



## Population Control Policy Implementation in the Framework of National Health Insurance

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### Abstract

The presence of National Health Insurance at the same time with the implementation of regional autonomy affects the implementation of many other policies, including population control. Different understanding and commitment of implementors resulted in mixed results, with unsuccessful trends of implementing population control policy in the frame of National Health Insurance. Cimahi as the most populous city in West Java needs to implement the policies effectively to prevent negative impact of overpopulation. An analysis needs to be conducted to assess the implementation of the policies in Cimahi. The purpose of this study was to analyze the implementation of population control policy within the framework of National Health Insurance. This research was conducted in Cimahi and used qualitative design with case study approach. Data collected through in-depth interview and questionnaires to the implementors of the policies. Data analyzed with the concept of Edwards III and Analysis Hierarchy Process. The results showed that the policies implemented facing difficulties, with National Health Insurance not necessarily encouraging population control through the use of contraceptive. It is suggested that Cimahi City Government improve policies implementation by integrating mutually supportive policies, communicating and disseminating, increasing resources, and increasing cooperation between institutions.

### Introduction

Until 2019, Indonesia was still ranked as the fourth country with the largest population in the world, namely 273,523,615 people with a birth rate of 2.3%. West Java is the province with the largest population in Indonesia of 43 million people, with Cimahi City as the most populous area. The high number of people with good quality in a country can support the development and economic growth of the country. However, too much population can also cause problems such as unemployment, food shortages, social problems, and environmental degradation (Bahadur, 2019). In modern times, high-income countries are associated with high levels of quality human resources and low fertility rates, whereas low-income countries have the opposite trait (Zhang, 2017). Children with a good level of education tend to come

from families with a small number of children; therefore it boosts the level of economic development of the country (Fernihough, 2017).

Population problems cannot be separated from the impact of population policies that apply in the country. China, which was overpopulated, in 1979 implemented a one-child policy for its entire population, in which families with more than one child would be “forced” to undergo sterilization, and were penalized in many other ways (Zhang, 2017). In Indonesia, population control is carried out by the BKKBN. At the present time the implementation of population control is carried out in tandem with other policies, including the National Health Insurance policy. Population control in JKN is regulated through family planning programs in the preventive aspect.

The high population of Indonesia causes

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the implementation of this policy to require high financing. To cover the existing lack of funds, the government tends to take advantage of out-of-pocket payments from the public. This means that the goal of national health insurance will never be achieved. Therefore, it is necessary to streamline the main funding sources, such as taxes, and to improve the efficiency of the benefit package, such as controlling catastrophic diseases (Wagstaff, et al., 2018). The type of program the government chooses to fund also needs to be continuously analyzed. For example, the preventive health program in Ethiopia, namely measles and pneumococcal vaccination, is the most effective program in reducing community mortality, in addition to the sectio caesarea financing program (Verguet, et al., 2015). In the United States, in order to streamline health financing in the National Health System, a Population Health Management (PHM) was formed which focuses on the prevention and management of chronic diseases, as well as maintaining optimal public health (Mehta, 2016). The Indonesian government can follow the same example.

Population control in the framework of the National Health Insurance is also influenced by changes in the Indonesian government system which is now embracing decentralization. This has led to many changes in terms of institutions, bureaucracy, to laws and regulations and policies. Several policies issued by the central and local governments often contradict, causing confusion in implementation, including in terms of population control in JKN. As stated (Winarni, Najib, & Wijayanti, 2019) that the planning mechanism for the procurement of contraceptive devices and drugs in Jepara is carried out on a top-down basis, that is, it is fully regulated by the central government, resulting in discrepancies between the available stock and what is needed in the regions. This shows that the collaboration flow from BKKBN as a provider has not been synchronized with the local government as a user.

Changes in many things cause the problem of population control policies in the context of National Health Insurance in Indonesia to be very complicated. Seeing the large impact and affecting various aspects of

life, it is possible that population problems that are integrated with health will become the category of wicked problems such as corruption and terrorism. For this reason, in-depth analysis and improvement is absolutely necessary in the near future before a problem is categorized as wicked problems (Daviter, 2019). As the most populous city in West Java, Cimahi City has an EFA reaching 15%, with Cimahi City's JKN membership rate being only 92.05%. Cimahi City has not yet established a BKKBD as mandated by legislation, and there is no integration between population control as part of JKN. Therefore, it is necessary to conduct an analysis of policy implementation in Cimahi City. This study aims to analyze the implementation of population control policies in the context of implementing the National Health Insurance in Cimahi City.

## Method

The research uses a qualitative design with a case study approach in Cimahi City from July to August 2020. Research sources are implementers of population control policies in the context of implementing National Health Insurance in Cimahi City, namely: Head of Family Planning Division, JKN Payment Analyst of Cimahi City Health Office, and 4 people Family Planning Officer (PKB). Data was collected by means of in-depth interviews, observations, literature studies, and filling out the AHP questionnaire.

The data were analyzed using the Miles and Huberman (1984) technique through data reduction, data presentation and temporary conclusions drawn from the results of interviews and observations. The results of the analysis are then discussed using the policy implementation analysis approach by Edwards III (1980). Data from filling out the questionnaire were analyzed using the Analysis Hierarchy Process (AHP) method with the help of the Expert Choice 11 application. The validity of the research data was maintained by the method proposed by Stainback (1988) by fulfilling four criteria, namely the degree of credibility, transferability, dependability, and confirmability. It includes the use of data triangulation, member checking, and the use of reference sources.

### Results and Discussion

Based on the population census conducted by the Central Bureau of Statistics of the City of Cimahi, the population in the City of Cimahi continues to increase from year to year. The population of Cimahi City in 2017 was 601,009, increased to 607,811 in 2018, and increased to

614,304 in 2019. This high population is the majority of the childbearing age group. The achievements of the family planning program are reported regularly by the Family Planning Division of Cimahi City once a year. Here are the results for the last 3 years:

**TABLE 1.** Family Planning Program Achievements in Cimahi City

| No | Description                                   | 2017         |       | 2018         |       | 2019         |       |
|----|---|--------------|-------|--------------|-------|--------------|-------|
|    |   | Achievements | %     | Achievements | %     | Achievements | %     |
| 1  | EFA   | 93.251       |       | 91.773       |       | 92.339       |       |
| 2  | MKJP Active Family Planning Participants      | 22.717       | 31,03 | 23.118       | 31,89 | 23.354       | 32,04 |
| 3  | Number of Active Family Planning Participants | 73.209       |       | 72.491       |       | 72.897       |       |
|    | a. IUD  | 18.940       | 25,87 | 19.170       | 26,44 | 19.492       | 26,74 |
|    | b. MOW  | 2.916        | 3,98  | 2.958        | 4,08  | 2.791        | 3,83  |
|    | c. MOP  | 203          | 0,28  | 212          | 0,29  | 202          | 0,28  |
|    | d. Condom                                     | 1.420        | 1,94  | 1.409        | 1,94  | 1.733        | 2,38  |
|    | e. Implant                                    | 658          | 0,90  | 778          | 1,07  | 869          | 1,19  |
|    | f. Inject                                     | 38.485       | 52,57 | 28.132       | 52,60 | 38.204       | 52,41 |
|    | g. Pil  | 10.587       | 14,46 | 9.832        | 13,56 | 9.606        | 13,18 |
| 4  | Unmet Need                                    | 9.142        | 9,80  | 8.763        | 9,55  | 8.497        | 9,20  |
| 5  | Number of Family Planning Villages            | 4            |       | 8            |       | 12           |       |

Source: secondary data

Based on data obtained from N6, JKN participation in Cimahi City in 2020 has reached 92.05%. A total of 509,715 people have been registered in JKN, with details of

354,144 (69.48%) being independent non-PBI participants, and 155,571 (30.52 percent) being PBI participants.

**TABLE 2.** JKN Membership in Cimahi City

| PBI      |          |         | Non PBI |        |
|----------|----------|---------|---------|--------|
| PBI APBN | PBI APBD | PPU     | PBPU    | BP     |
| 117 017  | 38 554   | 218 270 | 112 489 | 23 385 |
| 22.96%   | 7.56%    | 42.82%  | 22.07%  | 4.59%  |

Source: secondary data

The financing of the National Health Insurance in Cimahi City is carried out in 2 ways, namely claims and capitation payments. Claims are payments made by BPJS Health to hospitals in Cimahi City and in collaboration with BPJS Health. Meanwhile, the capitation

payment is the payment of a certain amount of funds made by BPJS Health to all First Level Health Facilities (FKTP) in Cimahi City. The FKTP includes 13 community health centers that are part of the Health Office of the City of Cimahi.

Table 3. Capitation Payment of Cimahi City August 2020

| No | Name PPK       | Number of Registered Participants |         |         | Capitation Rate/<br>Participant | KBK weight | Total Funds Paid |
|----|----------------|-----------------------------------|---------|---------|---------------------------------|------------|------------------|
|    |                | PBI (APBN & APBD)                 | Non-PBI | Number  |                                 |            |                  |
| 1  | Citereup       | 11.338                            | 5.258   | 16.596  | Rp6.000                         | 95%        | Rp94.597.200     |
| 2  | Cibeber        | 7.876                             | 4.065   | 11.941  | Rp6.000                         | 90%        | Rp64.481.400     |
| 3  | Leuwigajah     | 12.626                            | 1.945   | 14.571  | Rp6.000                         | 90%        | Rp78.683.400     |
| 4  | Central Melong | 6.959                             | 4.027   | 10.986  | Rp6.000                         | 90%        | Rp59.324.400     |
| 5  | Pasirkaliki    | 4.798                             | 3.597   | 8.395   | Rp6.000                         | 100%       | Rp50.370.000     |
| 6  | North Cimahi   | 14.961                            | 11.249  | 26.210  | Rp6.000                         | 95%        | Rp149.397.000    |
| 7  | Cipageran      | 15.837                            | 5.778   | 21.615  | Rp6.000                         | 95%        | Rp123.205.500    |
| 8  | Central Cimahi | 8.955                             | 12.754  | 21.709  | Rp6.000                         | 95%        | Rp123.741.300    |
| 9  | Cigugur        | 15.920                            | 3.488   | 19.408  | Rp6.000                         | 95%        | Rp110.625.600    |
| 10 | Padasuka       | 17.147                            | 6.031   | 23.178  | Rp6.000                         | 100%       | Rp139.068.000    |
| 11 | South Cimahi   | 8.340                             | 10.351  | 18.691  | Rp6.000                         | 90%        | Rp100.931.400    |
| 12 | Melongasih     | 9.270                             | 9.215   | 18.485  | Rp6.000                         | 95%        | Rp105.364.500    |
| 13 | Cibereum       | 18.412                            | 6.835   | 25.247  | Rp6.000                         | 90%        | Rp136.333.800    |
|    | Cimahi City    | 152.439                           | 84.593  | 237.032 |                                 |            | Rp1.336.123.500  |

Source: secondary data

The National Health Insurance (JKN) has been running for more than 5 years, but has not been able to reach the entire Cimahi community. There are 44,040 people or 7.95% of the people of Cimahi who have not been accommodated. The reasons people do not become JKN participants are various, such as being economically incapable and unable to register as PBI participants and not having an administrative identity. There are also non-PBI participants who are then unable to pay the dues but find it difficult to change their status to become PBI participants, so that the arrears of the Health Social Security Agency contributions are very large. A number of other communities are wealthy people who choose not to participate for their own reasons. This means that policy communication about JKN is still lacking, because Presidential Regulation 82 of 2018 concerning National Health Insurance mandates that all Indonesian people are JKN participants.

The presence of JKN does not necessarily have a significant impact on the use of contraception in Cimahi City, especially the long-term method and the steady method. According to N1, N2, and N3 after the JKN era, contraceptive services for short-term methods such as pills and injections increased because contraceptives were accessible for free by the public. The IUD method that is used at the

puskesmas is still not widely accessed by the public. Steady operating methods in the form of MOP and MOW are still low in achievement. The reason is because many people do not know that family planning services are one of the benefits provided by JKN. One of the health benefits of health insurance that remains low in achievement is the maternal and child health sector, including family planning programs (Nguhiu, Barasa, & Chuma, 2017). Mass media socialization is an important factor that supports the use of contraception by the community. It is necessary to socialize by each implementer of the JKN integrated population control policy in Cimahi City so that its utilization can be more effective (Bhuvanendran, Thyagarajan, & Viswan, 2014).

JKN financing organized by BPJS Health through capitation funds in August 2020 reached 1.3 billion Rupiah. According to Permenkes 21/2016, if the capitation funds owned by the puskesmas as FKTP belonging to the regional government are still remaining, it can be used for the next fiscal year. This means that the more efficient the management of the capitation funds owned by the puskesmas, the greater the remaining funds will be. If the remaining budget is large, it can be used to improve health services for the community.

According to (Fagan, Dutta, Rosen, Olivetti, & Klein, 2017), Integrating family

planning programs into the National Health Insurance scheme requires the government's role to: target the poor population and the informal sector, make family planning one of the benefit packages, ensure adequate financing for family planning programs, and minimize non-financial barriers. With these measures, the state can increase financial protection for family planning and better guarantee the right to health of the poor and marginalized. As a component of the SDGs, national health insurance is absolutely achievable. Middle-income countries are believed to be able to achieve this if they are equipped with qualified policies. Indonesia as a country with upper middle income should be able to fulfill this. However, with the confusion and overlapping implementation of population control policies in the national health insurance, this will be difficult to achieve (Stenberg, et al., 2017).

Based on in-depth interviews with 6 expert sources, a significant statement was obtained which was described into 4 dimensions of policy implementation according to Edwards III (1980). The main problem in implementing population control policies in the context of implementing JKN in Cimahi City is the different perceptions of the many parties involved. Meanwhile, in terms of resources, especially contraceptive tools and drugs, it is quite adequate. This is much different from the country of Ghana, where the implementation of the health insurance scheme is actually constrained by the lack of resources, supervision, and equity, so that the quality of the health services it facilitates is still low (Dalinjong, Wang, & Homer, 2018).

There are 3 groups of policies related to the implementation of population control policies within the framework of JKN in Cimahi City. The policy groups in question are population, health, and regional autonomy policy groups. If the three groups of policies are not communicated properly, it will cause policy implementers to have different interpretations and carry out policies in different ways. The transmission of population control policies-JKN in Cimahi City is not going well, as evidenced by N1-N3 who are completely unaware of the applicable laws and regulations. N4 and N5 know some rules. N6 said that all JKN programs

implemented in Cimahi City follow the existing laws and regulations at the center and do not make additional regional regulations that can encourage the implementation of JKN-integrated population control activities.

The large number of regulations governing population control-JKN requires a detailed understanding of these regulations. All of the informants did not know the detailed regulations. This can cause the implementation that is running to be out of sync and uniform because each implementor has their own understanding, so that the effectiveness of policy implementation is reduced. The main obstacle to existing regulations regarding population control-JKN is the difference in the contents of one regulation and another. The entire population group legislation mandating local governments to form BKKBD was negated with the issuance of Law Number 23 of 2014 concerning Regional Government. Population and family planning issues in Law Number 23 of 2014 are included in the category of concurrent government affairs, which are carried out by the central and regional governments. The attachment to Law Number 23 of 2014 states that the implementation of population and family planning affairs utilizes PKB personnel from the Central BKKBN.

Communication between the government and each authorized field in each public service is important to be carried out properly to ensure the smooth implementation of policies (Putra & Khaidir, 2019). Actions that can be taken to increase the success of communication on the implementation of control policies and family planning-JKN in Cimahi City are socialization and policy communication between the Family Planning Division and other fields within the Cimahi City Government. The socialization was carried out by introducing the profile of the family planning sector and its programs. Two-way communication is carried out by holding regular inter-sectoral meetings to discuss public problems in Cimahi City, to then discuss their solutions. With direct communication, each sector can refer to the regulations and policies that each have.

The Population Control and Family Planning Policy in Cimahi City is mainly implemented by Family Planning Officers (PKB), in

accordance with the mandate of Law No. 23 of 2014 concerning Regional Government. The explanation section of the law explains that the local government utilizes the PKB which is an element of the central BKKBN to carry out the task of controlling the family planning population in Cimahi City. This utilization itself causes some confusion in its implementation, because PKB whose employment status is a central officer. The number of human resources implementing population control and family planning policies in Cimahi City consists of 3 types of personnel, namely PKB workers with ASN status and are elements of the Central BKKBN utilized by the Regional Government, TPD workers with Non ASN status and are West Java Provincial Government personnel, and cadres IMP consisting of cadres at the RT and RW levels. There are 8 PKB in Cimahi City who work on population control and family planning tasks in 15 urban villages in Cimahi City. Based on the age aspect, 4 PKB (N1-N4) are above 50 years old, and stated that their abilities are not as good as they used to be. N5 said that every year the Family Planning Division always proposes to increase the number of human resources, but considering the limited budget so that it cannot be realized. This imbalance in the number of PKBs was overcome by adding additional TPD personnel, which were equally utilized by the City Government, even though they were not elements under it.

HR implementation of population control policies in the framework of the National Health Insurance in Cimahi City is very few, if the quality of human resources is inadequate then the implementation process will be increasingly difficult. All PKB in Cimahi City do not have a population or health background. Furthermore, the Family Planning Division in the Cimahi City Government is not led by human resources with population science backgrounds. Echelon 3 and 4 officials in the Cimahi City Government regularly experience divisional changes or promotions every 1-2 years, so it is not uncommon for an official to hold a new position before mastering and animating the field previously occupied. In order to deal with acceptors who are not handled in FKTP and acceptors who do not have BPJS, the City of Cimahi routinely carries

out family planning service celebrations. The activities carried out were the installation of IUD contraceptives and implants carried out in collaboration with the Kesdim, as well as vasectomy and tubectomy in collaboration with private hospitals. The costs arising from this gebyar activity are borne by the BKKBN and the Cimahi City Government.

According to N1-N4, PKB and TPD maximize the infrastructure provided by the Central BKKBN. The mechanism for this provision also passes through the family planning field first, so that often the assistance is felt to be less than optimal. PKB resource persons admitted that they often feel confused because people ask about the funds in question, but the Cimahi City Government stated that there were no funds for these activities. The community on the other hand participated in training or exchanged information with other districts/cities and knew that there were actual facilities available, but did not dare to confirm it with the City Government of Cimahi.

In terms of supervision, the implementation of population control policies within the framework of JKN in Cimahi City, activities carried out by each implementor are reported through the Provincial BKKBN and then forwarded to the center. In reporting PKB using the E-Visum application media, TPD uses the E-Klop application media, and cadres using the Silili application. PKB as ASN also works every 6 months on the List of Proposed Credit Score Assessment (DUPAK) whose mechanism is first checked by the Civil Service Sector of the Cimahi City Government and then proposed to the Provincial BKKBN. N1-N3 said that the Civil Service Human Resources in the Cimahi City Government did not master the techniques needed to assess DUPAK PKB so that it often caused delays in submitting to the Provincial BKKBN.

According to N1 and N4, supervision is only reporting or bottom-up where the Provincial BKKBN only receives and forwards reports, while top-down evaluation of policy implementation to PKB or the target area has never been carried out. This causes the obstacles encountered by PKB in the field to be difficult to follow up. In terms of authority resources, the main problem lies in the authority of the

BKKBN in implementing population control and family planning policies at the regional level. The enactment of the 3 groups of policies as described in the previous sub-chapter changes the authority of the BKKBN to facilitate local governments in controlling the population. On the other hand, PKB as an element of the BKKBN is utilized by local governments which should provide their own human resources. PKB has changed its authority in implementing population control policies in the field.

Human resources are a very important factor in an organization including policy implementing organizations. For this reason, HR must have the ability, skills and competence to be able to carry out their duties and functions. These things need to be continuously developed through various means including training. One of the important trainings is Competency-Based Training (CBT) which focuses on 5 strategies, namely: organizational scanning, strategic planning, competency profile, competency gap analysis, and competency development (Prabawati, Meirinawati, & Aoktariyanda, 2018). HR development is carried out quantitatively and qualitatively. Quantitatively, the Cimahi City Government needs to analyze the need for personnel in accordance with the conditions experienced by the family planning sector. Qualitatively, HR development is carried out through training to improve the competence and professionalism of the implementers.

According to Edwards III (1980), implementors who have a positive attitude towards a policy and support it will implement the policy in accordance with its initial objectives, while otherwise the policy will fall into the 'zone of indifference'. Based on Law 23 of 2014 concerning Regional Government, regional autonomy provides high flexibility to regional governments to manage all their affairs independently, including population control and the implementation of National Health Insurance. That way, local governments have a great opportunity to support and not support existing policies in accordance with their wishes. All PKB resource persons stated that the commitment of the Cimahi City Government in implementing population control and family planning policies was much lower than before regional autonomy. This means that the

implementation of population control which should then be implemented integrated with the National Health Insurance is vulnerable to falling into the zone of indifference.

According to (Putra & Khaidir, 2019), providing incentives can increase the tendency of policy implementers to carry out their duties properly. Every individual has a motivation that underlies him to take an action in order to achieve his goals. Motivation can also be interpreted as the process of trying to influence and encourage the people he leads to do the desired work in order to achieve the desired goals. In the implementation of population control policies within the framework of the National Health Insurance in Cimahi City, the situation and conditions in the family planning sector are good but need to be improved, especially the relationship with PKB. The next action that can be taken is the provision of equal incentives for all policy implementers, both PKB, TPD, to cadres. Apart from incentives, other efforts in the form of a common perception regarding population control and family planning need to be made to increase acceptance and dispel myths and false beliefs about implementers (Maheen, et al., 2020).

Policies are made by the government which generally consists of various formal bureaucratic institutions (Chen, 2020). Bureaucracies exist in a wide complex environment and have different goals at each stage. Responsibility for a policy can be spread across several organizations. Each organization with its own tupoksi tends to oppose efforts to coordinate policies with other agencies that carry out related programs. This is because they are worried that they will experience a lack of access or change their program priorities.

The implementation of population control policies in the National Health Insurance in Cimahi City is spread over the family planning sector which is under the Social Service, Health Service, and the Population and Civil Registration Service which supports both programs. According to N5, there is no synergy with the Health Agency and other agencies in implementing existing policies and programs. N6 said that the task of the Health Service was only to pass on regulations from the central government to the puskesmas in the context of

administering the National Health Insurance. Whereas local governments are mandated to make regulations that support the optimal realization of National Health Insurance, one of which is through efficiency in health financing by implementing population control and family planning.

Mintzberg (1980) introduced an alternative structure of bureaucracy called adhocracy. Adhocracy structures have low complexity, centralization, and formalization. Adhocracy is considered an informal form of adaptive and flexible organization and provides opportunities for problem solving by cutting bureaucratic lines, including at the local state level (Chen, 2020). Decisions taken from adhocracy are collegial and democratic. Adhocracy can also be done in the form of advocacy on community-based primary health services to policy makers, including the importance of coordinating health services at the community level, collaborating with the community to increase understanding of primary health services, as well as collaboration with the private sector (Weel, et al., 2017). Cooperation with the private sector cannot be denied to encourage the level of achievement of national health insurance (Chakraborty, Mbondo, & Wanderi, 2016). Adhocracy has proven to be effective in overcoming various sectors of public problems, including health. For that, we need leaders who are able to foster a culture of adhocracy (Njagi, Ngugi Kamau, & Muraguri, 2020). The Cimahi City Government can form an adhocracy in the context of implementing population control policies in the implementation of the National Health Insurance. The selected form adapts to the existing conditions. Members who are included in the work unit or committee are mainly the Family Planning Division and the Health Office of Cimahi City.

The alternatives that have been described can be carried out according to the availability of resources and the capabilities of the existing implementers. For this reason, decision making is more suitable to use the judgment of decision makers in this case the implementer itself, namely the KB, PKB, and Cimahi City Health Offices. The selection of alternative recommendations used in this study is the Analysis Hierarchy Process (AHP). Based on the analysis using

the AHP method, it is known that the priority dimension in implementing population control policies in the implementation of the National Health Insurance in Cimahi City is the bureaucratic structure. For this reason, the institutional aspects of the agencies involved in policy implementation and the fragmentation of policies that occur need to be understood first before proceeding to the dimensions of resources, disposition, and communication. This is in line with what Edwards III (1980) said, namely an understanding of the bureaucratic structure is a fundamental factor in reviewing policy implementation.

For the selection of which recommendation decisions need to be made first, the experts through AHP stated that the integration of policies that support each other is a priority. The KB and PKB sectors need to discuss with the Health Office to integrate existing policies to determine the next steps. The integrated policies will provide an overview of the needs, expectations and motivations of each agency. Motivation can then be increased by creating positive situations and conditions and setting a pace making for shared goals. It is also necessary to provide incentives for implementers at lower levels, namely PKB, TPD, and cadres.

The next priority is the socialization and communication of integrated policies to policy makers from the Mayor to all City Government officials. Through socialization and communication, the Family Planning Division and the Health Office can advocate for policy makers at higher levels, including for the provision of incentives and resources. The next alternative priority is the addition of resources in the form of additional human resources, provision of training, and infrastructure. The last priority is to increase cooperation with the BKKBN and BPJS Health in the form of adhocracy to implement population control policies in the context of administering the National Health Insurance.

## Conclusion

The conclusion that can be drawn from this research is that the achievement of the family planning program of Cimahi City is good with an unmet need of 9.20. Based on JKN membership as much as 92.05% of the



total population has been accommodated, of which Cimahi City bears 7.56% of the JKN PBI participant fees. The use of family planning services with the National Health Insurance is still not widely known, so it has not encouraged an increase in the use of contraception, especially vasectomy and tubectomy. The implementation of the JKN integrated population control policy is still experiencing many obstacles. The existing problems are mainly dominated by the transmission of policies that do not reach all implementers, policies that are not consistent with each other, inadequate human resources and infrastructure, low local government commitment, and the lack of synergistic cooperation between institutions in implementing existing policies. The recommendations generated based on the analysis using the AHP method result in a priority order of implementation, due to the availability of resources and the ability of policy implementers. Based on this, the researcher recommends integrating policies to support each other, communicating and disseminating policies to increase proportional resources, as well as increasing cooperation between the BKKBN, the Family Planning Division and the Health Office of Cimahi City.

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