The Implementation of Giving Birth Guarantee Program (Jampersal) in Semarang Regency

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Semarang Regency, Central Java Province, has implemented Giving Birth Guarantee Program (Jampersal) as mandated by the Act of the Minister of Health Affairs of the Republic of Indonesia No. 515/MENKES/SK/III/2001 on Jampersal Program, which is implemented pursuant to Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011 on Technical Guidance for Jampersal. The Giving Birth Guarantee Program has been delivered since June 2011. This research applied a qualitative method. It pursued to answer questions on the implementation of Jampersal Program, including factors supporting the implementation of the policy in Semarang Regency. Informants in this research were selected by a purposive sampling technique, in which the researcher became research instrument. This research found evidences that supported the implementation of the Giving Birth Guarantee Program in Semarang Regency. They were namely consistent implementation of the program, adequate budget of the 2012 Jampersal Program, adequate number of nurses as paramedics, qualified formal implementing agencies, qualified midwives in supporting pregnant mothers, high awareness of the local people on medical check-up during early stages of pregnancy, delivery help, after-birth services by paramedics, and the decrease of traditional "*healers*". On the other hand, impending factors that hampered the implementation of the Jampersal Program were also found. They included namely inadequate socialisation, difficulties in claiming the Jampersal cost, inadequate human resource as verificators either at Heath Affairs offices or at public health service centers in Semarang Regency, lacking delegated human resource that provided the Jampersal services, and resistance from local people to get involved in the implementation of the policy, especially on trainings on maximising the improvement of the human

resources, as well as multiplying number of staff responsible for implementing Jampersal Program.

Keywords: Jampersal, midwives, pregnancy, women, claim.

(Implementasi Kebijakan Program Jaminan Persalinan (Jampersal) di Kabupaten Semarang)

Abstraksi

Kabupaten Semarang di Jawa Tengah melaksanakan kebijakan Program Jaminan Persalinan (Jampersal) sesuai dengan Keputusan Menteri Kesehatan Republik Indonesia Nomor: 515/ MENKES/ SK/ III/2011 tentang Program Jampersal dan dijalankan dengan merujuk pada Peraturan Menteri Kesehatan Republik Indonesia Nomor 2562/MENKES/PER/XII/2011 tentang Petunjuk Teknis Jaminan Persalinan. Program Jampersal mulai bulan Juni 2011. Penelitian ini menggunakan metode kualitatif yang berusaha menjawab pertanyaan apa saja yang menjadi aspek pendorong dan aspek penghambat dalam implementasi kebijakan Program Jampersal di Kabupaten Semarang. Teknik pemilihan informan dalam penelitian ini adalah *purposive sampling* dan yang berperan sebagai instrumen penelitian adalah peneliti sendiri. Berdasarkan penelitian yang telah dilakukan, ditemukan fenomena-fenomena yang menjadi aspek pendorong dalam implementasi kebijakan Program Jampersal di Kabupaten Semarang adalah Pelaksanaan pelayanan Program Jampersal di Kabupaten Semarang sudah konsisten, besaran tarif pelayanan Jampersal tahun 2012 sudah dirasa cukup, jumlah para Bidan sebagai tenaga medis di Kabupaten Semarang yang dinilai cukup, para agen pelaksana formal yang sangat mendukung, bidan desa yang dinilai sangat baik oleh masyarakat dan bertanggungjawab dalam pendampingan kesehatan para ibu hamil, tingginya kesadaran masyarakat Kabupaten Semarang untuk melakukan pemeriksaan kehamilan sejak dini, pertolongan persalinan, dan pelayanan nifas oleh tenaga kesehatan, serta keberadaan profesi sebagai Dukun Bayi sudah jarang bahkan tidak ada lagi. Selain itu, aspek penghambat implementasi Program Jampersal di Kabupaten Semarang yaitu masih minimnya sosialisasi, proses pencairan dana klaim Jampersal membutuhkan waktu sangat lama, keterbatasan SDM sebagai tenaga verifikator baik di Dinas Kesehatan maupun puskesmas yang ada di wilayah Kabupaten Semarang, belum adanya penunjukkan dan penugasan SDM khusus sebagai petugas Jampersal, masih ada sedikit dari masyarakat Kabupaten Semarang yang belum mau memanfaatkan Program Jampersal. Rekomendasi dari hasil penelitian ini adalah melakukan peningkatan kinerja SDM dari seluruh pihak yang terlibat dalam implementasi kebijakan Program Jampersal di Kabupaten Semarang melalui pemaksimalan pelatihan-pelatihan yang dilakukan yang diharapkan mampu meningkatkan kinerja SDM dalam menyelesaikan pekerjaannya, serta melakukan penambahan jumlah pegawai yang ditugaskan dan ditunjuk secara khusus untuk mengurusi Program Jampersal.

Kata kunci: Jampersal, bidan, kehamilan, wanita, klaim.

BACKGROUND

Indonesia is ranked fourth in the world in case of the number of population. According to the *Statistics Indonesia* (BPS), there were 237,641,326 millions of population in this country in 2011. However, maternal mortality rate (AKI) and infant mortality rate (AKB) in Indonesia are considered high compared to other ASEAN countries. This fact can be evidenced in the Demographic Survey of

Indonesian Health (SDKI), in which in 2007 the country's AKI was 228 per 100,000 alive birth, AKB was 34 per 1,000 alive birth, and born-infant mortality rate (AKBN) was 19 per 1,000 alive birth. According to a global convention (Millennium Development Goals) 2000, it is expected that by 2015 AKI will have decreased to 102 per 100,000 alive birth and AKB will have decreased to 23 per 1,000 alive birth, as stated in the Act of the Minister of Health Affairs No. 2562/MENKES/PER/XII/2011 on the Technical Guidance for Jampersal.

Maternal mortality is caused by eiter direct or indirect factors. A household health survey (SKRT) in 2001, which was regulated under the Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011 on the Technical Guidance for Jampersal required that the direct factors causing the maternal mortality in Indonesia consisted of giving birth (90%) and after-giving birth due to bleeding (28%), eclamsia (24%), infections (11%), pueperium complication (8%), obstructed labor (5%), abortion (5%), obstetic trauma (5%), embolism (3%), and other factors (11%). Whereas, the direct factors, which also caused the maternal mortality consisted of access, socio-culture, education, and economy (dubbed "*tiga terlambat*" dan "*empat terlalu*").

Vary measures had been taken by the Government of Indonesia to decrease the maternal, infant, born-infant, and toddler mortalities, for examples, by hiring midwives in rural areas, households and people empowerment in using the so called "Buku Kesehatan Ibu dan Anak" (Buku KIA), or Maternal and Child Health Cards, and Program of Giving Birth Planning and Complication Prevention (P4K), providing health-care facilities such as Basic Emergency Neonatal Obstetric Service (PONED) at public health service centers and Comprehensive Emergency Neonatal Obstetric Service (PONEK) at hospitals. Nevertheless, in practice, all of these efforts did not quite significantly help decrease the mortality rates of the above-mentioned groups. This sound failure demanded further actions, which was then responded by the government in 2011 by promoting a program of giving birth guarantee, namely "Jampersal". Jampersal referred to the Act of the Minister of Health Affairs of the Republic of Indonesia No. 515/MENKES/SK/III/2011 on Jampersal Program.

Semarang Regency is one of regencies in Central Java Province that implemented the policy on the Giving Birth Guarantee. The implementation was

pursuant to the Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011 on the Technical Guidance for Jampersal. The program began in June 2011.

The high maternal and infant mortality rates in Indonesia were the main factors for the government to write down a policy on the Jampersal Program. In Semarang Regency, the infant mortality rate for the past six years (2006-2011) always increased, from 8.27 per 1000 alive birth (2006), to 12,7 per 1000 alive death (2007). Eventhough there was a slight decrease in 2008 (12.6 per 1000 alive birth), the rate was then rose to 13.40 per 1000 alive death in 2011. There was an increase compared to the previous year (2010), 10.46 per 1000 alive birth. The most dominant infant mortality cases was due to low weight infant birth (BBLR) and "asfiksi" with mortality age of 0-7 days.

Maternal mortality rate in Semarang had been fluctuative for six years (2006-2011), as seen in Table 1. The 2011 data showed that the maternal mortality rate (146.2 per alive birth) was higher than that of 2010 (101.92 per 1000 alive birth). This figure did not fulfill the 2011 standard minimum service of 123 per 100,000 alive birth.

Table 1

Maternal Mortality Rate in Semarang Regency (2006-2011)

Year	**MMR**	**Standard Minimum Service Target**
2006	126.63 per 100,000 ab	123 per 100,000 ab
2007	157.35 per 100,000 ab	
2008	107.23 per 100,000 ab	
2009	125.66 per 100,000 ab	
2010	101.92 per 100,000 ab	
2011	146.2 per 100,000 ab	

Source: KIA Program in Health Profile of Semarang Regency in 2011

Research Objective

This research was done to answer questions of supporting and impending aspects of the implementation of the policy on the Giving Birth Guarantee (Jampersal) Program in Semarang Regency, especially in the first level giving birth service.

Review of Literature

- **Public Policy**

Dye (1951:1) in Agustino (2012:7) writes that public policy is which being preferred by the government to be or not to be performed. Such definition brings us to an understanding of difference between what to be done by the government and what should be done by the government. Futhermore, public policy is a political decision developed by governing bodies and/or government officials. Therefore, unique characteristics are embedded within the public policy, in which the political decision is formulated by what David Easton (1965:212) (in Agustino, 2012:8) refers as to "authority" in a political system. Authority consists of senior officials, supreme chiefs, executives, legislators, judges, administrators, advisors, kings and so on.

- **Public Policy Implementation**

Implementation is a policy study, which projects the process of the policy implementation. Daniel Mazmanian and Paul Sabatier in "*Implementation and Public Policy*" (1983:61) (in Agustino, 2012:139) defines policy implementation as an implementation of the government political decisions in the forms of bills or acts, eventhough they can be important requirements or decisions issued by executives or judicial authorities. In general, the decisions identify problems to be solved, strictly mention objectives and goals to be achieved, and any other effort to structurise or to regulate their implementation process.

- **Factors Affecting Public Policy**

Whether a public policy is successfully implementation depends on many factors. Each of them are interwined. The followings are factors that affect the policy implementation:

George C. Edwards III Model of Public Policy Implementation

This model has a *top down* perspective as George C. Edwards III writes in his "*Direct and Indirect Impact on Implementation*". In the approach to the Edwards III theory, four influential variables to the success of a policy implementation are introduced: (1) communication, (2) resources, (3) disposition, and (4) bureaucratic structure (Agustino, 2012:150-153).

Daniel A. Mazmanian and Paul A. Sabatier Model of Public Policy Implementation

This model was offerred by Daniel A. Mazmanian and Paul A. Sabatier in their "*A Framework for Policy Implementation Analysis*". They contends that important role

of the public policy implementation will be its ability to identify interwinning variables towards formal objectives in the whole implementation process (Agustino, 2012:145). There are three variables that affect the success of the policy implementation (AG. Subarsono, 2011:94-99): (1) problem characteristics, (2) policy characteristics, and (3) environment.

Donald Van Metter and Carl Van Horn Model of Public Policy Implementation

Donald Van Metter and Carl Van Horn proposes a top down approach as they write in "*A Model of the Policy Implementation*". Such implementation process is an abstraction or performance of a policy implementation that is intentionally performed in order to obtain higher rate of the public policy implementation that occurs due to interwinning variables. This approach introduces six variables that affect the policy implementation performance: (1) implementor agency characteristics, (2) size and objective of the policy, (3) resources, (4) implementor attitude/tendency, (5) interorganisation communication and implementor activities, and (6) social, economic, and political environment (Agustino, 2012:141-144).

RESEARCH METHODOLOGY

Research Design

This research applied a qualitative research method, in line with its objective to find out phenomenon of what being experienced by research subject, such as, behaviors, perceptions, motivations, acts, and the likes, holistically, and to describe things in words and language, in a particular context, which is natural and using vary scientific methods (Moleong, 2011:6).

Research Location

This research took place in Semarang Regency due to the fact that maternal and infant mortality rates in this area were still considered high. In 2011, maternal mortality rate in Semarang Regency increased as compared to the previous years, from 101.92 per 100 thousands alive birth (2010) to 146.2 per 100 thousands (2011). The increase was also found in infant mortality rate, from 13.40 per 1000 alive birth in 2010 to 10.46 per 1000 alive birth in 2011.

Research Phenomenon

Based on theories of George C. Edwards III, Daniel A. Mazmanian and Paul A. Sabatier, and Donald S. Van Metter and Carl Van Horn, the research "The Implementation of Giving Birth Guarantee Program (Jampersal) in Semarang Regency" concerns the following aspects in its implementation:

- **Communication**

George C. Edwards III (in Agustino, 2012:150-151) concludes that communication will definitely determine the success of goal achievement of the public policy implementation. An effective communication occurs when decision makers have already knwon what they are doing and what they are to do. Indicators of this communication aspect consist of transmission, clarity, and consistency.

- **Resources**

While contents of the policy have been clearly and consistently communicated, adequate resources must be available to implement the policy effectively. They can be human (implementor competency) and financial resources. Resources are important to create an effective policy implementation. In absence of resources, policy will be nothing but a written document.

- **Implementing Agency Characteristics**

Focus on implementing agency dealt with formal and informal organisations that were involved in implementing the public policy. This concern was very important because the performance rate of the public policy implementation was affected by the characteristics of the implementing agency.

- **Economic, Social, and Cultural Conditions**

Van Metter and Van Horn (in Agustino 2012:144) contends that improper social, economic, and political conditions may cause unsuccessful policy implementation. Therefore, efforts to implement the policy should deal with appropriateness of any external environmental condition.

Types and Sources of Data

Data for this research consisted of texts, written statements, and acts that illustrated and presented people and events on the research location. In addition,

statistical data, in particular the qualitative ones, were also used. Statistical data were capable of giving illustration of subject tendencies to the research location (Moleong, 2011:157). Data were collected from both primary and secondary sources.

Informant Selection

Informants were selected by a purposive sampling technique. It meant that the researcher intentionally collected the samples in order to get key informants, persons who were knowledgeable and trusted. The informants of this research consisted of Implementing Team of the Jampersal of Semarang Regency and Implementing Team of the Jampersal at Public Health Service Centers in Semarang Regency (Sumowono and Leyangan Public Health Service Centers). Sumowono a Public Health Service Center was selected because during 2011 this working area received the largest Jampersal claim recommendations (Rp.49,520,000.00). In case of Leyangan, the Public Health Service Center was chosen because this working area received the smallest Jampersal claim recommendations (Rp.4,790,000.00). Additional informants consisted of three midwives and a Giving Birth Guarantee user.

Technique of Data Collection

Data for this research were collected by way of in-depth interview, document collection, and observation.

Technique of Data Analysis

Data analysis is a process of defragmenting data order by organising them into particular pattern, category and basic descriptive unit in order to produce a theme and formulation of hypothesis based on these data (Moleong, 2011:280). The study uses the following stages of data analysis: data reduction, data presentation, and conclusion development.

DISCUSSION

Factors Affecting Jampersal Implementation in Semarang Regency

1. Communication

The implementation of the Giving Birth Guarantee is pursuant to the Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011 on Technical Guidance for Jampersal. Semarang Regency had been implementing the Program since June 2011, but it was only

effectively implemented by October 2011. Such condition occurred due to time consuming preparation and socialisation.

Socialisation in introducing the Jampersal Program was communicated top-down, from the Implementing Team of the Provincial Jampersal of Central Java to the Municipal level of Semarang Regency. The socialisation continued to Public Health Service Centers, and then to midwives in the working area of Semarang Regency. The midwives socialised the program to the stakeholders, pregnant mothers, giving birth mothers, after-delivery mothers, and mothers with new-born babies, who had not had other giving birth guarantees.

The Municipal Office of the Health Affairs of Semarang Regency through the Impelementing Team of the Jampersal had been informed by the government about the program. The socialisation was given face-to-face and by facilitation of Technical Guidance to the Jampersal. Socialisation contents dealt with technical guidance to implementing the program as well as its concerned regulations.

Midwives are closely involved with the program's affected people. They who worked in the area of Semarang Regency were required to inform all pregnant mothers about the Program. They had made efforts to socialise the Program, such as by presenting the Program to PKK and Posyandu, installing pamphlets in strategic public places and at the polyclinics where the midwives worked. However this effort was deemped inadequate because no socialisation was made to the prospective stakeholders by the concerned parties. They knew the Jampersal Program from families or relatives who had been the users of the Program. This phenomenon limited the people knowledge about the Program. As the informants in this research, local people did not know the purpose of the Program. All they knew that the program was free-of-charge.

Inadequate socialisation was also reported by an informant who worked as a verificator at one of the public health centers in Semarang Regency. The informant suggested that the socialisation was just performed when the technical guidance changed, such as change in technical guidance for Jampersal from Act of the Minister of Health Affairs of the Republic of Indonesia No. 631/Menkes/Per/III/2011 to Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011. The time used for the socialisation was very limited.

The clarity of the information was inadequate, in particular on how the process of the program accoutability report to be developed. It took times to write down the correct and proper accountability report. On the other hand, in general, the implementation of the Jampersal program in Semarang Regency had been consistent to the its technical guidance, as seen by Inspector General of the Ministry of Health Affairs, concerning determination of service tariffs and claim requirements.

2. Resources

2.1 Financial Resource

The Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011 on Technical Guidance for Jampersal requires that cost of giving birth guarantee is an integral part of Public Health Insurance (Jamkesmas), so that its management by Implementing Team/Municipal Health Offices is not performed partially, either for the first-level or advanced-level services. In addition, the payment of the giving birth and Family Planning services is done by a "claim" mechanism according to number of pregnant mothers in the area. In 2011, Semarang Regency received Rp.4,890,685,000.00 budget with three stages of fund disbursement. In 2012, the budget increased to Rp.9,638,315,000.00 with four stages of fund disbursement. Of these funds, Rp.4,026,493,000.00 were allocated for the Jampersal Program.

The claim of the Jampersal Program at the initial/basic level was able to be process only if administration requirements for accountability report of the Guarantee claim had been fulfilled. The requirements included (1) copy of ongoing identity of the Program target, (2) copy of KIA, (3) photograph, and (4) copy of recommendation letter.

Midwives and Public Health Centers that had already delivered the Jampersal Program to the target stakeholders might arrange requirements mentioned-above and then submitted them to the Verificator at the Municipal Office of Health Affairs in Semarang Regency. Prior to this stage, midwives initially collected claim requirements of the giving birth guarantee claim at the public health centers, under the supervision of the Center's coordinator. Once the requirements was verified, the

Municipal office of Health affairs of Semarang Regency would process the claim under the mechanism of local budget (APBD).

The Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011 on Technical Guidance for Jampersal requires that funding of Giving Birth Guarantee Program is derived from National Budget (APBN) of the Ministry of Health Affairs allocated within the Bidget Implementation List (DIPA) of Secretariat of the Directorate General of Health Services if the Ministry of Health Affairs.

The process of claiming the funds disbursement from the central office took very long times and indefinite, creating problems that delay the implementation of the Jampersal Program in Semarang Regency.

The delay of the Guarantee claim would have never been a serious problem if the Program was still included within the same fiscal year. However, the time consuming claim process became a major complaint of the informants in this research, those who worked at the Municipal Office of Health Affairs of Semarang Regency, public health centers, and midwives in the regency working area. They regreted and objected that this problem occurred because midwives would face difficulties in fulfilling their daily practice needs. Midwives with ability to fulfill them would not have any problem,but those who were less capable might cost and time consuming.

Tariffs for the Guarantee service in 2012 was in line with the Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011 on Technical Guidance for Jampersal. The tariffs determined were deemed adequate by the informants because they were set according to local economic condition. The territory of Semarang Regency was dominated by rural areas, a factor that affected the tariff rate of the Guarantee. It was reasonable because living cost in rural areas was more efficient than that of urban areas. The Giving Birth Guarantee tariff in 2012 was higher than in 2011, as seen from an increase from Rp.350,000.00 (2011) to Rp.500,000.00(2012). This tariff was still considered low so that it could only fulfill basic, operational needs, whereas medical cost might need more budgets.

2.2 Human Resource

Human resource aspect was measured by the quantity and quality of those who implemented the Jampersal Program in Semarang Regency. In order to make the Jampersal Program more smoothly, effectively, and efficiently, the government organized an Implementing Team either at central, provincial, or municipal levels. The Jampersal management had to be proceeded collectively between the central, provincial, and municipal governments. The Program was integrated with Public Health Insurance (*Jamkesmas*) and BOK as stipulated within the Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011 on Technical Guidance for Jampersal.

Human resource quantity in the Implementing Team of the Jamkesmas and BOK of Semarang Regency consisted of seven staff, a number which was deemed pursuant to the number of personnel at the municipal level according to the Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011 on Technical Guidance for Jampersal, which requires at least six staff. However, the human resource lacked of capability in completing their jobs. Such condition was caused by delegation of the staff only to take on the Jampersal Program. The personnel were also responsible for BOK so that there were redundancies and overlapping duties between these two job descriptions. In addition, there was only one personnel who verified the Guarantee claim terms and conditions at the municipal level, which resulted in un-timely process.

Based on research results, to be part of the Implementing team of *Jamkesmas* and *Jampersal,* an individual had to possess unique skills, i.e., capable of operating the computer. They also did other duties as paramedics, verificators at Sumowono Public Health Center, and midwives.

All midwives, either state-owned or private-own, were required to attend Co-operation Agreement (PKS) of the Jampersal Program, in particular those civil servants or working in rural areas. This condition was governed by the municipal office of health affairs of Semarang Regency. They were required to have Midwivery Practice License (SIPB) and Midwifery Work License (SIKB). Both certificates were used for attending the co-operation agreement, which would be renewed annually.

There was an annual increase in midwives as paramedics in Semarang Regency. This phenomenon was in line with government objective to improve visits

at pregnancy service center (K4) in Semarang Regency. In 2012, there were 383 midwives, whereas in 2011 there were 373 midwives. The number of midwives were considered adquate to support the Jampersal Program.

3. Characteristics of Implementing Agency

Formal implementing agencies that took part into the Jampersal Program in Semarang Regency, especially at the first-level delivery (giving birth) service were personnel from the municipal government of Semarang Regency by delegating municipal office of health affairs, public health centers, and midwives in the working area.

Decentralisation of responsibilities for implementing the Program among the working units was done by issuing a Regent Letter of Notification, such as Regent Letter of Notification No. 30/2012 on Technical Guidance to Health Service at Public Health Centers of Semarang Regency. Public health centers became national health service centers that provided first-level health service and were responsible for taking any measure toward public health of their particular working area. The public health center provided as the followings: (1) curration, (2) prevention, (3) promotion, and (4) rehabilitation.

Public health centers and midwives in Semarang Regency supported the Jampersal Program, as evidenced by interviews. They did their responsibilities for guiding the health care of pregnant mothers in order to have a normal delivery (giving birth). Eventhough claim process took very long time, it did not decrease the motivation of the midwives. They always monitored the pregnancies from the first stage to the delivery process. It was expected that such conducive co-operation might decrease mortality rate in Semarang Regency. In addition, human resource at the municipal office of health affairs were also highly motivated eventhough their quantity was still limited.

Mortality rate in Semarang Municipality in 2012 decreased to 13.20 per 1000 alive birth, compared to 2011 of 13.37 per 1000 alive birth. Though the decrease was not dramatical, for the targeted rate was 8.11 per 1000 alive birth, the condition was promising. Meanwhile, maternal mortality rate in Semarang Regency also decreased from 146.2 per 100000 alive birth in 2011 to 78.01 per 100000 alive birth in 2012.

Such figure already exceeded the standardized minimum service of 118 per 100000 alive birth.

4. Economic, Social and Political Environment Conditions

The Act of the Minister of Health Affairs of the Republic of Indonesia No. 2562/MENKES/PER/XII/2011 on Technical Guidance for Jampersal requires that the Guarantee is not only focused on poor citizens, but also on citizens with medium-to-high economic status. Based on the surveys, the citizens of Semarang Regency who became the users of the Guarantee were dominated by those from medium and medium-to-low economic groups. They felt many advantages from the Program, from pregnancy check-up, delivery (giving birth), after-delivery, to new-born baby to family planning after-delivery processes.

The Semarang Regency citizens generally had high awareness of checking-up pregnancy to paramedics. According to the data from the Municipal Office of Health Affairs of the regency, there was an increase in visits from 88.3% in 2011 to 89.1% in 2012, though the figure had not achieved the standardised minimum service of 93%, as seen in the Table 2. Many efforts had been done by the Municipal Government of Semarang Regency by delegating the Municipal Office of Health Affairs in this stance.

Table 2
Percentage of Service Scope
Pregnant Mother Visit (K1) dan Pregnant Mother Health Care (K4)
In Semarang Regency 2007-2012

Year	K1	K4	Target K4 SPM
2007	96,96%	87,75%	93%
2008	96,62%	87,83%	
2009	99,26%	90,1%	
2010	97,64%	90,7%	
2011	95,9%	88,3%	
2012	98,5%	89,1%	

Source: KIA Program in Health Profile of Semarang Regency in 2012

Post-*Jampersal* era, the citizens of Semarang Regency generally did not need non-paramedic help. This might be evidenced by the increase of giving birth process rate by the paramedics from 92.1% in 2011 to 94.3% in 2012, or fulfilling the standardised minimum service of 93.75%. However, there were few of citizens who were still reluctant of using the paramedics. They were still afraid of using the Jampersal Program due to hesitation of discriminative attitudes towards them.

Table 3

Persentage of Delivery by Midwives or Paramedics in Semarang Regency 2007-2012

Year	Delivery by Paramedics
2007	95,78%
2008	89,67%
2009	93,1%
2010	92,9%
2011	92,1%
2012	94,3%

Source: KIA Program in Health Profile of Semarang Regency in 2012

The high awareness of the Semarang Regency citizens to check-up their pregnancies earlier at medical centers caused decrease in the number of “traditional healers”. There was a mutual agreement between “traditional healer”, midwives, and public health centers that the “healers” would be no more than helpers in delivery (giving birth) process.

The political condition of Semarang Regency was stable so that the Jampersal Program ran relatively smoothly. According to the research, the informants concluded that leadership of the government of Semarang Regency were aware of fulfilling the health needs of their citizens by providing optimal health facilities.

CONCLUSION

The above results led the researcher to draw the conclusion of the study of the Jampersal Program implementation in Semarang Regency, as follows:

Supporting aspects of the implementation of the policy on the Jampersal Program in Semarang Regency, especially in the first level giving birth service:

- Tariff rate of the Jampersal service in 2012 was affordable by informants, in line with the economic condition of the local people.
- There was an annual increasing number of midwives as paramedics in Semarang Regency. In 2012 there were 383 personnel who were effectively fulfilling and supporting the Program.
- Formal implementing agencies involved within the Jampersal Program in Semarang Regency, Municipal Government of Semarang Regency and Municipal Office of the Regency’s Health Affairs, Public health centers, and midwives in

the regency mutually and collectively supported the Program in order to decrease maternal and infant mortality rates.

- Midwives in Semarang Regency were responsible in delivering services to pregnant mothers without any discriminative manner to anyone who needed the Jampersal service.
- Human resources of the Regency' municipal office of health affairs were highly motivated in completing the jobs despite their limited numbers.

- The local people in Semarang Regency as the Program stakeholders routinely checked-up their pregnancies at early stage, requested help in giving birth and after-delivery services from the paramedics.
- Traditional healers decreased in numbers because of an mutual agreement between them, midwives, and public health centers concerning the safety giving birth process by the paramedics. These traditional healers only helped in massaging the babies.
- Political condition in Semarang Regency was stable so it supported and helped the implementation of the Jampersal.

Below are impending factors that affected the implementation of the Jampersal Program in Semarang Regency:

- Lacking socialisation of the Jampersal caused limited knowledge of the stakeholders about the Program.
- Ineffective socialisation by verificators at public health centers in Semarang Regency due to inadequate time. They did the socialisation as necessary so the stakeholders were often misinformed. The Program users should have had been well-informed about the funds disbursement claim process of the Jampersal. This ineffectiveness contributed to the delay of the development of the accountability report.
- The Jampersal funds disbursement claim at central level took very long time and was indefinite.
- Limited human resources, either quantitatively or qualitatively, causing delay in verifying terms and conditions of the Jampersal claim at the public health centers

as the coordinator for widwives and at the Municipal Office of Health Affairs of Semarang Regency.

- Uncertain delegation of the human resources who specialised their duties in providing Jampersal services. They were recruited from those also took responsibility in the BOK program, causing them overloaded burdens of responsibility.
- Only a few citizens in Semarang Regency who had not joined the Jampersal Program because they did not trusted in the quality of the services provided.

RECOMMENDATION

The implementation of the Jampersal Program in Semarang Regency had begun since June 2011. The situation was very promising and had to be maintained, even improved. Public health centers and midwives need to socialise more intensively by community-based activities and to provide prime services in order to build trust of the users in the Jampersal without any discriminative manner. Personnel who implement the program must improve their human resource quality by maximising trainings and performance to complete their jobs more timely, as well as multiplying the numbers of the staff towards more successful program's goal achievements.

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