staff of the District Health Bureau against targets for the expected birth rate of the village for the voucher services and was consequently compared with the non-voucher services provided. Midwives did their own reporting each month, filling in simple forms and sending them to the District Health Bureau. The achievement of targets was used as one indication that poor women were receiving the services they needed; it was also intended to show the progress midwives were making in becoming fully independent private providers. Bureau staff traveled to villages to investigate cases in which targets were not met.

The vouchers. Every low-income woman in a TPC village was to receive one booklet with vouchers for the six key midwife services, including delivery, referral to the hospital in case

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13 This was the total number of TPC midwives ever contracted through the project in Pemalang.
14 Source: nine TPC midwives from two sub-districts.
of complications, ante- and post-natal care, infant care, birth control, and family health care services. For each pregnancy, a poor woman received a new booklet.

Each time a woman received one of these services, she paid the midwife for it with one of her vouchers. Midwives were paid a set fee for each type of voucher. It was hoped that the vouchers would provide a financial incentive to midwives to seek out low-income pregnant women and provide services to them, as well as removing the financial barrier low-income pregnant women faced in seeking midwives’ services.

Identification of women to receive the voucher booklets was done mainly by the TPC midwives themselves, sometimes in cooperation with health volunteers (kader) and, in a few cases, village heads. Midwives were given a list of people who, based on criteria of the National Body for Family Coordination and Planning (BKKBN, or Badan Koordinasi Keluarga Berencana Nasional), were eligible for health cards. Criteria included having an earth (not sand) floor, eating at most twice a day, having just one set of clothes, being unable to afford sub-district health clinic services or sending children to elementary school, and being unable to afford the items necessary for the practice of religion. Based on the health card eligibility criteria, midwives then made their own lists for voucher eligibility. The fact that the same criteria were used suggests that in TPC villages, every pregnant woman who had a health card would also have received a voucher booklet.

Dissemination. Dissemination of information about the program to midwives, kader, and village heads was the responsibility of the District Health Bureau (Dinkes). At first, the sub-district health centers were excluded from the project by design. It was reasoned that because the midwives were supposed to become privatized, including the (government-funded) sub-district health centers would run counter to program success. Later, it became clear that the sub-district health centers, which offered a respected and trusted village-level showcase for the midwives’ services (the village health centers or posyandu), were crucial to the program.

Dissemination of information about the TPC pilot project to local women was done mainly by the midwives themselves. All midwives used the village health centers (posyandu) as a conduit to mothers, and some used kader as well. Kader, because they are local women, usually know who is pregnant, and what the socio-economic status of the women is. Active kader would drop by the TPC midwife’s home to let her know when a low-income woman became pregnant, so the midwife could in turn drop by the woman’s home to give her a voucher booklet and explain the voucher program to her. Village heads were also sometimes involved in dissemination. For example, in Ampelgading, village heads continue to organize monthly meetings with pregnant women during which information about pregnancy, nutrition, health, and pro-poor projects is discussed. In other villages, however, the village heads are not involved in the dissemination process.

TPC pilot project costs The total cost of base wages and voucher reimbursements for the 30 TPC midwives in Pemalang district was over Rp. 1.2 billion (~US$134,000) for the period 1999 to 2004; in addition, two staff from the District Health Bureau were each paid a

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16 This service was only included as part of the voucher booklet in 1999.
17 In 1999, each booklet contained 29 vouchers, including one for delivery, one for emergency referral, six for ante-natal care, three for post-natal care, four for family planning, eight for infant care, and six for family health care.
18 In 1999, the voucher payments were Rp. 60,000 for delivery, Rp. 30,000 for family planning, and Rp. 5,000 each for other services.
monthly salary of Rp. 150,000 for their role in monitoring. The District Project Monitoring Unit (DPMU) also received an unknown income for its work. Project costs were paid by the World Bank and the central government through 2003; 2004 costs for base wages were paid by the district while vouchers continued to be reimbursed by the central government with World Bank funding.

**A TANGLED WEB: THE DEMISE OF TPC**

In fact, PTT contracts were renewed in 1998 and again in 2001 and 2004. Thus, between 1998 and 2004, there were essentially two health care programs ongoing that provided maternal health services in Pemalang: the PTT and health card programs—intimately linked as only PTT midwives could provide health card-reimbursable services—and the TPC voucher project. Both the TPC project and the health card program were created to increase the access of the poor to health care, though TPC focused solely on maternal and child health and was implemented only in Java, while the health card program was national and not limited to maternal and child health. To ensure that vouchers would still be used, despite the overlap in target group of the two programs, the District Health Bureau issued a legal document (SK, or *surat keputusan*) that required that TPC midwife services only be paid for by voucher or cash, but not the health card.

PTT midwives, like TPC midwives, receive both a base wage and wages based on the number of poor clients they have. The payment systems for the two groups were, however, different. TPC midwives were evaluated monthly by the District Health Bureau before they could receive voucher payments. They were required to submit the physical vouchers with which they had been paid, proving services had been provided and greatly reducing the opportunity for fraud. PTT midwives, on the other hand, have government-established bank accounts in which their entire estimated yearly wages are stored. Each month, they simply withdraw their base wage and claims for maternal health services provided to health card clients—though they must first report to the head of the sub-district health center, whose signature is required for the withdrawal. They are not required to submit physical evidence of health card clients served. Thus, the PTT system is easier to dupe than the voucher system was.

Because the work of the TPC and PTT midwives was virtually identical, there was an expectation that wages would also be similar: an increase in the base wages and voucher or health card fees of one was expected to be followed by an increase in the base wages and voucher or health card fees of the other. In fact, TPC midwives’ base wages and voucher fees were increased twice, in 2003 and 2004, following similar increases in PTT incomes, but never reached the same level.

In 2002, tacitly abandoning the original goal of privatization of midwives’ services, the central government enacted a law allowing unlimited contract renewals for PTT midwives, but this did not extend to TPC midwives. Their contracts were due to expire at the end of 2003 with the end of the TPC pilot project. By that time, three of the TPC midwives had left the district to follow their husbands and one had received civil servant status; 26 were still practicing under the TPC pilot. Staff of the District Health Bureau were convinced that the TPC midwives were unable to become fully private practitioners. As 15 percent of district midwives were contracted under the TPC pilot project, they were also concerned about maintaining the access of low-income pregnant women in their district to midwifery services when the project ended. Hence, they decided to continue the voucher system on their own, taking the extraordinary step of funding TPC midwives’ base wages from their own resources. They were able to continue providing vouchers in TPC villages with funding from the World Bank.20 The district’s decision to continue the voucher system after the technical

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20 Staff of District Health Bureau.
end of the project itself was exactly what the central government (and the World Bank as funder) had been hoping would happen.

However, the government in effect sabotaged the continuation of the voucher system by its decision in November 2004 to hire more PTT midwives using central government funding. The district immediately decided to discontinue the voucher system, and all 26 TPC midwives were transferred to the PTT program. Despite the clear benefits of the voucher system—it increased midwives’ accountability and reached many poor pregnant women—the district knew that the health card program provides the same no-cost services to the poor, and is funded entirely by the central government. Discontinuing the voucher system thus would have no immediate impact on access, yet freed up district money for other purposes such as infrastructure works.

**Coda: Health insurance for the poor.** Starting in 2002, some districts began to replace the PKPS-BBM program (that entitles all poor households to free basic health services) with a program of health insurance for the poor. The specific package of services covered by this health insurance varies among the districts where it is implemented, but in all places it covers basic health services including maternal and infant care. By the end of 2004, over 30 districts (out of over 400 nationwide) had replaced the PKPS-BBM program with their own health insurance system.

In January 2005, the government mandated the implementation of a new health insurance for the poor (JPK-GAKIN) scheme in all districts in the country. By law, all districts should have already started implementing it, but as they got just one month’s notice, many districts, including Pemalang, have been unable to meet the deadline. The government has therefore decided to implement the program in phases, starting with East Indonesia. Thus, health cards are still being used in Pemalang.
IMPACT

DID THE TPC PROJECT INCREASE THE ACCESS OF THE POOR TO TPC MIDWIFE SERVICES?

In short, yes. The number of midwives in the district more than doubled between 2001 and 2003, from 82 to 192.\(^{21}\) By 2004 there were 244.\(^{22}\) In 2003, 86 percent of Pemalang’s villages had midwives; coverage reached about 95 percent by early 2005.\(^{23}\) It is not surprising, then, that there was also an increase in utilization of midwives’ services. Evidence is readily available. District Health Bureau statistics show that the number of paying clients of TPC midwives increased by nearly 70 percent between 2000 and 2004 (using paid deliveries as a proxy for number of paying clients served). During that time, the number of voucher (poor) clients actually dropped by 44 percent, due mainly to changes in the number of vouchers issued. This drop masks the fact that midwife use by the poor went from almost nothing in the late 1990s to 1,164 poor women in 2000. Poor women stated that they started using midwives for the first time only after TPC midwife placement in their villages. Despite the increase, however, only about 40 percent of TPC village babies were born with TPC midwife assistance each year.\(^{24}\)

Utilization of TPC midwives was higher than utilization of PTT midwives in villages where both types had worked, according to sub-district health clinic doctors and the TPC facilitator. PTT midwives had problems getting clients in part because of their lack of experience.

Equity in access to midwives’ services has increased because prior to the pilot, almost no poor women were using midwives, while now, many are. The ratio of non-paying to paying clients of TPC midwives, which was 46:54 in 2004, is close to the ratio of poor to non-poor in the poorest sub-districts of Pemalang, 40:60. Together with the fact that poor women have a higher birth rate than non-poor women, this suggests that the poor are equitably represented among TPC midwife clients.

However, there were huge variations in numbers of vouchers used—a decrease of 65 percent in 2001, a further decrease of 20 percent in 2002, followed by an increase of 26 percent in 2003 and a final decrease of 8 percent in 2004. These variations were not driven by changes in the number of poor pregnant women in the district, but caused by unclear and constantly changing program rules and inconsistent implementation. In the first few years, the District Health Bureau put no limitations on the number of vouchers that midwives could give out: well over 1,000 were issued in 2000. In 2001, however, the District Health Bureau limited the number of vouchers based on a more accurate estimate of the number of deliveries expected by poor women. This brought the number of voucher clients down to 565 (using delivery numbers as a proxy) by 2002. The establishment in 2002 of the District Program Management Unit (DPMU) further reduced the number of voucher clients as the DPMU enforced more strictly the previously-set birthrate target on which number of vouchers issued was based. In 2003, this target was increased and consequently so was the number of vouchers, while the DPMU pushed midwives more strongly to achieve targets.\(^{25}\) These changes were reflected in an increase to 712 of the number of voucher clients delivering with TPC midwives that year.

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22 Source: District Health Bureau.
23 Team estimate based on interviews with midwives.
24 Calculation of the research team: the birth rate in Pemalang is about 2 percent, or approximately 26,000 children annually. This is roughly 117 births per village. A TPC midwife normally delivered about four babies a month in her village, or 48 a year, representing 41 percent of the estimated 117 village births annually.
25 Source: staff of District Health Bureau.
While equity of access to midwife services certainly increased overall—especially given that before the pilot, poor women had had virtually no access—wildly fluctuating numbers of vouchers used imply that the project management was unclear about the size of the target group and how best to reach it. It is possible that some poor pregnant women still lacked access to midwives’ services.

WHAT ASPECTS OF THE TPC PROJECT BROUGHT ABOUT INCREASED ACCESS?

The simple fact that more villages had midwives following the introduction of the TPC project was the driving force behind the increase in utilization by the poor. Prior to the pilot project, a woman who wanted to deliver with a midwife had to spend the time and money to travel to a village where there was a midwife and then pay for the services; most poor people could not afford to do so. The cost of a delivery assisted by a private midwife is about Rp. 250,000, much higher than the cost of a dukun’s services (Rp. 60,000-100,000). In villages where there had been no midwife pre-project, there had been virtually no use of midwife services by the poor. While midwife placement in their villages gave poor women the opportunity to use midwives’ services, vouchers made it financially possible for them to do so. Giving midwives the primary responsibility for dissemination of information about the voucher project, and linking their incomes to the use of vouchers, encouraged them to seek out new clients. Initial exploratory use of midwives’ services inspired trust: some mothers reported that TPC midwives “reduced pain and time in labor.” The growth of trust in the TPC midwives assured continued use of their delivery services, as well as increasing the use of TPC midwives for other services and by non-voucher holders.

WHAT WAS THE IMPACT OF TARGETS FOR EVALUATION ON MIDWIVES’ QUALITY AND MOTIVATION?

The quality of midwife services did improve during project implementation, but this was not due to the use of targets, nor was the effect limited to TPC midwives. Local mothers
assessed midwife quality in part according to how long their recuperation periods were following delivery. They also looked at midwives’ experience and access to high-quality facilities and the necessary drugs. According to these criteria, local mothers feel that the quality of all midwives—whether TPC or not—is high, and specifically, greater than that of the dukun. The key difference between the skill of midwives and of dukun lies in the capacity of each to handle emergencies. TPC and PTT midwives received extra training in handling emergency situations (asuhan persalinan normal) from the District Health Bureau (organized nationally by the Ministry of Health). The perceived overall increase in midwife quality is reflected in an improvement in the district’s maternal mortality rate, from 51 per 1,000 live births in 1997 to 32 in 2003.

The midwives did not fully understand the program’s objectives. The midwives interviewed were unsure whether the purpose of targeting was to increase the quality of services, or to push midwives into delivering more services. According to the staff of the District Health Bureau, this lowered midwives’ motivation.

WHAT HAPPENED WITH THE ORIGINAL PROJECT GOAL OF PRIVATIZING MIDWIVES’ SERVICES?

Between 2000 and 2004, the TPC midwives’ monthly income nearly doubled from just over Rp. 1 million to nearly Rp. 2 million. During that period, the monthly base wage increased from Rp. 150,000 to Rp. 425,000 (~US$48), and income from vouchers increased marginally from Rp. 338,000 to Rp. 386,000 (~US$44). However, the main source of the increase was paying clients, whose contributions to midwives’ income increased from about Rp. 500,000 to over Rp. 1 million (~US$113) per month in that period. The data thus imply there was some progress toward achieving financial self-sufficiency.

It was envisioned that the increased quality of the midwives, due to training, would result in more private clients seeking their services enabling the midwives to become independent of government funding. This did not happen. It is true that the proportion of TPC midwives’ clients who were voucher-holders dropped significantly from 72 percent in 2000 to just 46 percent in 2004, and the proportion of midwives’ income due to paying clients increased

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26 Sub-district clinic doctors still report isolated incidents of malpractice due to the inexperience of some PTT midwives.
27 Source: District Health Bureau.
29 Using number of voucher-paid deliveries as a proxy for total number of voucher clients; source: District Health Bureau.
slightly from 54 percent in 2000 to 58 percent in 2004. Nevertheless, the proportion paid by
government (either through base wages or voucher payments) still represented a hefty 42
percent of midwives’ income in 2004. The continued large portion of income from
government was due in part to increases in 2003 and 2004 in the fees for voucher services,
as well as in the amount of the base wage.

By 2002, the government had already realized that privatizing the midwives would decrease
access to these essential public health care services by the poor; thus, it began to allow
unlimited contract renewals for PTT midwives, in effect abandoning the objective of
privatization.

**HOW DID STAKEHOLDERS’ BEHAVIOR CHANGE AS A RESULT OF TPC?**

It is clear that the behavior of poor pregnant women has changed dramatically—they are
now delivering with midwives when they had not done so before. There is also evidence of
changes in attitude of poor pregnant women. The majority say they want to continue using a
midwife to deliver their children because the midwife’s quality is seen as superior to that of the
dukun; some even say they would continue going to their midwife if they had to pay. Almost all women, both poor and well-off, continue to pay for the services of the dukun (for post-natal care) in addition to those of the TPC midwife, however, so the total cost of childbirth to poor women has not gone down.

TPC midwives reported an initial increase in motivation (sometimes later decreasing as a
result of conflict with the health card program) and an increased interest in looking for poor
patients as a result of the project.

**VOUCHERS FOR MIDWIVES: LOOKING TO THE FUTURE**

**FACTORS LIMITING VOUCHER IMPACT**

Difficulties in identifying and reaching the target group probably reduced access for
some of the poor. It is still unclear how many poor pregnant women there actually were in
the district, and thus how many vouchers should have been issued. The fact that the number
of vouchers used varied from a low of 565 (2002) to a high of 1164 (2000) certainly implies
that identification and quantification of the target group was problematic, since birth rates of
the target group could not have varied so widely. Central government identification of the
poor is in general imprecise, and often the official poverty estimate is lower than the actual
rate. It seems that in Pemalang, however, local officials at first went the other direction
(overestimating the number) until the entrance of a new, external organization, the DPMU, in
2002, which pushed the number of voucher clients to a five-year low. The fact that voucher
use went up again after 2002, however, implies that the DPMU did not have its numbers
right either.

While the District Health Bureau were playing the numbers game, it was largely up to the
TPC midwives to actually pass vouchers on to the target group—poor pregnant women. The
project design required midwives not to be in charge of distribution of vouchers to avoid
conflict of interest, but districts found this burdensome and did not comply with the design.
The design of the voucher project—TPC midwives were only paid after submission of actual
vouchers—worked to encourage midwives to issue as many vouchers as possible. Because
the Bureau does not have a close relationship with communities, it was difficult for it to check
whether voucher issuing was done properly. Involving kader in the process of handing out
vouchers was said to increase the system’s effectiveness. Poor data collection, however,
makes it impossible to know to what extent vouchers actually reached the target group.
Insufficient dissemination limited the access of some poor women to vouchers. Dissemination of information depended largely on the TPC midwives themselves, a task which they enjoyed and were glad to do, but which added much time and effort to their already-full days. Where they had the support of highly motivated kader, dissemination was still wide, but in other villages, where kader may not even have heard of the project, dissemination was low. In one TPC village visited, a number of lower-income women had not even heard of the voucher project. The District Health Bureau was unable to make the process more effective. Because it lacked a strong connection to the villages, it relied on counting the number of services TPC midwives had provided to voucher holders as a means of assessing the success of the process, but this did not provide the information necessary to accurately judge and then re-design the dissemination process for greater effectiveness.

Motivation of healthcare staff makes a difference in reaching the poor. Village A has a diligent midwife and kader who set up monthly meetings between the village head and all pregnant women. Through these meetings, information was provided about useful programs and on healthy behavior and nutrition. These meetings also helped in the identification of those who were entitled to vouchers. This process of dissemination and identification of the poor appeared to be very effective, as in this village those who are poor did receive project benefits.

In Village B where the TPC midwife and kader were less active in providing information to villagers, targeting of the poor was less effective; the team spoke to many villagers who had never heard of the voucher project.

Inadequate collection and analysis of project data made mid-course project adjustments for better targeting impossible. Local District Health Bureau staff did not understand the purpose of the work for which they were responsible: collection and analysis of data about TPC midwife service utilization. Nor were they sufficiently trained in data collection and analysis. Two of the District Health Bureau staff received one week of training in Jakarta, but this was only six months after the start of the TPC project, and the staff also state that it was not enough to do real analysis. At the same time, the central government with final responsibility for ensuring project success did not request the necessary information. Collection of key data would have provided the information necessary to re-jig the project midstream for better results. For example, basic data about who is poor in a TPC village and where each of the pregnant women in that group went to deliver in a given year would have helped show whether the vouchers were reaching, and convincing, the right people. Data on maternal deaths for poor and non-poor mothers before and after the project, comparing clients of TPC and PTT midwives, would have helped to quantify the quality of services available to the poor through the project. Data comparing utilization of TPC versus PTT midwives would have helped to gauge the demand for, and thus perceived quality of, services provided through the two projects. Better training for data collectors is not enough; the design of a data collection system that is useful (e.g., collects the data needed to continually assess and strengthen the project), transparent (so people aren’t afraid to ask for and answer questions about the data), and easy to use is also important.

Ineffective project management reduced opportunities for problem-solving during implementation. Though the Ministry of Health was responsible for the pilot project at the national level, there was no single team within the Ministry that could provide support to the district when it faced problems; moreover, the teams changed during the life of the project. There was a lack of communication between the stakeholders. The Ministry team, such as it was, often simply did not respond to questions and problems posed by local departments. The Ministry itself was not fully aware of the objectives of the project. In fact, the staff of the District Health Bureau report that the Ministry of Health sometimes consulted Pemalang district for advice, instead of vice versa. Moreover, though midwives are the responsibility of the sub-district health centers, they were required to report directly to the District Health Bureau, so the sub-district centers were often unaware of key aspects of the project. Had
project management been clearly assigned to one person and his or her clearly identified team, and had that team been responsive to the implementation units at district level, data collection would have improved, targeting would have been more accurate, and the front line—the TPC midwives—might, because of their greater understanding, have been more effective in ensuring accurate targeting of the poor.

**Conflicts between overlapping systems reduced midwives’ motivation.** The large overlap between the TPC project and the health card program produced confusion among TPC and PTT midwives, because they provided the same services and were both linked to the sub-district health centers but were not paid at the same level or in the same way. This decreased the motivation of many TPC midwives.

**The limited extent of the pilot project meant only a small number of poor women benefited.** Clearly, the fact that only 30 of 222 villages in the district had TPC midwives, and only about 40 percent of TPC village babies (or just 7 percent of all district babies) were born with the assistance of TPC midwives each year, limited the project’s impact on the poor.

**USING VOUCHERS TO INCREASE ACCESS OF THE POOR TO MIDWIVES’ SERVICES**

Midwife services for the poor are a public good and hence require public funding. The TPC pilot project failed in its intent to move toward privatization of midwives because this conflicted with its paramount objective of strengthening the sustainability of midwife services at the village level. By 2002, the government had already realized that poor pregnant women would be needing midwives’ services for a long time to come, development notwithstanding, and funding for contracted midwives was ensured (and later, increased).

The voucher system, if implemented well, can help midwives’ services reach the poor better than the health card program. Three aspects of the voucher pilot project made it more effective than the health card program in increasing the access of the poor to midwife services. Of greatest importance was the requirement that midwives actually submit vouchers in order to get paid for their services to poor women, which gave them strong motivation to seek out poor clients. PTT midwives, paid through the health card program, are essentially pre-paid, and therefore have no financial motivation to encourage the poor to use their services. Second, because vouchers had to be presented for payment, there was little room for fraud. It is reported that PTT midwives, who only needed the signature of the sub-district health clinic head for payment, often resort to fraudulent reporting to get higher wages, wasting money that should have been spent on actual services to poor women. And third, the vouchers were for specific services. It is possible that simply having the voucher booklet thus raised the awareness of poor pregnant women of the services to which they are entitled and which they should seek. This may have resulted in more poor voucher-holders seeking midwife care than poor non-voucher holders, despite the fact that pregnancy services are free under both the TPC pilot project and the health card program. Because of inadequate data collection on the project, however, it is impossible to know whether this last point is true.

The new national health insurance program presents an opportunity to build on the success of the voucher pilot in reaching poor pregnant women. The five years of the voucher pilot project clearly increased the access of poor pregnant women to higher-quality maternal care. With the new national health insurance program, JPK-Gakin, there is an opportunity to reintroduce the use of vouchers and thereby maintain and build on pilot project success. District Health Bureau staff suggest that if vouchers were used under the national health insurance program, they could be paid directly by sub-district health clinics, which are already responsible for monitoring and payment of midwives. This would reduce the voucher-related management time and costs of the District Health Bureau. The only additional costs of reintroducing vouchers would be for production of the vouchers.
themselves, dissemination of information, and training and wages for data collectors, all likely payable by the district.

If vouchers were blended with the new national health insurance program, it would be crucial to avoid the pitfalls of the pilot project. The target group of poor pregnant women should be clearly defined, based on reasonable and widely-understood criteria, and counted in a transparent manner, ensuring that all stakeholders understand who is included and why. Annual re-counts of the target group should be institutionalized using a consistent and fair process. Responsibility for dissemination of information about the vouchers should not be the sole responsibility of the midwives but should be shared with kader and village heads. These stakeholders should be involved in monitoring to increase their knowledge of and commitment to the system. A useful, simple, effective and transparent monitoring plan should be designed, focused on collecting data on who should receive vouchers, who does and does not receive vouchers and why, and how the vouchers are used. Basic maternal and infant health statistics, and data on use of other maternal health service providers, should also be collected, including maternal and infant deaths. People responsible for monitoring of the voucher system should be well trained in the purpose and use of the monitoring system. Management of the voucher system should be simple and clear, based on the usual management structure and lines of communication related to health services at all levels of government. A system should be set up to allow regular meetings among all stakeholders to increase their understanding of the purpose of the vouchers and thereby increase motivation.

The voucher system was an excellent beginning to increased access to quality maternal health care for the poor.

BIBLIOGRAPHY

Central Statistics Agency (Badan Pusat Statistik), “Kabupaten Pemalang”

Hariyanto, Slamet, “Laporan Akhir Proyek Safe Motherhood Kabupaten Pemalang” (December 2004)


Pemalang District Health Bureau, data on “Caring Mothers Movement”