Preface

Maternal health issues remain in the spotlight globally, regionally, and in Indonesia itself. The challenge in Indonesia is how to achieve the Millennium Development Goals target number 5 on the reduction of maternal mortality.

Accessing quality maternal health care services is still a challenge for some women in many regions in Indonesia. One of the barriers is financial. The Government of Indonesia has responded to this issue by launching a national health insurance scheme for maternal health, known as Jampersal, in 2011. The scheme provides free maternal services for all women in Indonesia regardless of their economic status. The scheme discourages unsafe home births and also promotes postpartum contraception. Jampersal will be replaced by the Universal Health Coverage scheme (UHC) in 2014, which will provide more extensive coverage, including family planning.

Since the inception of the Jampersal scheme, UNFPA in Indonesia has taken a lead role in identifying gaps in the service and in raising local awareness of the services. In collaboration with Centre for Health Policy Management at Gadjah Mada University (UGM) in Jogjakarta, UNFPA conducted a series of studies on the Jampersal programme in the first year and in the last year of its implementation. The findings from these studies will be useful for policy recommendations, particularly as lessons learned for the UHC programme in the future.

With great appreciation, UNFPA Indonesia and UGM would like to extend our gratitude to all those involved in this study: University of Sumatera Utara, University of Hasanuddin, University of Nusa Cendana, University of Cenderawasih, officers of the District Health Offices in the 10 districts supported by UNFPA, and all of those health providers who work tirelessly in delivering quality maternal health care to the women in need.

Our hope that this study will feed into the improvement of the maternal health programme in Indonesia and will help improve the health status of all women in the country.

Jose Ferraris

UNFPA Representative

Laksono Trisnantoro

Principle Researcher, CHPM-UGM

Jampersal Review 2013:

Collaborative Study for Ten Indonesian Districts

Executive Summary

Improving maternal and child health is an important agenda for Indonesia. Despite the 40 percent decline in maternal deaths in the last two decades, a recent survey showed a startling high maternal mortality rate (MMR) and stagnancy in the neonatal mortality rate (NMR) (DHS, 2012). As a result, Indonesia is predicted to be unable to achieve MDG goals 4 and 5 in 2015.

The Jampersal program, providing health insurance for maternal and child health (MCH) services, was launched in 2011 as one of the government's effort to reduce the MMR and NMR, by providing financial protection for MCH services for all regardless of their economic status. Previous studies showed a number of implementation issues of the program, including the high out-of-pocket payment borne by the patients and the small reimbursement for health providers, as well as low utilization of the program in areas with limited health facilities and resources.

The ongoing program would require continuous reviews to assess the possible challenges in improving the health of women and children. In relation to the upcoming National Health Insurance scheme for Indonesia in early 2014, other areas that need to be explored is the district readiness in terms of health system supply side and in managing the national insurance system. The review aims to assess the aspects of improvement in order to ensure the success of any health financial protection scheme in Indonesia.

Scope and Methods

The research scope is to provide a review of the impact of the Jampersal program towards maternal and child health service coverage, and also to assess the challenges and opportunities in the implementation of the program. The Jampersal as a financial protection scheme towards universal health coverage for women and children is reviewed using the WHO framework of three dimensions of universal health coverage: the breadth, depth, and height of the program. This review also assesses the readiness of the districts for the upcoming National Health Insurance scheme (JKN) in early 2014, looking from the supply-side perspective of the health system.

This review takes place in ten districts located in five provinces in Indonesia. The districts are Nias and Nias Selatan districts in North Sumatera Province, Mamuju Utara and Mamasa districts in West Sulawesi, Jayapura and Merauke districts in Papua province, Manokwari district in West Papua province, and Alor, Manggarai and Timor Tengah Selatan districts in NTT province.

The research is a collaborative project between the Center for Health Policy and Management of the Faculty of Medicine, Universitas Gadjah Mada with four faculties located within the study location. The partner institutions are faculties of public health from Universitas Sumatera Utara, Universitas Hasanuddin, Universitas Cenderawasih and Universitas Nusa Cendana.

Overview of Methods

This study is a cross-sectional study with a mixture of quantitative and qualitative methods. Quantitative methods are used to see the difference between the coverage of health services before and after Jampersal program implementation, as well as the effectiveness of the program in achieving the goals of the program itself. Qualitative methods are used to obtain perceptions of service providers, program managers and patients towards Jampersal program and the challenges in the implementation process. Quantitative and qualitative

methods are also used to look at the districts' readiness to face SJKN 2014. Quantitative data obtained from the district and provincial health reports and the Jampersal claims data. Quantitative data are used to obtain the coverage of maternal and child health services before and after the program Jampersal. In connection with the upcoming JKN implementation in 2014, quantitative data provide an overview of the adequacy of personnel and health facilities in the district, while qualitative data capture the readiness from the management systems perspective to implement the new health insurance scheme.

Overview of Findings

The utilization of Jampersal program for all MCH services is still below the expected target population, with similar findings across all the ten study districts. Continuous services including antenatal care and postnatal care experience the lowest coverage level, indicating quality problem in the overall services due to discontinuity in service utilization. Higher utilization levels were observed for the normal delivery by skilled birth attendant. However, the coverage level was still below the number of expected target population of the Jampersal program. Postpartum family planning service has the lowest utilization, nearing 0% in many of the study sites. This indicates that the program is not putting the family planning service on the front run, which is not in line with the formally stated program goals.

The analysis on the impact of the Jampersal program towards the overall improvement in MCH services shows no significant increase in all MCH services in the ten study locations. This could indicate that the financial protection scheme is not the panacea for low health care utilization in Indonesia. Several common themes appeared across all study sites that affect the utilization for Jampersal services:

(i) **The exclusion of transportation cost from the Jampersal benefit package**: This was an overarching issue identified as the important consideration that affects patients' utilization to the health care facilities in general. Financial accessibility is still a major hindrance for health care utilization, thus not covering for the transportation cost is perceived as a major drawback of the program. Given the local condition of the study sites, a large number of communities may have significant geographical barrier and would require significant amount of transportation cost.

(ii) **Lack of community socialization**: Although the program has been implemented for the last three years across Indonesian region, many of the target population still unsure about the benefit package included and the administration processes that need to take place.

(iii) **The existence of out-of-pocket payment**: Women covered by the Jampersal program are still prone to expensive out-of-pocket payment, particularly among the poor population. Rather than paying for the possibly inaccessible health facilities, some women still prefer to use traditional birth attendant.

The program success is also influenced by the participation of the health providers, both public and private providers. Even though all public health facilities are automatically providers of the Jampersal program, their performance and competing preference in treating the patients are aspects that would influence the overall program success. The main findings of challenges in the program implementation, from the providers' perspective, are:

(i) **The lengthy reimbursement process and the late disbursement of the funding**: Bureaucratic reimbursement process that requires multiple validation and reporting to various institutions has made the Jampersal reimbursement a labor-intensive and not appealing for the providers

(ii) **The limited amount of service fee provided by the program:** Health providers in general, perceive that the amount of reimbursable service fee is much too small; making the mandatory participation for public health providers a burdening additional work and optional participation for private health providers a less attractive offer.

The district's readiness to start implementing the universal health coverage (JKN) was viewed from two perspectives:

(1) quantitative analysis of the current health resources; and
(2) current knowledge and management capacity for the upcoming new health insurance scheme.

Most of the districts have low doctors to population ratio, and a lower ratio of midwife and nurses to population compared with the national level. Health facilities are also lacking, showed by the fact that most of the study districts have low hospital bed to population ratio. A number of modern technology health equipment was assessed in this study to capture the district capacity in delivery high cost treatment that should be covered under the UHC scheme. However, even life-saving equipment such as the hemodialysis unit is still not available in all study districts. From the management aspect, several district health managers are still not familiar with the UHC system or the reimbursement processes. This would pose a potential future mismanagement of the program.

Conclusion & Recommendations

The Jampersal program is potentially a good program that would cover every woman throughout pregnancy and delivery and postnatal periods. However, due to accessibility problem in Indonesia, health financial protection only is not enough to increase demand-driven health care utilization. Transportation costs, as was observed multiple of times during this study, serve as the sole strong reason for under-utilization of the MCH services.

The experience from Jampersal program implementation should be used to improve any future health insurance program, including the universal health coverage (UHC) that has taken place since early January 2014 in Indonesia. Five recommendations that can be provided based on the review are:

(1) The inclusion of transportation costs as part of the benefit package, where underutilization in geographically and economically challenged areas was found to be correlated with limited transportation fees coverage.
(2) The importance of increased effort to socialize the program to both the health care providers and program beneficiaries.
(3) Improvement in the insurance claims system to ensure health care providers' performance
(4) A system for monitoring quality health care services, including sound referral system to ensure equitable access to basic and comprehensive care
(5) Human resource provision and health facility improvement in underserved areas. The absence of such investment could resulted in higher health inequity, as health funding would be pooled in more developed areas with well-equipped facilities and high health care cost. Areas with limited human resource for health and health infrastructure would have even less underutilization could result in greater health inequity.

The program is intended to reduce maternal and neonatal deaths through increase in health care utilization. However, data collected in this study show that there is no significant increase in health care service coverage even after the introduction of the Jampersal program. Some challenges include that the low socialization for the community, the disincentives due to the amount of reimbursable service fee, and the out-of-pocket payment that reduce demand-side utilization.

Based on the challenges identified and that the goals of the program have not been entirely achieved, further improvement should be made on any future health insurance program.

Introduction

The improvement of the maternal and child health is an important agenda for development countries, including in Indonesia. Regardless of the decrease of 40% in maternal deaths in the last two decades, the latest Indonesia Demographic Health Survey (DHS) showed a surprising increase in MMR from 228 per 100,000 live births in 2007 to 359 per 100,000 live births in 2012. One of the most efficacious evidence-based interventions that could alleviate maternal death burden, the family planning program, has experienced much lower uptake in the last decade. The analysis of the DHS from 1987-2012 shows that the increase in modern CPR has slowed to a mere 0.5-0.7% since 2003. unmet need for family planning one of target indicator for MDG5B even increase 2.5% in the last 10 years (8.9%, IDHS 2002-2003 and 11.4%, IDHS 2012). Indonesia is also struggling in achieving MDG number 4, having stagnated in neonatal mortality rate at 32 per 1,000 live births. Indonesia is predicted to be unable to achieve both MDG 4 and 5 targets by 2015.

The Indonesian government has launched numerous efforts to reduce MMR and IMR, including by increasing coverage in antenatal care, delivery facility, and family planning, as well as services for complicated deliveries and neonatal emergency care. Other health policies include the revitalization of village midwives, development of the village birth facilities, maternal waiting homes, and also training and infrastructure development for BEMOC and CEMOC services. However, the latest health survey (Riskesdas, 2013) shows that financial barrier is still a crucial hindrance in service delivery (NIHRD, 2012). In an effort to tackle the issue, the Indonesian Ministry of Health launched a universal social health insurance scheme specifically directed towards maternal and neonatal health, called ***Jampersal***.

The Jampersal program provides financial coverage of MCH health services for all, regardless of the economic status. Previous review on the program shows several implementation issues, including the existing high out of pocket payment, the absence of coverage for crucial transportation costs for emergency cases, and the low utilization in areas with limited health facilities and resources.

A previous study conducted in 2011 by PKMK of the University of Gadjah Mada and supported by UNFPA highlighted some aspects of improvement but noted concerns including:

(1) Jampersal program has introduced significant over-burden on public health providers;
(2) the insufficient service fee perceived by both the public and private health providers, causing disincentives for the services provided under the Jampersal scheme;
(3) the high out of pocket payment;
(4) the failure of the program in improving accessibility of health facility, resulting in disproportionate use by population residing with better access to health facility; and
(5) the Jampersal program is not designed to support the existing family planning program by not promoting the ideal number of children.

This 2013 study is intended as a follow up to the previous studies by looking further into the program implementation at its third year of implementation, by specifically assessing the impact of the program on:

(1) MCH service utilization;

(2) disparities in health care utilization; and
(3) the perception on quality of the services provided under the Jampersal program, both from the providers and users perspective.

This study's aim is also related to the upcoming launch of the National Health Insurance scheme (Jaminan Kesehatan Nasional) or the JKN, which will begin in early 2014, by assessing the district readiness to implement the new health insurance scheme. Jampersal will be incorporated into the UHC which also provides financial coverage for other health services.

This study is a collaborative research project between universities at the study locations and Universitas Gadjah Mada, with the support of UNFPA in Indonesia. The collaboration is expected to develop institutional capacity in evaluating health insurance programs and will be used as a basis for future national collaborative projects.

Study Aims and Objectives

This study aims to assess the impact of the Jampersal program towards maternal and child health service coverage and also to assess the challenges and opportunities in the implementation of the program.

Specific objectives are:

1. To assess the coverage of the Jampersal program in ten districts in Indonesia;
2. To assess the effectiveness of the program in improving MNH service utilization;
3. To analyze the use of Jampersal program among the community;
4. To assess current challenges and the perceptions on the program implementation; from the perspectives of the program managers, health service providers and users;
5. To review the existing health insurance at the district level;
6. To assess the district readiness in implementing the upcoming universal health coverage scheme
7. To improve academic capacity in evaluating future health insurance programs;

Methods

Study Setting

The study is conducted in ten Indonesian districts, as follow;

1. Nias
2. South Nias
3. Mamasa
4. North Mamuju
5. Manokwari
6. Jayapura
7. Merauke
8. Timor Tengah Selatan
9. Alor
10. Manggarai

Researchers participating in this study are from PKMK Faculty of Medicine of the Universitas Gadjah Mada, Faculty of Public Health of the Universitas Sumatera Utara, Faculty of Public Health of Universitas Hasanuddin, Faculty of Public Health of Universitas Cenderawasih, and the Faculty of Public Health of Universitas Nusa Cendana.

The study was conducted from October to November 2013.

Study Design

This is a cross-sectional study using mixed methods of quantitative and qualitative research.

The quantitative method is used to assess the difference in health service coverage before and after the Jampersal program implementation and the effectiveness of the program in achieving the program goals. Qualitative method is used to acquire the perception towards the program implementation from the health providers, program managers as well as the patients or users of the program. District readiness in implementing the upcoming UHC program is assessed through both quantitative and qualitative approaches.

Quantitative data is gathered from the district health office reports, claims data, as well as from the local bureau of statistics.

Study Subjects

Respondents for the qualitative methods include:

A. Hospital
   1. Hospital director
   2. Hospital managers for Jamkesmas (social insurance scheme for the poor) and Jampersal
   3. Hospital finance manager
   4. Obstetricians
   5. Midwives

B. District health office
   1. Head of district health office
   2. Family health director
   3. Finance director
   4. Jamkesmas-Jampersal managers
   5. Midwives association coordinators

C. Technical health providers
   1. Private practice midwives
   2. Public practice midwives
   3. Private-public practice midwives

In conducting the research interviews, researchers differentiate between rural and urban areas. Based on the predefined categories, each researcher uses the following approach during the data collection:

1. Interviews at the rural and urban primary health centers
   a. Primary health center managers for health insurance
   b. Primary health center general practitioners
   c. Primary health center midwives
   d. Village midwives

2. FGD (focus Group Discussion) with the following:
   a. Women who use Jampersal at both urban and rural settings
   b. Women who do not use Jampersal at both urban and rural settings

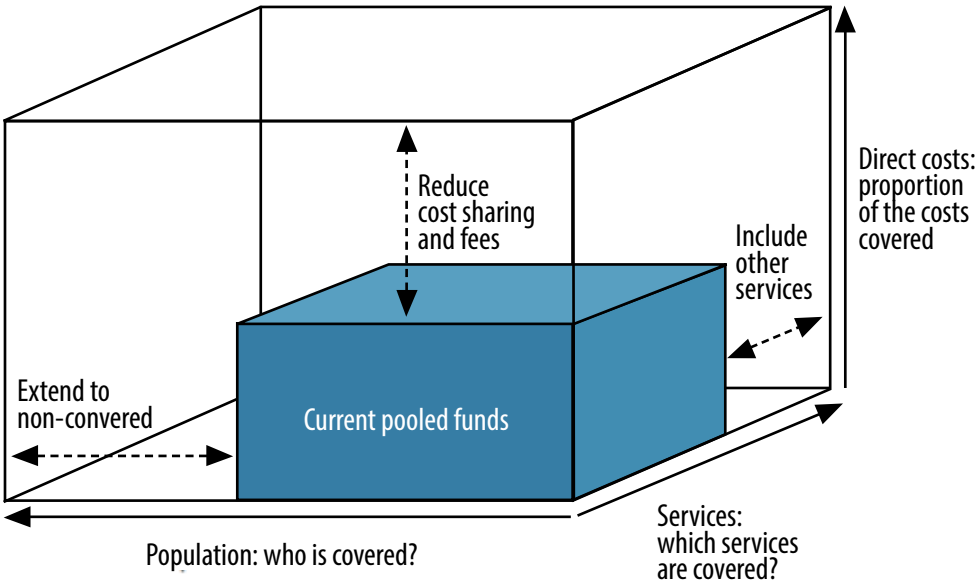
Data Analysis

Jampersal program is a form of a financial protection in an effort to achieve universal health coverage for women and children. The program thus analyzed using the WHO framework for universal health coverage, by assessing the following three dimensions:

(1) breadth, or the population coverage;

(2) depth, or the extend of the service provided under the program; and
(3) height, or the financial protection actually acquired by the target population.

Both quantitative and qualitative data analyses are used in this review.



Quantitative Data Analysis

Descriptive quantitative analyses are done to assess the population coverage under the Jampersal program, the coverage of participation of the health providers, completeness of Jampersal services as well as increased coverage of MCH services including antenatal services (K1 and K4), delivery by skilled health personnel, and postnatal care.

1. Jampersal program population coverage (*breadth*)
   In accordance with the 2012 Technical Guideline, Jampersal program aims to provide health insurance to women who are currently do not have any health insurance. Jampersal program itself was launched as a complement of existing Jamkesmas program that targets the poor and near-poor population. Jampersal could cover those without any Jamkesmas membership. In other words, after the enactment of the Jampersal, all people with Jamkesmas card and those without health insurance can take advantage of the Jampersal.

   The coverage target for Jampersal is calculated under the assumption that Jampersal will cover all pregnant women without any insurance and topped with those already covered with Jamkesmas. The estimated target for pregnant women was obtained from district-level data and the proportion of population without insurance was obtained from Susenas 2011 survey. The coverage for Jampersal service was calculated using the following formula:

$$\frac{Number\ of\ Jampersal\ claims\ for\ specific\ MNH\ service}{Jumlah\ sasaran\ bumil - bulin\ \times\ \%masyarakat\ tanpa\ jaminan\ kesehatan + \%\ masyarakat\ anggota\ Jamkesmas}$$

   This method has several drawbacks:
   - Insurance ownership data acquired from Susenas survey are household-level data, and not at individual level. The resulting coverage numbers cannot be directly interpreted as Jampersal utilization rate, but the figures may provide a description of the targets for Jampersal program

- Number of targeted pregnant and delivering women is acquired from the provincial or district level database. The validity of the calculation may affect the accountability of the calculated coverage data

2. Coverage of health providers participation in Jampersal program
   Coverage for health providers participating in the Jampersal program is calculated by dividing the number of health care providers participating in Jampersal program with the total number of providers in a given district:

$$\frac{Number\ of\ health\ providers\ participating\ in\ the\ Jampersal\ program}{Total\ number\ of\ health\ providers\ in\ a\ given\ district}$$

   Health providers include: primary health centers, public district hospitals, private hospitals or clinics, and private practice midwives and general practitioners.

3. The completeness of services under Jampersal program (*depth*)
   In accordance with the 2012 Technical Guideline, the MCH services guaranteed by Jampersal include: four antenatal care visits, normal delivery or with complications, postnatal care for mothers and newborns, referral services and postnatal family planning services.

   The completeness of MCH services guaranteed by Jampersal is assessed based on the number of claims that cover all MCH services included in the Jampersal package. This information was obtained from the providers' data and from the district health office.

   This approach could have some drawbacks, including:

- Not all districts could provide complete individual claims data on Jampersal, so purposive sampling was applied to see the completeness of MCH services acquired by the patients. This method cannot produce direct proportion of complete service. Nonetheless, this method will provide an overview of the actual utilization of MCH services under the Jampersal program

4. Jampersal effectiveness in increasing MCH services utilization
   Comparison of MCH service coverage before and after 2011, when Jampersal was launched could depict any increase in MCH service coverage during the Jampersal implementation. District level MCH data were used to assess the following indicators:
   - Coverage of antenatal care services (K1 and K4)
   - Coverage of normal delivery assisted by skilled birth attendant
   - Coverage for delivery with complications, including cesarean section
   - Coverage of postnatal care service
   - Coverage of postnatal family planning service

Qualitative Data Analysis

Qualitative data analysis was done by using the method of content analysis. Interviews were converted into transcripts. Thematic analysis using interview matrix was done to map the content of each interview answer based on the qualitative instrument. Context units were developed based on observation on the local conditions, the role and the reality on the ground at the time of the interview or FGD.

Qualitative data obtained through in-depth interviews and focus groups were translated into transcripts by researchers at each university. Each researcher completes the verbatim transcript with interview context, which contains information about the condition at the time of the interview, observation, interview setting, and explanation on the role of each of respondent and other data related to the interview process.

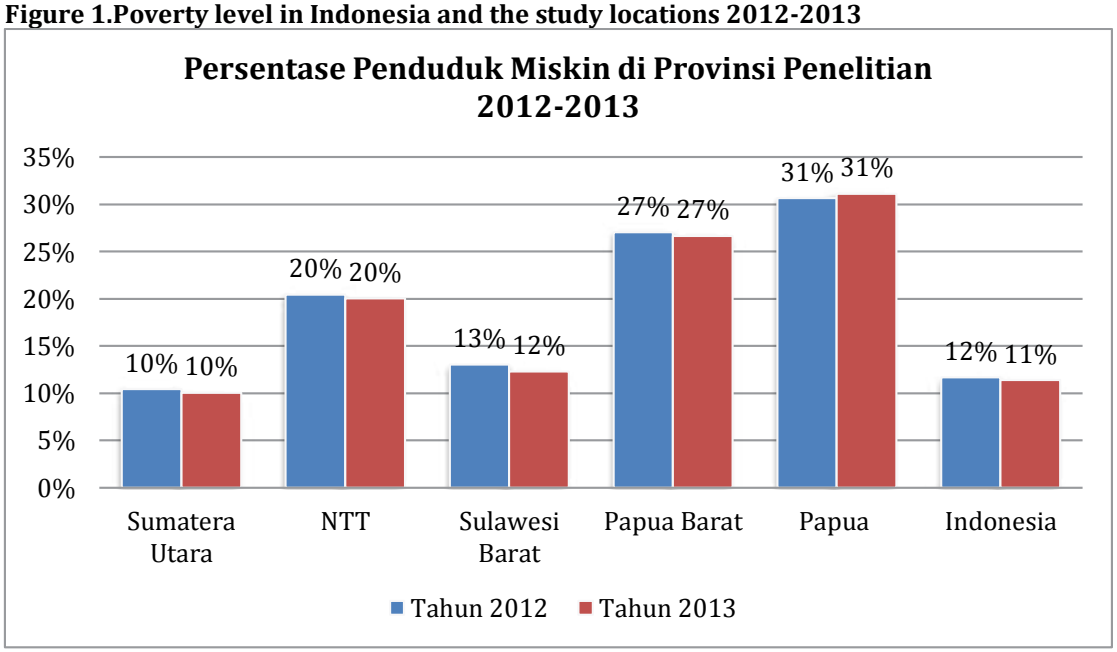
Once the transcript is composed, researchers identified the content unit in accordance with the expected response of each research question. Researchers completed the interview matrix with the identified content units. Matrix analysis is a method of thematic analysis (deductive), which is used to map the findings based on a predetermined theme. This method has the limitation of not capturing phenomenon outside the specified themes. This drawback was overcome by creating new theme coding in addition to the predetermined matrix, while carefully crosschecking the transcripts. Instruments and thematic matrix are included in the appendix.

Overview of Study Locations' Health and Socioeconomic Situation

Health and Socioeconomic Indicators
(refer to local universities' reports)

Poverty Level

Figure 1.Poverty level in Indonesia and the study locations 2012-2013



Source: BPS 2013

Indonesia has high poor population. 2013 data from the Indonesia Central Bureau of Statistics showed there are approximately 28.07 million poor population or 11.37% of the total Indonesia population. There has been a decrease in the percentage of poor population from 2012-2013, with most of the provinces showing similar trends. Nusa Tenggara Timur Province had a 0.38% decline, North Sumatera with 0.37% decline, West Sulawesi with 0.69% decline, and West Papua with 0.37% decline. However, there are provinces showing increase in the number of poor population, Papua province included in this category.

In comparison with the national level of poor population, four out of five provinces where this study was conducted are worse-off (Papua, West Papua, and West Sulawesi and NTT). Papua, West Papua and NTT provinces have much higher level of poverty, with higher than 20% poor population.

Results

Data and Study Respondents

Quantitative Data: Data Limitation and Challenges

- Data sources
  - Pregnant women and deliveries target coverage figures were obtained from district health offices. For Jayapura and Merauke district, the coverage targets were obtained from the Provincial Health Office.
  - MCH service coverage, coverage of participating health providers and the recapitulated Jampersal claims data were obtained from the district health office
  - By-name claims data were obtained from the district health offices and primary health centers.
  - Data on health facilities and human resources were obtained from the district health offices and district hospitals

- Data limitation
  - In several districts, figures used as target coverage and actual service provided were the same. This could lead to an underestimation of actual population target in the districts
  - MCH service coverage, Jampersal recapitulated claims data are scattered between the district health offices and district hospitals, with very little data pooling between the two institutions
  - By-name Jampersal claims data were compiled by each service providers. These data were verified by the district health office through validation of relevant evidence including the MNCH book, identity cards and partographs. The research team did not conduct further verification of the data

- Quantitative data validation was conducted through 2-days workshop in Yogyakarta. Research team discussed missing data and conducted cross-checks to verify the data, particularly for abnormal data, such as decrease in coverage target from the previous year and inconsistent Jampersal recapitulated data.

Qualitative Data: Respondents list and study limitation

District	**Respondents who were unavailable for interview**	
	Institution	
Jayapura	a. District health office	Midwives' association coordinator
	b. Hospital	Obstetricians
		Jampersal manager
	c. Primary health center	Private practice midwife
	d. Community	FGD with women of non-Jampersal users in rural area
Merauke	a. District health office	Health service coordinator was represented by MCH coordinator
	b. Hospital	General Practitioner
	c. Primary health center	Private practice midwife

District	Respondents who were unavailable for interview	
	Institution	
	d. Community	FGD with women of non-Jampersal users in rural and urban areas
Manokwari	a. District health office	Head of DHO
		Health service coordinator was represented by health promotion coordinator
	b. Hospital	Jampersal manager
		General practitioner
		Private practice midwife
Mamasa	a. Hospital	Director
		Finance manager
		Private practice midwife
		Obstetricians
Mamuju Utara	Hospital	Finance manager
Alor	a. District health office	Midwife association coordinator was represented by the secretary
	b. Hospital	Director was represented by the general secretary
Manggarai	a. District health office	Head of DHO was represented by the MCH coordinator
		Health service coordinator was represented by health promotion coordinator and insurance coordinator
	b. Hospital	Hospital director was represented by nursing coordinator
Timor Tengah Selatan	a. Hospital	Finance director was represented by the treasurer
		Obstetrician
	b. Community	FGD with women of non-Jampersal users in rural and urban areas
Nias	a. District health office	Health service coordinator was represented by health promotion coordinator
	b. Hospital	Finance manager
		Private practice midwife
	c. Community	FGD with women of non-Jampersal users in rural and urban areas
Nias selatan	a. District health office	Midwife association coordinator
	b. Hospital	Finance manager was represented by the treasurer
		Private practice midwife
		Obstetrician

The unavailability of the respondents for interviews was caused do the following reasons:

- Absence from work or was not located in the district during the data collection period
- Unwillingness for an interview
- Respondents believe that others in her/his institution is more informative on Jampersal subject, so should be represented by others
- There was no private practice midwife in Jayapura, Merauke, Manokwari and Mamasa districts

- Difficulty in identifying women who do not use Jampersal in a number of areas
- Timor Tengah Selatan: Only four women identified as not using Jampersal, the FGD was altered to be in depth interview

Additional Respondents

In addition to interviews and FGDs with the target respondents, researchers adapted to the development during the data collection, and changes were made in identifying the target respondents. The additions were made if the respondents were perceived as useful informants, even though previously not considered as the main target respondents. The following are the additional respondents included in the study:

a. Manokwari district;
   - Primary health center: Midwife coordinator and coordinator for delivery room (rural area), midwife coordinator and Jampersal manager (urban area)
b. Alor district:
   - District health office: Head of Finance Department
   - Hospital: Health service sub-unit director
   - Primary health center (PHC): Head of PHC (urban and rural areas), auxiliary midwife in rural area
c. Manggarai district;
   - Primary health center: Head of PHC (rural areas) auxiliary midwife in rural and urban areas
d. Timor Tengah Selatan district;
   - Primary health center: Midwife coordinator in rural area, head of PHC in urban area
e. Nias district;
   - Primary health center: Head of PHC in rural and urban areas and midwife coordinator in rural area
f. Nias Selatan district;
   - District health office: human resource for health development (Pengembangan Sumber Daya Kesehatan – PSDK) unit manager

1. Analysis ResultsImplementation and Utilization

Proportion of population covered under the Jampersal scheme

The implementation and health service utilization under the Jampersal program can be divided into five services:

(1) antenatal care;
(2) normal delivery assisted by skilled birth attendant;
(3) postnatal care covering post-partum and neonatal care;
(4) postnatal contraception; and
(5) emergency obstetric care.

Tables 1a-1e each shows coverage for the aforementioned services under the Jampersal program in study locations.

Jampersal coverage of antenatal care for population without insurance card

Table 1a.Jampersal coverage for antenatal care, 2011-2012

	Absolute number of Jampersal claims for antenatal care[1]		Estimated absolute number of pregnant women not insured in other health schemes[2]		Number of required ANC for uninsured pregnant women [3]		Jampersal coverage for antenatal care for uninsured pregnant women	
	2011	2012	2011	2012	2011	2012	2011	2012
Nias	0	5326	2531	2753	10123	11012	0.0%	48.4%
Nias Selatan	6042	10106	8556	7990	34223	31960	17.7%	31.6%
Mamuju Utara	1489	1489	2699	2703	10797	10810	13.8%	13.8%
Mamasa	2824	2824	2764	2766	11056	11066	25.5%	25.5%
Alor	2629	5466	3846	4778	15384	19111	17.1%	28.6%
TTS	0	5183	10780	10932	43121	43728	0.0%	11.9%
Manggarai	0	6515	7336	7456	29345	29825	0.0%	21.8%
Jayapura	no data	682	3341	3441	13366	13764	No data	5.0%
Merauke	5860	92	3544	3662	14175	14646	41.3%	0.6%
Manokwari	2254	957	3319	3735	13275	14942	17.0%	6.4%

[1]Data from recapitulated district Jampersal claims for antenatal care 2011-2012

[2]Proportion of uninsured pregnant women (from Susenas 2011) times the number of targeted pregnant women in 2012

[3]Estimated number of ANC visits required for uninsured pregnant women, with the assumption of a minimum four ANC visits for each pregnant woman

Table 1a. shows the percentage of antenatal care services that were covered under the Jampersal scheme in 2011-2012 in the ten study locations. The coverage figures were calculated under the assumption that each pregnant woman require at the minimum four antenatal care visits during the course of pregnancy.

In 2011, almost all districts had low Jampersal coverage for antenatal care, ranging from 0-22%, except for Alor and Merauke districts that had 60% coverage. The possible explanation of the low coverage level in 2011 is because Jampersal was just launched in middle 2011, and that the registration did not differentiate between those covered with Jampersal and other means of payment.

Regardless of the above explanation, even in 2012 most of the study sites had low antenatal coverage level for Jampersal program. Three districts located in Papua and West Papua provinces had less than 10% coverage and even less than 1% in Merauke district. The low absolute number of Jampersal claims for antenatal care in these districts was the cause of the low coverage. Other explanation includes the incomplete visits of ANC, i.e. most women

had less than four visits during the pregnancy. This phenomenon was observed in detail through the by-name claims data.

Figure 1a. Jampersal coverage for antenatal care, 2011-2012

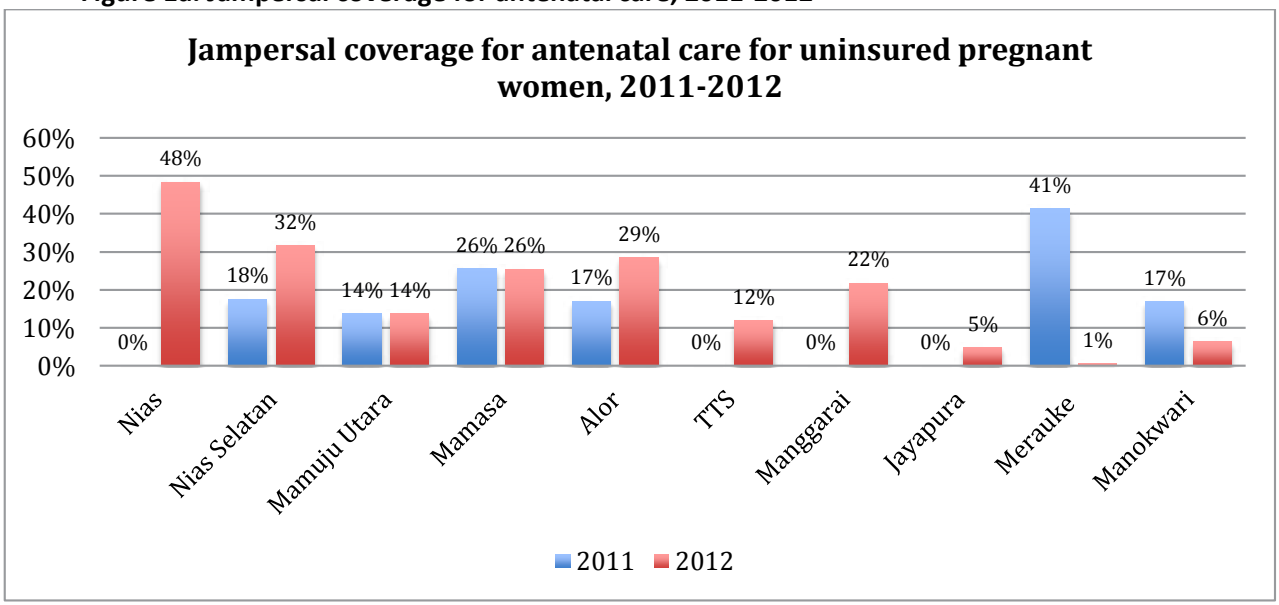


Figure 1a shows increases in antenatal care coverage under the Jampersal program in several districts, i.e. Nias, Nias Selatan, Alor, Manggarai, and Jayapura districts. However, Mamuju Utara, Mamasa and Merauke districts did not experienced a significant increase of antenatal care coverage under the Jampersal scheme, indicating that Jampersal was not fully utilized by the target population or pregnant women still pay out-of-pocket payment for the services. In addition, study districts located in West Papua (Manokwari) and Papua (Merauke) provinces had a decrease of coverage in antenatal care.

Qualitative findings showed that there are still cases in which pregnant women only visited health facilities close to childbirth (7-8 months gestation). ANC utilization is influenced by the availability of personnel and accessibility of the health facilities (especially for women in remote areas). Mothers living in difficult areas still prefer to go to traditional healers (shaman) during pregnancy.

Furthermore, targeted Jampersal beneficiaries (pregnant women - maternity - new mothers) generally have not received complete package of services in the two districts located in Papua province (Merauke and Jayapura). The majority of services provided by health professionals limited to antenatal care (antenatal care) - mostly in the form of K4, deliveries in health facilities and postnatal care.

> *" ..as people in the field, we only see K4 visits at the most. Except for the health centers with active midwives who would screen pregnant women diligently. But only for normal delivery... " (a general practitioner on duty at remote health centers of the district in the province of Papua)*

Another factor that could potentially hinder Jampersal services is the delayed reimbursements to health care providers. The delays could serve as a disincentive for health care providers, resulting in providers reducing the number of claims through Jampersal and

preferring to charge pregnant women directly where they would be in a position to pay (while initially still offering Jampersal service).

In the qualitative findings in South Nias regency, low utilization was caused by several things, including; women not knowing about the Jampersal program; and women without ID cards would tend to visit private-practice midwives or traditional healers. As expressed by one of the staff in Nias Selatan district hospital;

> *" .... Then when we asked for paperwork, ID card or family card, sometimes there are still people here, in this district that do not have any legal documents, no ID card, family card ..."*

There is also a community perception that is shameful to use the Jampersal schemes, and that services under the program are of lower quality and untimely, that they would be provided with the wrong drugs and long administrative process. As was expressed by some FGD respondents:

> *"….usually such free-of-charge services, bad medicine and lengthy bureaucratic stuff, so I'm not interested…. She (midwife) offered me (the service), but well I was not interested…"*

Table 1b. Jampersal coverage for normal delivery assisted by skilled birth attendant, 2011-2012

	Absolute number of Jampersal claims for normal delivery[1]		Estimated absolute number of pregnant women not insured in other health schemes[2]		Jampersal coverage for normal delivery for uninsured women	
	2011	2012	2011	2012	2011	2012
Nias	no data	1385	2628	2628	No data	52.7%
Nias Selatan	3021	3678	8238	7627	36.7%	48.2%
Mamuju Utara	1217	1217	2070	2158	58.8%	56.4%
Mamasa	1268	1268	2764	2766	45.9%	45.8%
Alor	1281	1755	3699	4073	34.6%	43.1%
TTS	0	1373	10290	10429	0.0%	13.2%
Manggarai	0	2361	7003	7117	0.0%	33.2%
Jayapura	0	1583	3190	3285	0.0%	48.2%
Merauke	1335	913	3383	3380	39.5%	27.0%
Manokwari	0	1090	3168	3307	0.0%	33.0%

[1]Data from recapitulated district Jampersal claims for normal delivery 2011-2012

[2]Proportion of uninsured pregnant women (from Susenas 2011) times the predicted number of deliveries in 2012

[3]Estimated number of normal delivery service required for uninsured pregnant women, with the assumption of a one normal delivery for each pregnant woman

Table 1b shows the percentage of coverage for services Jampersal normal delivery attended by skilled health personnel in the ten study sites. For 2012, the coverage for normal delivery under the Jampersal program was higher than the antenatal coverage. A number of districts (Nias, Nias Selatan, Mamasa, Mamuju Utara, and Jayapura) had coverage around or above 50% for women giving birth who do not have health insurance. This suggests that the Jampersal can help in improving access to health services for women. However, this coverage is still low, with only covering half of the pregnant women who do not have health insurance. Furthermore, some districts have even lower coverage, i.e. in Alor (43.1%), Timor Tengah Selatan (13.2%), Manggarai (33.2%), Merauke (27%), and Manokwari (33%).

Based on the interviews with both management and technical staff at the Department of Health and Hospitals, Jampersal was perceived to be very effective in improving the demand side, especially among the poor families. Women who come from poor families are concerned with the high payment burden at health facility. With the Jampersal program, midwives are able provide information about the free of charge care, if the women are willing to utilize routine prenatal care and have deliveries at health facilities.

> *"... this Jampersal is a good program. The MNCH revolution program has attempted to encourage facility deliveries. Before the Jampersal program, it was difficult to encourage antenatal care visit or facility delivery to the community..." (Puskesmas in NTT)*
>
> *"Actually, this program is very helpful for the society and also for us, because it was usually difficult for improving facility-based delivery. They would rather go to a shaman because of the high service fees... " (Head of Family Health at one district in NTT)*
>
> *"This Jampersal program is good, women can get free maternal care. Especially in our own primary health center, Jampersal is very good, particularly for the indigenous people who are not financially capable. " (Puskesmas located remotely from district capital in Papua)*
>
> *"This Jampersal is a good program, because it encourages the community to visit primary health facilities. The previous fear is on the costs of the services. But the community takes it for granted that all services are free, while there is no coverage for transportation costs and also baby clothing..." (Puskesmas located near the capital city of Papua)*

Figure 1b. Jampersal coverage for normal delivery assisted by skilled birth attendant (SBA), 2011-2012

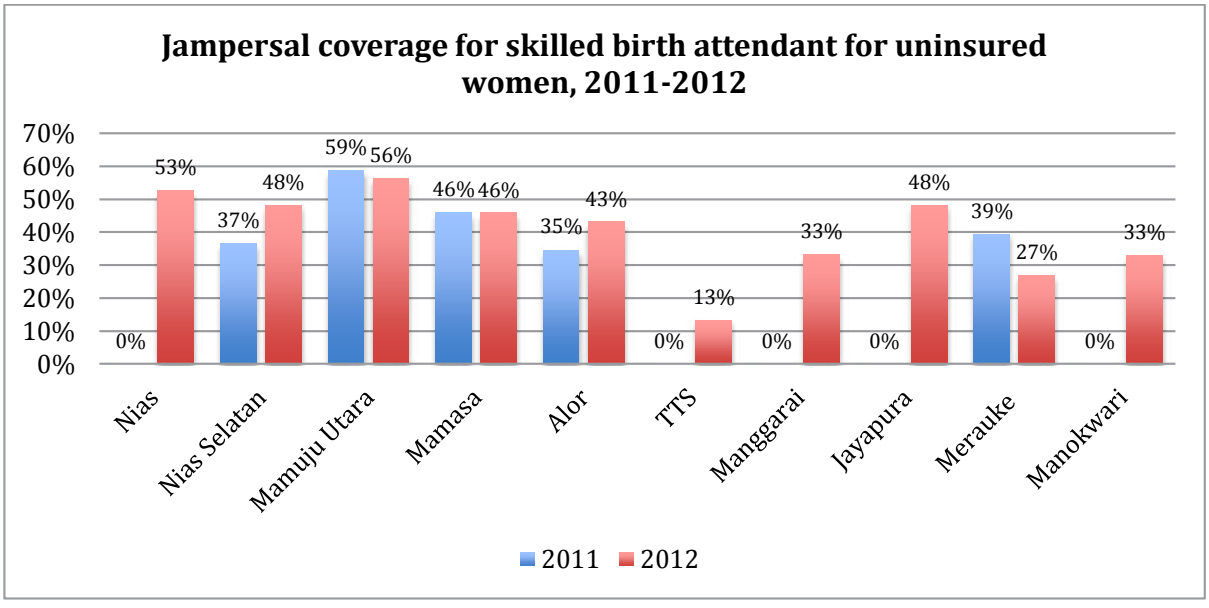


Figure 1bshows the trend in Jampersal coverage for SBA 2011-2012. The graph shows an increase in all study sites. In 2011, some of the study sites had 0% coverage, i.e. Timor Tengah Selatan, Manggarai, Jayapura and Manokwari districts. This may have been due to the possibility that during the earlier stage of the program implementation, the claims were not yet differentiated between claims under the Jamkesmas, Jampersal or out-of-pocket payment.

The coverage for normal delivery under the Jampersal program was higher compared to antenatal care services. It was shown by the higher number of claims used only for normal delivery and that there were incomplete antenatal care visits. The analysis of the completeness of the services provided under the Jampersal program is discussed further in detail in table 2.

Perception of the Jampersal users towards service quality

Qualitative findings showed that most of the Jampersal population target was satisfied with the normal delivery services received in ten study sites. The level of satisfaction was particularly influenced by the attitude of health workers who assisted the deliveries. In general, Jampersal users did not make an issue out on the types of drugs administered or the services provided. Most of the pregnant women prefer midwives or health facilities that are already familiar.

> *“I am satisfied, the baby is healthy, and I don’t have to pay... the conditions were simple as well, midwife service was good...” (FDG respondent in Manggarai district, NTT)*

> *"Although labor costs are very helpful, we were not satisfied, because the maternity room and the health facility is lacking.... too crowded... and there was also additional costs to buy diapers and medicine. Midwife here has served well, 24 hours, midwives also excellent in serving patients ... " (FGD respondent in Manokwari, West Papua)*

Although most of the target population have been using Jampersal, but there are still a fragment of population groups who are not willing to use Jampersal scheme. Qualitative findings in Nias and South Nias show that, for people who did not use the program because there is a presumption that Jampersal services at health centers and public hospitals are less good, incomplete health facilities, and the long waiting time as well as the drug issues and prolonged administration process. In addition to the above perception, a large number of Nias and Nias Selatan community still prefer to visit the traditional birth attendants for the delivery process.

Table 1c. Cakupan Jampersal untuk Layanan Postnatal Care, 2011-2012

	Absolute number of Jampersal claims for postnatal care		Estimated absolute number of pregnant women not insured in other health schemes[2]		Jampersal coverage for postnatal care for uninsured women	
	2011	2012	2011	2012	2011	2012
Nias	0	4359	2628	2628	0.0%	41.5%
Nias Selatan	6042	9334	8238	7627	18.3%	30.6%
Mamuju Utara	4049	4049	2070	2158	48.9%	46.9%
Mamasa	344	344	2764	2766	3.1%	3.1%
Alor	4216	8136	3699	4073	28.5%	49.9%
TTS	0	5105	10290	10429	0.0%	12.2%
Manggarai	0	10302	7003	7117	0.0%	36.2%
Jayapura	0	1840	3190	3285	0.0%	14.0%
Merauke	0	95	3383	3380	0.0%	0.7%
Manokwari	0	1455	3168	3307	0.0%	11.0%

[1]Data from recapitulated district Jampersal claims for postnatal care 2011-2012
[2]Proportion of uninsured pregnant women (from Susenas 2011) times the target number of deliveries in 2012
[3]Estimated number of postnatal care required for uninsured pregnant women, with the assumption of four visits for each pregnant woman

Table 1c. Shows the Jampersal coverage for postnatal care in 2011-2012. Postnatal care consists of four visits, i.e. two postnatal visits for postpartum women and two neonatal visits. However, based on the claims data, most of the study sites do not provide complete postnatal care. Hence, the low utilization of postnatal care in all study sites with less than 50% coverage.

Figure 1c. Jampersal coverage for postnatal care, 2011-2012

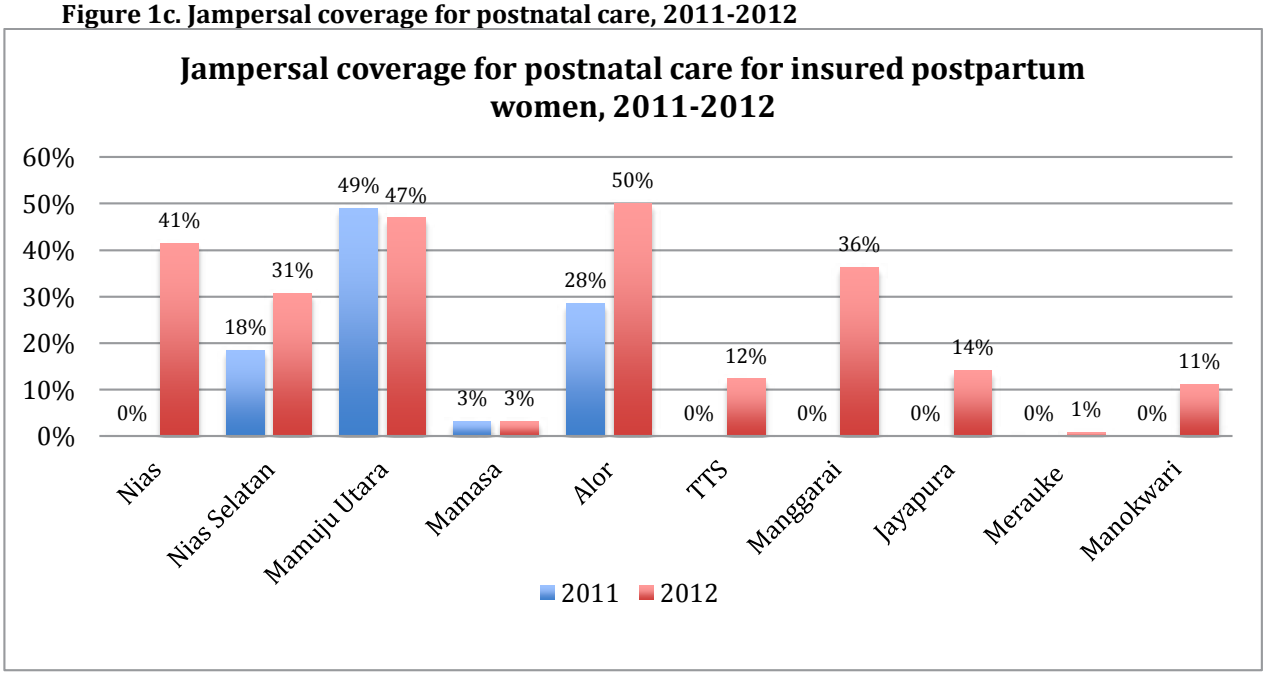


Figure 1c shows a relative increase in the Jampersal coverage for postnatal care visits from 2011-2012 in almost all of the study sites. This increase means that there were higher program utilization rate for postnatal care in 2012 compared to when the program was launched in 2011.

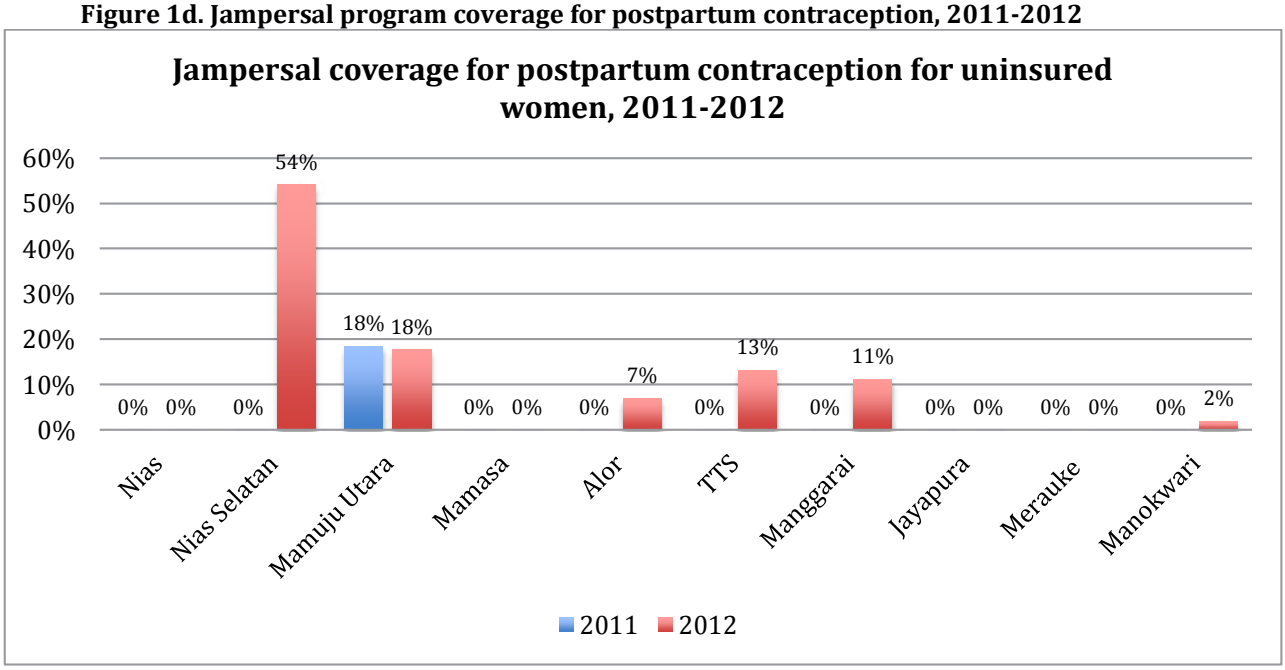
Table 1d. Jampersal coverage for postpartum contraception, 2011-2012

	Absolute number of Jampersal claims for postpartum contraception		Estimated absolute number of pregnant women not insured in other health schemes[2]		Jampersal coverage for postpartum contraception for uninsured women	
	2011	2012	2011	2012	2011	2012
Nias	0	0	2628	2628	0.0%	0.0%
Nias Selatan	no data	4120	8238	7627	no data	54.0%
Mamuju Utara	381	381	2070	2158	18.4%	17.7%
Mamasa	no data	no data	2764	2766	no data	no data
Alor	0	285	3699	4073	0.0%	7.0%
TTS	0	1373	10290	10429	0.0%	13.2%
Manggarai	0	790	7003	7117	0.0%	11.1%
Jayapura	0	no data	3190	3285	0.0%	no data
Merauke	0	no data	3383	3380	0.0%	no data
Manokwari	0	218	0	11277	0	1.9%

[1]Data from recapitulated district Jampersal claims for postpartum contraception in 2011-2012
[2]Proportion of uninsured pregnant women (from Susenas 2011) times the number of deliveries in 2012
[3]Estimated number of postpartum contraception required for uninsured pregnant women, with the assumption of a one postpartum family planning service for each postpartum woman

Table 1d shows the coverage of Jampersal program for postpartum family planning services for uninsured women. The Jampersal program explicitly stated that the postpartum contraceptive is part of the benefit package. However, as is seen from the above table, most districts have very low coverage level for the service. Only Nias Selatan has coverage that is above 50%, while other districts range between 0% and 18%. Based on the analysis of the claims data, some districts do not integrate the records of postpartum care into Jampersal program claims, leading to a potential underestimation of the coverage.

Figure 1d. Jampersal program coverage for postpartum contraception, 2011-2012



Family planning (KB) program aims to improve the welfare of family and society so that every individual can thrive and contribute optimally for the community. This program is implemented through several initiatives, one being the Jampersal program. Based on the qualitative findings of this study, postpartum family planning is not a mandatory service but

is optional for postpartum women (health providers should offer the service and the women would decide to use the service or not). Most of health providers (midwives and doctors) in the ten study sites stated that the coverage for postpartum family planning is still low. The main contributing factors include the local tradition, the preference to have more children, the concern of the procedure itself and factors from the husband or extended family who would suggest postponing using contraception.

> *"The patient refused to use contraception, the family also declined due to the local culture 'Atoin Amaf' (any decision should be made with the approval from respected family member or the extended family)..." (A hospital doctor in NTT)*

> *"People refuse …especially for permanent method... During the last period of puerperium, we suggest for postpartum contraception, but some say to wait first... and when they came back, the women is already pregnant again". (a midwife working at a primary health center in NTT)*

> *"Yeah, sometimes the same family does not give permission and said should wait for the next period (menses), or because the child is still young, we always motivate them to join the family planning program as early as possible" (a midwife in primary health center located far from the district capital in Papua province)*

The postpartum family planning program Nias and Nias Selatan districts has not gone well. Postpartum family planning is one of the services covered under the Jampersal scheme, thus health providers are expected to provide the service. However, the program has not been well accepted among the community. Some of the causes include:

- Families prefer to have both female and male children. If the family has not have a pair of children, then husband and wife tend to keep on trying
- Some women who use postpartum family planning service complained that the program is physically very inconvenient and can cause diseases
- The common perception among the community that the Jampersal program would cover for all children anyhow, regardless of the amount of children. Thus, there is no need to limit the number of childbirth

> *"... It was already advised that the patient should use postpartum contraception, but the patient reply was "it's OK, the service for delivery is free anyhow. And the doctors would serve us well. No differentiation whatsoever, so it's really great...." (A health provider at a district hospital)*

Table 1e. Jampersal program coverage for obstetric complications, 2011-2012

	Absolute number of Jampersal claims for complicated obstetric care		Estimated absolute number of complicated obstetric cases among pregnant women not insured in other health schemes[2]		Jampersal coverage for complicated obstetric care for uninsured women	
	2011	2012	2011	2012	2011	2012
Nias	0	0	2628	2628	0.00%	0.00%
Nias Selatan	no data	0	8238	7627	no data	0.00%

	Absolute number of Jampersal claims for complicated obstetric care		Estimated absolute number of complicated obstetric cases among pregnant women not insured in other health schemes[2]		Jampersal coverage for complicated obstetric care for uninsured women	
	2011	2012	2011	2012	2011	2012
Mamuju Utara	-	-	2070	2158	no data	no data
Mamasa	128	128	2764	2766	30.87%	30.85%
Alor	0	0	3699	4073	0.00%	0.00%
TTS	0	22	10290	10429	0.00%	1.41%
Manggarai	0	no data	7003	7117	0.00%	no data
Jayapura	0	no data	3190	3285	0.00%	no data
Merauke	0	no data	3383	3380	0.00%	no data
Manokwari	0	0	3168	3307	0.00%	0.00%

[1]Data from recapitulated district Jampersal claims for complicated obstetric care 2011-2012
[2]Proportion of uninsured pregnant women (from Susenas 2011) times the target number of deliveries times 15% in 2012 (estimated proportion of complicated obstetric cases)
[3]Estimated number of expected complicated obstetric care among the uninsured women, with the assumption that 15% out of deliveries are complicated and would require obstetric care

Table 1e shows the Jampersal program coverage for complicated obstetric care services in 2011-2012. The number of complicated delivery was calculated using the global assumption that 15% of deliveries are complicated cases. This percentage is derived from international standard based on globally published researches. Data from table 1e show the low rate of utilization of the Jampersal program for delivery complications, where most study sites have 0% coverage, except for Mamasa district (30.9% coverage). It is important to note that most study sites have not adopted sound recording and reporting of complicated obstetric cases, which may lead to substantial under-reporting of cases.

Figure 1e. Jampersal program coverage trend for complicated obstetric care, 2011-2012

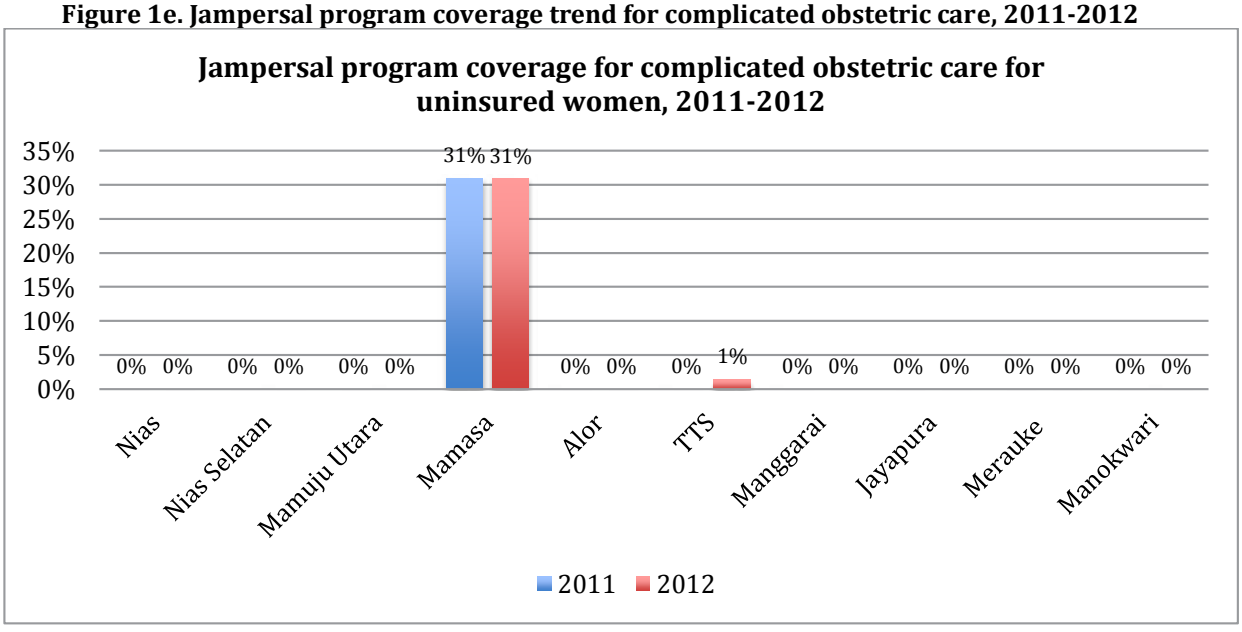


Figure 1e shows that the trends in complicated obstetric care in all study districts remained low between 2011-2012. The possible explanation is the low rate of case referral due to the lack of referral system, the limited knowledge among birth attendants in handling complicated cases or the limited knowledge that Jampersal can actually cover for case referral and emergency obstetric cases.

Qualitative data, however, show different findings. The majority of health providers at both the district health office and hospital stated that the Jampersal program is very effective in improving the case referral. Jampersal has provided the means for women to acquire better care at higher health facilities. The issue is that Jampersal has not been covering for transportation cost. Some primary health centers could use their operational budget to transfer patients to the district hospital.

All study districts in Papua (Manokwari, Jayapura and Merauke) already have district hospitals that receive referred cases from primary health centers and private health practices. The referral process is claimed to be well managed. Jayapura district hospital (Yowari hospital) receives referred cases not only from the surrounding primary health centers, but also from the highland districts. The common problem in Yowari hospital is that patients often do not bring any referral letter from primary health centers and other administrative requirement for the reimbursement of the health insurance. Yowari hospital also has established an agreement with the Dok II hospital in the capital city and Abepura hospital, so that obstetric case overload can be referred to the larger hospitals (Yowari hospital has only one obstetrician).

> *"Our referral system also receives cases from the highland areas. Referred cases from the surrounding Jayapura primary health centers have been well managed. There is no significant problem, but we do only have one obstetrician, so it is a problem if the doctor is out of town. So then we would have to refer the cases to the city, Abe or Dok II (hospitals)..." (hospital director)*
>
> *"As far as I know, this Yowari hospital receives referred cases from the primary health centers or auxiliary Puskesmas and also from the highland areas. We have one obstetrician who can handle complicated delivery cases." (a general practitioner at district hospital)*

Financial reimbursement for referral cases can be claimed to Jamkesmas, Jamkesda or Jamkespa (if there were non-native Papua patients need to be referred, then Jamkesmas can be used or the patient will have to pay out-of-pocket). The following statements show that Yowari and Manokwari district hospitals do not implement the Jampersal financial scheme:

> *"In the referral process, we in Yowari use Jamkesmas for maternal services because we do not implement Jampersal here." (hospital director)*
>
> *"If there is a referral from the primary health center, we would treat it using Jamkesmas. Those without the card and happened to be Papuan native, will be treated using the Jamkespa or Jamkesda" (a general practitioner in the hospital)*
>
> *"Because here we do not implement Jampersal, so for native Papuans we would use Jamkespa or Jamkesda. For non-native Papuans, we would use the Jamkesmas, unless if the patient is able to pay…" (hospital insurance schemes managers)*

Merauke hospital already use Jampersal scheme to finance referred patients. There is one problem associated with financing Jampersal in Merauke that is not covering the transportation costs. Thus patients often could not return to their homes.

> *"…there is one drawback in the referral mechanism, when referred patient is sent back to the primary health center or his/her home… often the patients could not afford the costs for transportation … when it's not the hospital's responsibility anymore." (hospital director that has been implementing the Jampersal program)*

Challenges that arise from the user's side Jampersal in NTT is that most people do not understand the requirements for Jampersal, especially for referral cases. Often patient's family does not have complete documents for Jampersal administration, becoming a challenge for the administrators. In relation to the overall referral system, hospital doctors stated that the system should be improved, where normal deliveries should take place at the primary level. In general, aspects that could be improved include; development of better referral manual specifying types of procedures and at which level of care; there needs to be better socialization to the target population (socialization on the scope of services, administrative requirements); better job descriptions and delegations among staff in each health institution, and; the need to adjust the current incentives for health service providers.

> *"(should) use referral system manual, grouped by risk group... For referred patients with hemorrhage, there should be initial communication prior to the referral with the hospital (referral hotline) on the patient's condition" (the doctor on duty at the hospital)*

In general, Jampersal program is considered to be very effective in supporting the referral process in NTT province. The existing referral system in Alor is relatively similar to the referral process in Manggarai and Timor Tengah Selatan districts. There were four perinatal referral cases from Alor district hospital to the provincial hospital in Kupang. The effort to bring pregnant women to birth facilities in timely manner has often face obstacles and would potentially cause maternal and neonatal deaths. The main challenges found in NTT relate to the geographical access. Most of Alor, Manggarai and Timor Tengah Selatan districts are highland areas, with limited transportation accessibility. The limited access is one of the reasons to prefer traditional birth attendant over facility-based delivery. If complication arose, the pregnant woman would be brought to the local midwife and finally to the local hospital. However, usually the women or newborns condition was already severe and unsuccessfully resuscitated.

The in depth interviews show that Jampersal has helped with the referral process, particularly for perinatal emergency cases. However, some families would refuse the referral due to the costly transportation fee, regardless that the health services are provided free of charge.

> *" ... Very effective... very, very helpful, especially for poor people who do not have other insurance coverage such Jamkesmas... " (Nursing coordinator, as a representation of hospital director)*

Qualitative findings reveal the use of Jampersal for referral purpose has been successful in Nias and Nias Selatan districts. Patients were able to be referred to higher level health facility. However, there are still obstacles in the referral management where many midwives

are still unfamiliar with the referral manual. Hence, patients were referred in unstable condition due to severe complications. Health workers often try to handle the patients at the primary health centers as much as possible. But if the patient's condition worsened, case referral would be done. As was stated by a midwife working in Nias district hospital:

> *"… (patients) are referred to the hospital only after the condition is at its worst. We had one yesterday, a midwife referral, gave birth at the midwife's house, but was referred in very severe state, and the patient died en route to the hospital due to hemorrhage…"*

2. Benefit package under Jampersal program

The Jampersal Technical guideline stresses the importance of the completeness of the benefit package for maternal and neonatal health services. This part of the report uses the by-name Jampersal claims data acquired from the study sites. Data were collected from nine out of the ten study locations, while no data were available from Manokwari district.

Jampersal claims data were gathered from several primary health centers visited during the data collection phase and from the district health offices. The claims data provide an overview of the completeness of the benefit package received by the patients.

Several challenges in this analysis include: (1) the unavailability of complete Jampersal claims data at the district health office, regardless that the technical guideline statement that all claims should be pooled at the district health offices, (2) differences in the claims format, where some services are not included in the claims forms. This include the postpartum contraception and complicated obstetric care services. Even though the Jampersal technical guideline provides a clear format for the claim forms, some district health offices still use inconsistent format.

Other consideration in interpreting this analysis is the different timing of the submissions of the claims data. For example, monthly claims submission could result in double reporting of a patient, providing false impression of incompleteness of the benefit package received by the patient. Other difference in reporting format includes the separation of postpartum family planning claims from the Jampersal claims format.

Table 2 shows the level of the benefit package completeness in the study sites, using the following description for the analyses:

- Complete benefit package that includes 4 ANC visits, normal delivery assisted by skilled birth attendant, postnatal care and neonatal visits, and postpartum family planning services
- Complete benefit package as above, without postpartum family planning services
- Claims of only for normal delivery
- Complete 4 ANC visits
- Incomplete ANC visit, i.e. 1-3 visits
- Pre referral care only
- Postpartum family care only

Table 2.Jampersal benefit package completeness

	Number of sample for Jampersal by-name claims data[1]	Complete benefit package without postpartum family care service (4 ANC, normal delivery, postnatal visits)[2]	Complete benefit package including postpartum family planning service[3]	Normal delivery only[4]	Complete ANC visits [5]	Incomplete ANC visits (<4 visits)[6]	Pre referral care service[7]	Postpartum family planning service[8]
Nias	403	0	0	84	0	2	168	0
Nias Selatan	719	0	0	271	0	0	402	68
Mamuju Utara	463	0	0	148	0	23	154	24
Mamasa	490	209	0	178	14	43	43	0
Jayapura	370	86	0	43	20	5	0	0
Merauke	702	8	0	640	12	7	20	0
Manokwari								
TTS	291	256	19	287	256	15	36	19
Manggarai	741	0	0	92	0	29	384	41
Alor	454	18	0	157	6	1	200	13

[1]Number of claims sampled
[2]Number of women receiving: 4 ANC visits, normal delivery, 4 postnatal care visits (postpartum care, neonatal care)
[3]Number of women receiving complete benefit package: 4 ANC visits, normal delivery, 4 postnatal care visits (postpartum care, neonatal care), postpartum family planning service
[4]Number of women receiving normal delivery care only
[5]Number of women receiving 4 ANC visits
[6]Number of women receiving 1-3 ANC visits
[7]Number of women receiving pre referral health service
[8]Number of women receiving postpartum family planning service only

Table 2 shows that only Timor Tengah Selatan district submitted reimbursement cases with complete benefit package (19 cases). The other nine study districts did not recorded any case receiving complete benefit package under the Jampersal program. The data shows that the Jampersal program has not been able to achieve the program objective, which is to provide complete quality care for pregnant and delivering women.

Complete benefit package without postpartum care was only provided for small fragment of women, i.e. 209 cases in Mamasa, 86 cases in Jayapura and 18 cases in Alor districts. Timor Tengah Selatan district was the only district that provided complete benefit package for most of the women under the Jampersal program (256 cases out of 291 claim samples).

Complete antenatal care of four visits during the course of pregnancy was provided only in some of the districts. This indicates that the quantity of the services is still lacking, with possible impact to the overall quality of the Jampersal services. Similar finding applies for the postpartum family planning service, where only few claims applied for the service.

Qualitative findings

Consistent with the quantitative findings, benefit package received under the Jampersal program in NTT province is often incomplete. The majority of services provided were antenatal care, normal facility delivery and postnatal care. Most women do not use postpartum family planning service due to the local traditions and the need to acquire family's approval, even though all women were offered to use the service.

Also in line with the claims data analyses, Jampersal program population target in all study districts have not received complete benefit package in general. The majority of services provided are antenatal care, mostly only for the fourth visit, normal delivery and postnatal care. From the point of view of the patients, women have a pattern for health seeking behavior, influenced by the personality of the health providers (attention given and professionalism), accessibility to the health facility, the amount of possible out of pocket payment (transportation cost, food), the completeness of the medical examination and medication, etc.

Respondents who had been beneficiaries of the program revealed some level of satisfaction with the Jampersal package, and willing to reuse the program. However, Jampersal benefit package was perceived to also cover for transportation cost for referral cases. Based on the findings, health providers do not differentiate treatment given between those using Jampersal and those who pay out of pocket.

a. <u>Financial protection for Jampersal program beneficiaries</u>

The amount for service fee covered under the Jampersal program was determined and stated in the technical guideline. However, findings from all study districts reveal that the amount was perceived to be too small, especially for Papua where prices are high. Apart from the cost of the health care itself, the financial burden is also high due to high transportation costs and other additional expenses. Patients would sometimes have to pay extra to get the health services covered Jampersal. A similar phenomenon was observed in other study districts. In specific context of Papua, the Jamkespa program can serve as buffer program for the Jampersal scheme.

From the point of view of the health system in Papua and Manokwari, the amount covered through Jampersal scheme would sometimes cause dissatisfaction among the health providers, where the amount is not appropriate for the services provided. Most respondents stated that the reimbursement of funds should be faster than the current 1-year reimbursement process.

> *"The common problem is dissatisfaction with the amount. Many have proposed to add the amount. "(Chief Medical Officer in Papua and West Papua)*

Qualitative findings in NTT showed that the nominal amount of the claim paid under the Jampersal scheme also cause dissatisfaction to health care workers who directly serve patients. Nominal received are often not in proportion to the work they have done. This is because the nominal received was adjusted by the portion of the distribution on education level.

> *".. Yes, it is not enough, when compared with the time where we have to stand by for 24 hours." (Midwives working in the health center near the capital).*

Most of the respondents expect that fund reimbursement could be done in shorter period than one year, and the funds should be reimbursable within one, three- or at least six-month period. Currently, based on the observation of this research, fund reimbursement is on yearly basis.

Based on qualitative data collection in Nias, Jampersal patients do not need to pay except for transportation costs and the costs for the accompanying family. Transport costs to health facilities by motorcycles can reach IDR100.000 (roundtrip). Such additional cost is a burden for the family, particularly for the poor. Similar observation was found in Nias Selatan, but some patients would voluntarily provide some money to health workers as a form of gratitude, as expressed by a health worker:

> *"… as a thank you note, here in Nalowa village, there are a lot of poor communities, so we're not expecting too much, some give cash or in other forms, fifty (thousand rupiah), one hundred (thousand rupiah), depends on the awareness and we're not pushing them (to pay)…"*

Transportation cost is still paid by the beneficiaries, particularly for case referrals:

> *"… just some gas money, around two hundred thousand (rupiah)…"*

This additional cost for Jampersal beneficiaries is not in line with the current guideline. The technical guideline stated that transportation costs for case referrals could be paid based on the current standard cost unit, and the district transportation cost. There are some misperceptions on the transportation cost, as was expressed by one of the heads of district health office in Nias Selatan district:

> *" ..we cover for all transportation cost, using (local revenue) APBD, we cannot ask the patients for the money…" (Head of district health office)*

This opinion was supported by the hospital director from Nias Selatan;

> *"…For costs (such as) accompanying family member or for ambulance, those are not covered, so we use our own funding (hospital)…"*

3. Coverage of health providers participation in Jampersal program

Jampersal program success also relies on the participation of health providers for maternal and child health services, including the private sector. Private health providers include the private midwives and clinics or private hospitals.

This section uses the registration data of health care providers who have participated and have cooperation agreement to provide services under the Jampersal program in ten districts Jampersal study sites.

The data in Table 3 below shows that all public health facilities participate in the program, except for Manokwari (33.3%). However, the participation among private providers is still low. This is evident from the data that show most of the clinics or private hospitals did not participate in the Jampersal program. This is also true for private practice midwives in Alor, Manggarai, and Manokwari districts. Some districts did not have any private clinic (Nias, North Mamuju, and Jayapura) or private practice midwives (Nias, South Nias, Mamasa, Jayapura and Merauke).

Table 3.Coverage of health providers in Jampersal program

	Number of MCH service providers participating in Jampersal program									
	Total number of MCH service providers in study districts		Public hospital		Puskesmas		Private hospital/ clinics		Private midwives/ doctors/ practice	
	Total	% Jampersal participation	Total	% Jampersal participation	Total	% Jampersal participation	Total	% Jampersal participation	Total	% Jampersal participation
Nias	11	90.9%	1	100.0%	10	100.0%	0	-	0	-
Nias Selatan	38	100.0%	1	100.0%	36	100.0%	2	50.0%	0	-
Mamuju Utara	11	18.2%	1	100.0%	11	0.0%	0	-	3	66.7%
Mamasa	19	94.7%	1	100.0%	17	100.0%	1	0.0%	0	-
Alor	26	92.3%	1	100.0%	22	100.0%	6	0.0%	2	0.0%
TTS	37	100.0%	1	100.0%	30	100.0%	1	100.0%	5	100.0%
Manggarai	25	88.0%	1	100.0%	21	100.0%	2	50.0%	1	0.0%
Jayapura	21	100.0%	1	100.0%	19	100.0%	-	-	0	-
Merauke	23	95.7%	1	100.0%	21	100.0%	1	0.0%	0	-
Manokwari	44	18.2%	-	-	24	33.3%	2	0.0%	6	0.0%

Jampersal program is implemented in all government-owned health facilities. Challenges arise when the local governments want to involve private health facilities to participate and implement Jampersal program. In order to participate as Jampersal providers, private health facilities should first obtain license to practice in accordance with the local administration processes. Having obtained a license to practice, private providers need to adapt their systems to the Jampersal financial system. Not all private health care facilities can easily adjust to the reimbursement system and that the current service fee provided under the Jampersal program is perceived to be too low.

Private practice midwives and private facilities stated that Jampersal service fee is much too low compared with the actual costs. Private health facilities also have specific market segments, namely women from upper middle class. Based on interviews with health care providers, women from middle socioeconomic groups are emphasizing more on the comfort side of the health service, in which the women are looking for comfortable rooms and well treatment services (friendly attitude, supporting medical facilities).

Based on interviews with several staff at Nias district health offices, there were no private hospitals or private practice midwives who participate in the Jampersal program. This is due to the complicated reimbursement system and lengthy procedure. In addition, service fees are perceived to be too low compared to the efforts for providing health services.

4. Jampersal program effectiveness in achieving program goals

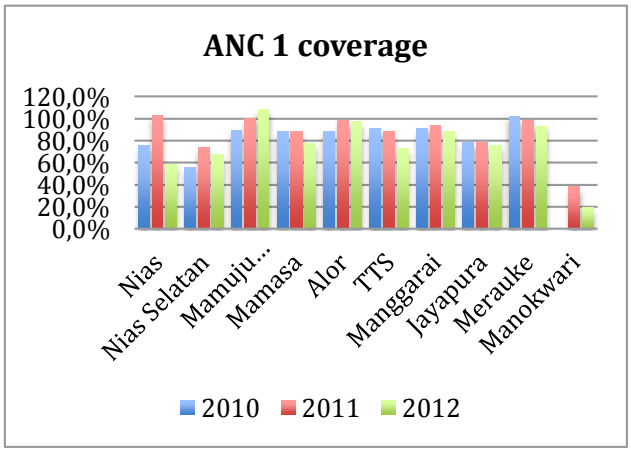
The Jampersal program aims to improve a number of MCH services, namely antenatal care, facility-based delivery and skilled birth attendance rate, postnatal care, post-delivery contraceptives, proper treatment for complicated deliveries and neonatal complications. This section provides information on the changes or trends of the aforementioned service coverage.

Table 4 and Figure 4 show the trend of the first antenatal care coverage (K1) and the fourth (K4) in the ten study sites. First antenatal care service coverage for 2010 ranged from 55% (South Nias) to more than 100% (Merauke), and relatively higher than the national coverage. Merauke district has coverage of more than 100% because there are a number of women who come from outside Merauke and still recorded in the health department registration, i.e. from surrounding districts and from Papua New Guinea. First ANC visit coverage did not show a significant increase between the years of 2010 to 2012, even after the Jampersal program initiation in 2011. Similar trend is applicable for ANC 4 coverage, with a lower number because it is a continuation of the first antenatal services. These data indicate that the implementation of the Jampersal program have not have any impact on the improvement of antenatal care services in the study district.

Table4.Antenatal care coverage (K1 and K4)

	ANC 1 coverage			ANC 4 coverage		
	2010	2011	2012	2010	2011	2012
Nias	75.5%	102.7%	58.7%	67.4%	68.4%	47.3%
Nias Selatan	55.6%	73.9%	67.7%	46.1%	61.0%	57.4%
Mamuju Utara	89.9%	100.0%	108.6%	69.7%	76.6%	81.7%
Mamasa	88.7%	88.7%	77.0%	70.0%	70.0%	68.3%
Alor	88.3%	98.3%	97.4%	71.0%	80.7%	78.0%
NTT	90.7%	88.4%	73.3%	59.1%	73.5%	65.6%
NTT	90.9%	94.3%	88.1%	62.2%	68.8%	78.2%
Jayapura	78.2%	78.3%	75.8%	22.4%	21.6%	27.9%
Merauke	102.5%	97.9%	92.9%	42.8%	50.6%	43.5%
Manokwari	No data	38.4%	19.5%	20.4%	32.3%	15.6%

Figure 4.1 and 4.2 ANC 1 and ANC 4 coverage in study sites, 2010-2012



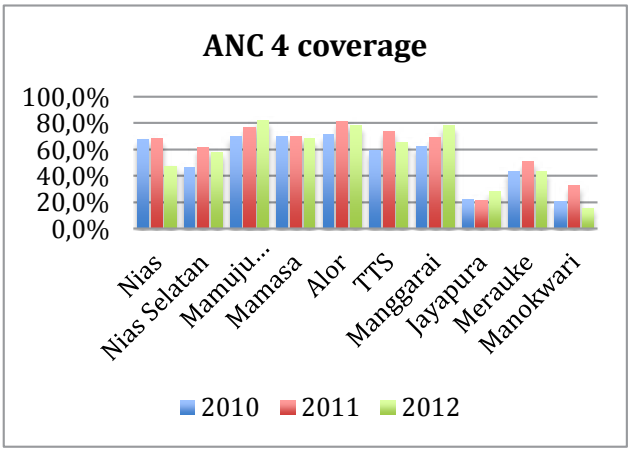


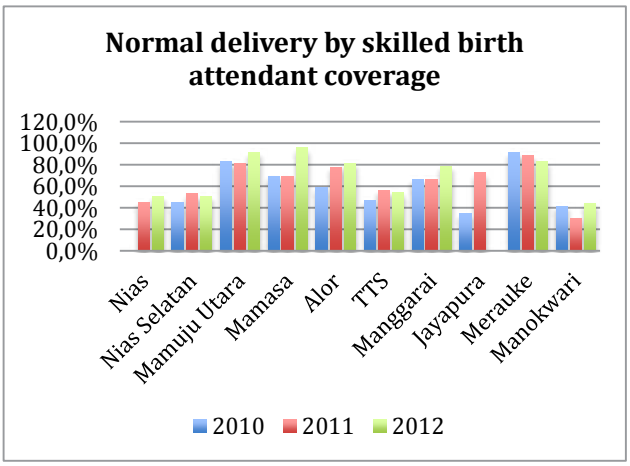
Table 5 and Figure 5 show the coverage of normal delivery by skilled birth attendant and postnatal care in the study districts.

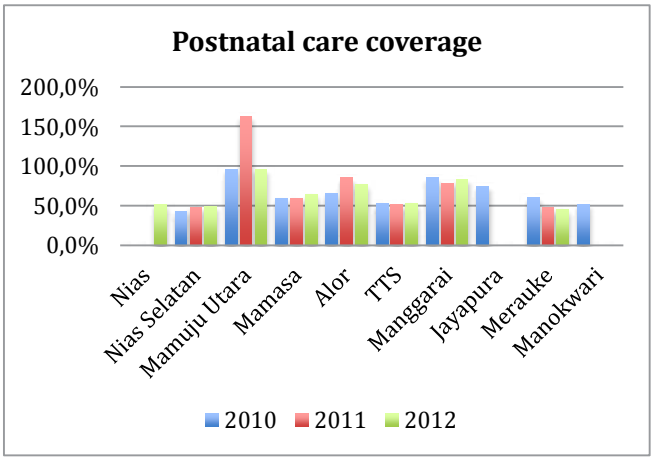
Normal delivery by skilled health personnel coverage in Manokwari district is the lowest of the ten districts, followed by Nias and South Nias. Figure 5 shows no significant increase in the service coverage from 2010 to 2012. Similar trend was also found for postnatal care coverage.

Table 5.Coverage for normal delivery by skilled birth attendant and postnatal, 2010-2012

	Cakupan Persalinan Nakes			Cakupan Kunjungan Postnatal		
	2010	2011	2012	2010	2011	2012
Nias	No data	45.1%	50.7%	No data	No data	51.5%
Nias Selatan	44.4%	52.7%	50.3%	42.6%	48.0%	48.8%
Mamuju Utara	82.8%	81.2%	91.4%	95.4%	163.1%	95.2%
Mamasa	69.1%	69.1%	95.5%	59.8%	59.8%	64.1%
Alor	58.8%	77.2%	81.0%	65.0%	85.1%	77.3%
NTT	47.3%	56.0%	54.4%	53.2%	52.0%	52.2%
NTT	66.1%	66.8%	78.3%	84.8%	78.3%	83.2%
Jayapura	34.3%	72.3%	0.0%	74.4%	No data	No data
Merauke	90.9%	89.1%	82.7%	60.9%	47.7%	45.0%
Manokwari	41.5%	30.2%	43.9%	51.1%	No data	No data

Figure 5.1 and 5.2Coverage of normal delivery assisted by skilled birth attendant and postnatal care, 2010-2012





There is limited data for the postpartum family planning service coverage, where information is not available at the local health facility. Registration form at the health facility has not differentiated between postpartum family planning service and general family planning services. Referring to the qualitative findings, the demand for postpartum family planning is low; women tend to have concerns or scared of the procedure due to limited knowledge on the actual methods. Women also feel scared after seeing the FP medical devices. Midwives have tried to provide information and explain the benefits of family planning, but the decision-making is fully with the patient and the patient's family. Postpartum family planning service has not been optimally utilized in the ten study sites.

Table 6 shows the caesarean section and emergency obstetric care service coverage in the study locations. There were incomplete data for both types of services and low validity. For Manggarai, the caesarean section coverage exceeds 100%, indicating over-utilization of the service or invalid data or recording system.

Table 6.Coverage for Caesarean section and emergency obstetric care service, 2010-2013

	Cesarean Section Coverage[1]				Emergency obstetric care service coverage			
	2010	2011	2012	2013	2010	2011	2012	2013
Nias	No data	No data	No data	No data	No data	No data	No data	No data
Nias Selatan	No data	No data	No data	65.8%	60.3%	59.3%	No data	No data
Mamuju Utara	No data	0.0%	No data	0.0%	0.0%	0.0%	No data	0.0%
Mamasa	0.0%	0.0%	0.0%	63.2%	63.2%	36.0%	0.0%	0.0%
Alor	0.0%	0.0%	0.0%	37.7%	62.0%	61.8%	0.0%	0.0%
TTS	0.0%	0.0%	0.0%	91.7%	36.8%	35.9%	0.0%	0.0%
Manggarai	100.5%	103.2%	182.2%	14.2%	83.2%	35.3%	100.5%	103.2%
Jayapura	No data	No data	No data	No data	No data	No data	No data	No data
Merauke	No data	258.8%	235.4%	38.6%	139.7%	63.9%	No data	258.8%
Manokwari	0.0%	0.0%	0.0%	No data	No data	No data	0.0%	0.0%

[1]Estimated number of complications requiring Cesarean Section is 5% of all deliveries

[2]Estimated number of obstetric cases requiring emergency care is 15% of all deliveries

5. Perspectives, Challenges and Constraints on Jampersal Scheme Implementation

a. Recruitment

The process of recruiting health providers to participate in the Jampersal scheme still largely influenced by the local bureaucracy. Take for an example in Alor, for private clinic to be accepted as Jampersal provider, the private clinic must have a license and should tailor its systems to adjust the Jampersal scheme. Some of private midwives in Alor have already known the Jampersal scheme but they prefer not to participate due to the lower service fee in Jampersal. They felt that the service fee reimbursed by Jampersal is too small compared to what they usually earned.

> *"...We have several private midwives but they haven't participated (in Jampersal scheme). Some of them already knew about Jampersal. But the fee is not suitable for them. They usually have higher fee compared to what Jampersal covered..."*

Meanwhile in Jayapura and Manokwari, the recruitment process was quite simple. Private midwives only need to apply for a license at the DHO, and then they can be included in the Jampersal scheme.

> *"...Yes we have several private midwives who already set up collaboration with DHO. We paid for what they claimed..."*

In Nias and Nias Selatan, there is an automatic recruitment process to include all government-owned health facilities and all public-based health workers. Thus, all government-owned primary health centers and auxiliary primary health centers, and hospitals must participate in this scheme. As stated by a DHO staff:

> *"...We don't have any problem in the recruitment process. For Jampersal, opportunity to participate opens widely. Not only for Jampersal, we also do not have any problem with other similar scheme. Last year, Jamkesmas was short of budget, but then Jamkesda covered it up. But I don't think it will happen with Jampersal, there is a lot of money for Jampersal..."*

One of the midwives working at primary health centers also mentioned that all community health centers and all midwives working in the community health centers supposed to be automatically involved as Jampersal providers.

However, there is a constraint with the private practice licensing process. Currently, none of private midwives participated as Jampersal providers because the local decree only allows midwives with 3-year diploma (D3) to have the license, but not for midwives with 1-year diploma (D1). In the field, most of the D3 midwives were assigned as village midwives, which required to stay at the village the whole day and working full-time in primary health centers. Whereas, those who are not working full-time in primary health centers, usually senior midwives, which have D1 education. Some of the D1 midwives have private practice, in which they claim the Jampersal only for the normal delivery process, but not for the antenatal or postnatal care. The general practitioners and obstetricians work in the hospitals only; they don't have their own practice.

Similar to Nias and Nias Selatan, Mamuju Utara and Mamasa also have an automatic recruitment for health providers to be collaborated in Jampersal scheme.

> *"...We work as civil servants in government-owned health facilities; that's why, according to the announcement from DHO, we are automatically included in Jampersal..."*

The outsourced midwives also were recruited to fulfill the lack of health workers in some villages.

Mamuju Utara has serious problem in health worker sufficiency. Some primary health centers have 2-3 midwives while some others do not have any midwives at all. In some areas, midwives established collaboration with traditional birth attendants.

b. Process of claim and reimbursement

The length of process of reimbursement is varied across the districts.

1) Manggarai, Alor and Timor Tengah Selatan

   In average, the reimbursement process (starting from the proposed claim to the DHO by health providers to the payment from the DHO to the health providers) took 1 year. Claim data from all primary health centers and health providers were supposed to be compiled monthly to the DHO, altogether with the monthly case reporting, but in reality, the process was often delayed. The amount of claim was based on the Jampersal technical guidance. The DHO then submitted the compiled claims to the national level. After the claim was approved, the money is disbursed to the district account. The DHO will reimburse the claim to the health providers if the DHO finished the verification process. The implementation of reimbursement process in these districts is already in line with the technical guidance. The claim of Jampersal and Jamkesmas (other health insurance scheme for the poor) has already distinguished in these districts.

   One of the main challenges experienced by the staff is the increased workload due to the additional administrative work to prepare the claim proposal. For the reimbursement purpose, the health providers must submit the claim data which is completed by supporting documents. In addition, the whole delayed reimbursement process means that the health providers have to cover the service fee for a long time before the claim is approved, which caused inconvenience and dissatisfaction among the health providers. Another problem also occurred after the reimbursement money was distributed to each health facility. There is often discrepancy between one facility and another. Also, the money distribution to the workers often became a problem within a health facility. Some staff also stated that because the claim process was done manually, there could be a possibility of inappropriate amount of reimbursement.

   > *"...There were some issue on the Jampersal money distribution, not here (in DHO) but in the primary health centers. One center got 40 million and another center got 70 million. The distribution within the center is the problem. I think it was internal problem at the primary health center..." (Head of Family Health Division, DHO)*

The problem within a health facility was also stated by a general practitioner working in hospital's delivery room.

> *"...it's about the fee distribution (for the health workers). We work in the delivery room, and this is where most of Jampersal cases occurred. But the fee distribution is the same (with other workers in other department)..."*

Some midwives in the hospital admit that they are aware that the Jampersal fee will be distributed equally to other hospital staff such as: doctors, and auxiliary health workers. The long waiting period of reimbursement process could hinder the service delivery in the hospital. One of specialists proposes that the claims proceed every 3 or 6 months.

> *"... well as I mention before, if the (reimbursement) process (can be done) every 3 or 6 months, it will be good... I don't expecting the service fee to much, because it is not that much. But it is important (to speed up the reimbursement process) for the procurement (of hospital equipment and consumables)..."*

Similar to the hospitals, staff working at primary health center also complained on the delayed reimbursement process. They expect that the claim and reimbursement for Jampersal to be proceed every month. They also suggested that the fund to be channeled directly to primary health care's account, just like BOK fund (another funding which is disbursed directly to PHC).

In terms of knowledge or familiarity regarding Jampersal, most of hospital staff, including: specialists, general practitioners and midwives have a good understanding.

2) Manokwari, Jayapura and Merauke

The reimbursement process will last approximately 3 months after the claim submission. The amount of money paid to the health providers depends on how much budget was available in DHO. In Manokwari, all claim data from health providers was compiled and managed at the DHO. After being verified by DHO staff, the DHO distribute the money to the health providers (directly to the midwives, not through PHC).

The amount of claim is based on the Jampersal technical guidance. According to the DHO staff, ideally, the claim should be submitted by each health provider, but in the reality it was often delayed. Within the DHO, the claims for Jampersal and Jamkesmas were already distinguished.

Currently, no existing specific monitoring system for Jampersal. There was routine meeting at PHC level, they might do some review on the coverage of the Jampersal, but DHO rarely visit the PHC because of no budget allocated for monitoring purpose.

> *"...(the monitoring meeting) usually performed in the PHC, but DHO staff couldn't visit them because there is no budget for that purpose. If we had some field visit, we can use that opportunity to check their Jampersal report..." (Head of MCH division, DHO)*

Jayapura and Manokwari district hospital prefer to claims the cost for delivery to Jamkesmas instead of Jampersal, because Jampersal had a serious delayed for the reimbursement process. The delayed of reimbursement process worsen by the obligation that the Jampersal to be transferred to the district account first before transferring to the district hospital's account. Lack of coordination between hospital and DHO-based verification also worsen the delay.

> *"...I think it (Jampersal) could have the same delay in reimbursement process as Jamkesmas. All money must be transferred to the district's account first, it is too complicated..." (Director of the hospital which does not participate in Jampersal)*

> *"...because the verification is from the DHO and the coordination was not good between hospital and DHO, it often constrained the Jampersal..." (GP in the non-Jampersal hospital).*

The length of reimbursement process depends on the completeness of the claim data. To be completed, ID card or Jamkesmas card should be given along with the claim data.

Merauke hospital had already utilized Jampersal scheme. The main constraint comes from the huge increasing number of patients, thus too many data to be entered with manual software by limited number of staff. This leads to delay in processing the claim data in the hospital.

> *"...the new MoH decree 110, effective from July 1 2012, about the free healthcare service in the hospital. Our team is not ready with the enormous increase of patients. The software to input the data is just arrived, so we had to start over again. We finished the 2012 claim data by this year. So patient overload lead to the delay..."*

At the PHC level, many staff stated that they already submit the claim every month, but the reimbursement was given every three months. The claims from January-May 2013 have not been paid on October 2013. This is a serious delay. In addition, there was no transparency of the amount that should be given to the health workers. The administrative works related to Jampersal also gave an extra burden for the midwives.

> *"... (the midwives) are not satisfied with the money we received. It was not worth it compared to the attempts they did in the middle of the night attending delivery..." (GP working at remote areas)*

> *"...the fee should be more than 500,000 rupiah, maybe 1 million.... it is very far to reach health facility..." (midwives working at remote areas)*

> *"... the money paid for the doctors was too small..." (doctors working nearby the district)*

> *"..well actually (I'm) satisfied, if the claim were smooth..." (midwives working nearby the district)*

3) Nias and Nias Selatan

The claim and reimbursement process in Nias and Nias Selatan complies with the Jampersal technical guidance. The midwives submit claim to PHC which accompanied by partograph, MCH book, patient's ID card, and maternal register. The PHC compiled the claim data from midwives and submit the compilation to the DHO (Division of Health Promotion), to be passed through to the DHO treasurer. The DHO treasurer then submits the claim to the Regional Development Planning Agency (Bappeda).

The delay in submission from the midwives and error in filling claim form is the most common problem occurred in the field. This partly attributed to the lack of information (socialization) thus create differed knowledge among the health providers.

In addition, there was a high turnover for the Jampersal administrative staff without sufficient system for taking over the duty. In some cases, the claim data is kept and brought by the old staff.
Also, only 2 people in the DHO who responsible as verification to handle 36 PHCs; which is overloaded for them. This leads to a further delay.

In terms of amount paid by Jampersal, for antenatal care is 10,000 each (total 40,000 for 4 times antenatal care), 500,000 for delivery attendance, and 100,000 for referring maternal cases. However, some midwives who claimed the money via PHC only received 75% of the amount due to a cut from DHO. While those who set up own practice could receive 100% of the amount.
Some patients visit the midwives (health facility) more than 4 times, while only 4 ANCs were covered by Jampersal.

> *"...some mothers come every month. But I can only claim for 4 visits. It's impossible for me to reject them, they already came so far away from the mountain..."*

4) Mamasa and Mamuju Utara

The Jampersal claim and reimbursement process is submitted monthly from the PHCs. The claim should be accompanied by patient's ID card and MCH book. Particularity for delivery claim, the PHCs should attach the partograph. The DHO-based Jampersal staff prepare the report every month, and then submit it to verification and the national level. From the national level, the Jampersal fund will be transferred to the district, and then the district will distribute it to the PHCs. However, one staff contradicts the given flow and stated that the disbursement of Jampersal fund is not based on claim system.

> *"....we only submit the financial report (not the claim report). Actually it is not a claim system, we only need to wait the national level to transfer the money..."*

Some staff also complained about the low amount of reimbursement. In order to complete the claims, the staff need to copy the data which was quite expensive and difficult for places like Mamuju Utara. The midwives could

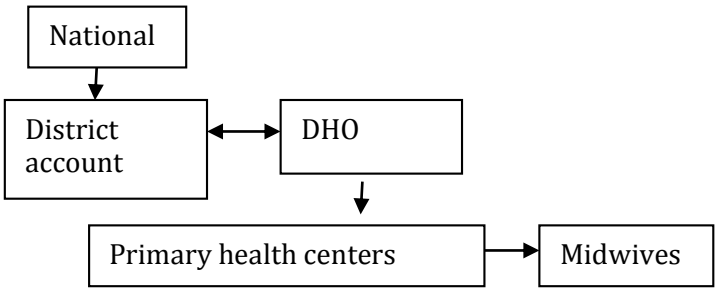
only get 85% or less of the reimbursement because of the photocopying things.

c. Fund channeling

1) Alor, Manggarai and Timor Tengah Selatan
As discussed previously, the reimbursement was delayed in these districts. This could be attributed to the delay at the parliamentary level in discussing the national budget, thus the Jampersal fund, which is included in the national budget, is delayed as well.
It is important that the money to be reimbursed as soon as possible, because it's not only hinder the procurement process within a health facility, but also largely decreased the satisfaction among health providers.

2) Kabupaten Manokwari, Jayapura and Merauke
Similar to NTT, the staff thought that the delay basically caused by the delay at parliamentary level. The DHO staff think that the money should be from social assistance (Dana Bansos) instead of national budget (APBN). Related to the "Dana Bansos" the MoH need to have a special auditor for each regions and set the guidelines for the monitoring/audit process

3) Nias and Nias Selatan
The fund channeling for Jampersal in Nias:

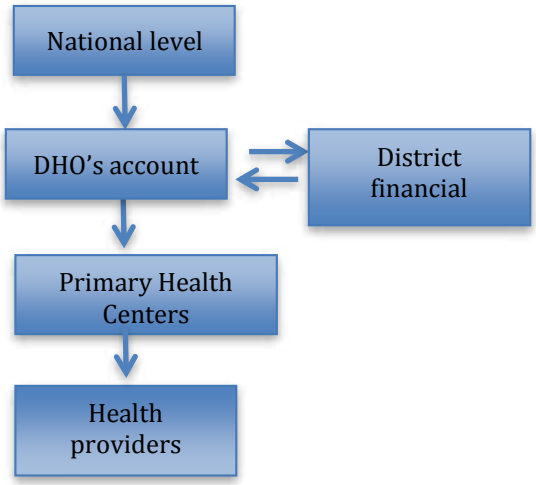


Notes:
The fund channeled to district account. The DHO compiled the claim, which is managed by the treasurer and signed by the head of PHCs, and then submit it to the district government. The money will be withdrawn by the treasurer to be distributed to the PHCs. Then the PHCs distribute the fund to the midwives according to the claim data submitted. The fund can be disbursed every 6 month, with the proposal of district budget (APBD).

The delay of fund channeling could be attributed to the delay of the DHO staff in taking care of the Jampersal claim and the DHO staff prefers to pay it once for several claims rather than one by one.

Fund channeling in Nias Selatan:
From the national level, the Jampersal fund is channeled to DHO's account at a certain but unscheduled period. For example, for term 2 2013, the money is channeled on June but no money transferred for the term 3 2013 until this October (2013).

The fund can be distributed to the PHCs by the DHO using the verified claim data from PHCs. The claim data is submitted to the district financial agency to get the approval. After being approved by the district financial agency, the DHO is allowed to withdraw and distribute the money to the PHCs then the PHCs channel the money to the midwives.
The main difference of Nias and Nias Selatan is that in Nias, the fund channeled from national to district's account while in Nias Selatan the fund channeled from national to DHO's account. The duration from the claim submission to the fund distribution could take 3 to 8 months.



Most health workers (midwives, etc.) feel not satisfied be it for the amount of the money and the delayed payment. However, they never complain to the DHO.

4) Mamasa and Mamuju Utara
National level channel the money to the districts 2 to 3 times a year, without a certain schedule. The delay could be due to the lateness of the original district fund (Pendapatan Asli Daerah) disbursement.

> *"...yes the constraint is because the disbursement process must pass through district budget (APBD). We need to arrange (the reimbursement) to the district government first..." (DHO-based Jampersal staff)*

d. Workload

1) Alor, Manggarai and Timor Tengah Selatan
Some staff feel that the increased workload in administrative job is more significant than the increase of patient load. They feel that the administrative job for Jampersal reduce their time to provide patient care. Since the implementation of Jampersal, the number of maternal visit has increased in both PHCs and district hospital, with more significant increase in the district hospitals. However, some staff feel that the workload increase is not proportionate to the additional fee received. There is a need to clarify the job description among the staff, especially regarding the Jampersal arrangement. The proportion of fee paid for the midwives and doctors should be increased.

> *"..yes, if the workload is too high but small pay..." (Hospital finance director)*

"...very heavy, 160 hours of work per month..." (midwife practicing at both the hospital and private practice)

"workload because the patients keep on coming... too much work and only limited number of human resources..." (GP at hospital)

In the PHCs, some staff in TTS feels that the workload is somewhat the same between before and after Jampersal implementation, while those in Alor and Manggarai feel the significant increase of workload especially for complicated obstetric cases. The staff need to fetch the patients, which could be located in very remote areas. Beside extra burden due to emergency obstetric cases, the administrative work also adds some workload to the staff.

"..after the implementation of Jampersal, we became busier in preparing the complementary documents for the claim purpose. But because this is the program (from national level), there's nothing we can do about it..." (midwives working in the non-remote area)

The respondents feel the need to hire additional staff to cover 3-shifts of work. One staff working in remote areas stated that the extra burden is caused by more patients coming.

"... those who provide Jampersal service have to be prepared because patients are always coming in…" (head of PHC in remote area)

2) Manokwari, Jayapura and Merauke
Not all districts feel the same increase of workload in the PHCs. One staff stated that the workload did increase due to the administrative work and the higher number of patient visits; however, so far the PHC staff can handle it. Another PHC staff feel the increased burden only occurred whenever the ambulance driver is not ready for 24 hour.

"...since Jampersal, the patient visit increased from 45-50 to 70 patients..." (GP in non-remote PHC)

The health workers who are working in remote areas feel that the increasing number of patients should be accompanied by hiring more staff. They stated that the number of village midwives need to be increased, especially when one or more colleagues are on leave due to continuing study. However, some of them feel that there is no different of burden between before and after the Jampersal implementation.

"...9 of our colleagues are currently continuing their study, so now we really feel lack of worker here..." (midwives working at a remote PHC)

"...Jampersal did not influence the workload. Healthcare service is provided just as usual..." (midwives working in a remote area)

The workload was increased more significant in the hospitals, in particular for the midwives and obstetrician.

3) Nias and Nias Selatan
The hospital staff stated that the patient load in hospital was significantly increased. There were more patients coming to the hospital with limited number of obstetrician and anesthesiologists. The doctors sometimes need to assist the delivery process or do the cesarean section. They also feel insufficiency of midwives, especially about their skills.

> *"...out of 10 midwives, only 2 of them can do normal delivery, it depends on the education institution..." (management staff of district hospital)*

Regarding the fee, the clinical staff feels that the amount doesn't reflect a good appreciation for them.

> *"...we treat very bad cases and follow them up until (the patients are) cured. But, is this all what we get..." (doctor in the hospital)*

4) Mamasa and Mamuju Utara
The hospital director stated that he began to feel the increased of workload and insufficient number of midwives since the Jampersal and other free healthcare service scheme. The schemes resulted in more patients visiting the health facilities.

> *"...so far we only have 11 midwives, and there is some people helping voluntarily..."*

e. Other challenges

1) The contradictory condition with family planning program.
Representatives from a health worker organization perceive a conflicting agenda between Jampersal and family planning, because Jampersal policy did not limit the number of children that can be covered by the scheme.

> *"...if I may conclude, I would say that Jampersal gave us a huge burden. Firstly (the patient load due to) an opportunity to have children as many as possible, secondly from the limited incentives..." (Representatives of professional organization)*

2) Unclear incentive distribution in the hospital
Currently, many staff working at hospital feel that the distribution of Jampersal incentive was unequal between clinical and non-clinical staff.
3) Inadequate Jampersal information (socialization) to the community as the prospective user, especially about the administrative documents.
4) Regarding the plan to establish UHC in 2014, the professional organizations stated that they haven't received further information, technical guidance or assistance about the claim and reimbursement system, capitation, and other things related to the UHC. They expect that the information about UHC to be delivered by direct meeting rather than mere advertisements. The hospital

staff also haven't received further guidance about UHC. Even worse, some staff still haven't heard about UHC 2014.

> *"..not yet... we haven't got any information (about UHC). Well, probably some of us have received the information, but not me. I know this from the TV advertisement" (Professional organization, NTT, Papua)*

> *"...I haven't seen special socialization for the hospitals...." (hospital director, Papua)*

5) Lacking supply of consumables, such as: anesthetic drugs, equipment for cesarean section, surgery consumables, etc.
6) Lack of transportation from the very or remote areas to refer maternal cases. This in particular in areas with difficult topography, and it occurred in almost all districts in this study.
7) Need to allocate budget for the DHO to perform monitoring to the PHCs.
8) Need to revitalize the population data, thus, when it is needed, it will make it easier to complete the Jampersal claim documents.
9) Need to distinguish between Jampersal and Jamkesmas fund.
10) Need a strategy to handle boundary problems. Health facilities in boundary areas often received patients from the neighboring countries, which could affect the reporting and recording process as well as the reimbursement.
11) Need to harmonize all kind of health insurance scheme at district level between Jampersal, Jamkesmas, Jamkesda and Jamkespa. So that the insurance scheme could fill in for other's limitation.
12) Need a better coordination between the verification at DHO and the hospitals.

> *"..the most important is the verification. We always have a problem with the verifications. We need to sit together and discuss about the verification." (hospital director)*

> *"the DHO need to give more training to the verifications..." (health insurance management staff at the hospital)*

13) Many people still do not have any identity card or other administrative documents. This will make the claim and reimbursement process more delayed.
14) Patient's belief that there must be a cost to obtain healthcare service in Puskesmas.

> *"...the main constraint is that the mother does not afford the transportation to Puskesmas. The delivery could be a free service, but it is unlikely that we don't buy anything more in the health facility. There must be something that we need to pay there..." (Midwives in Sulawesi Barat)*

15) Local culture/ belief that e pregnant women should not give birth outside the house.

> *"...the local culture is very strong here. People don't want to go out of their house at the time of giving birth…"*

16) Lacking number of bed in the hospitals/clinics/PHCs.

"..we only have two bed for maternal... After the Jampersal, there was huge increase of patient load. We don't have any more room for all patients…"

6. The non-Jampersal existing health insurance scheme at each district

The following health insurance scheme are available in all district: health insurance for civil servant (Askes PNS), Jamkesmas (health insurance for the poor), and health insurance for military or police department. Nias, Nias Selatan, three districts in NTT and the 2 districts in Papua have district health insurance (Jamkesda), in which the fund was allocated by the district government. Papua has another health insurance scheme which was funded by the provincial government (Jamkespa). Ideally, all maternal cases (antenatal care, postnatal care, delivery) are covered by Jampersal.

One staff in Nias Selatan stated that Jampersal, Jamkesda and Jamkesmas have complementary function in PHC, which means that PHC might claim the service fee from these three schemes.

a. *Breadth*

Not much information that already known about the coverage of the other health insurance scheme. There is an indication that main problem preventing people to use the other health insurance such as Jamkesmas, Jamkesda or Jamkespa is the low demand among the community. For the maternal cases, the low demand largely because more women feel more comfortable to have delivery at home, women feel that the health providers (health workers) are not comforting (not too kind toward) the patients, and women believes that giving birth at home is comply with the local culture. Another reason causing people not utilizing Jamkesmas or Jamkesda is because some citizens do not have any identity card or Jamkesmas card, which is the primary requirement for people to be able to use Jamkesmas or Jampersal. The other reason is that because the people are unfamiliar or have no information at all about the Jamkesmas, Jamkespa or Jamkesda.

b. *Depth*

In all district, Jamkesmas is provided to poor and near-poor people to cover all disease except for maternal cases. In Nias Selatan, Jamkesda is provided to all citizens who are not covered by Jamkesmas and Jampersal. Jamkesda will cover all cost of services. If the patients are required to be referred to other facilities, the Jamkesda will also cover:

- Transportation cost for patients, patient's family and health workers who accompany the patient
- Allowance for the patient's family
- Accommodation for outpatient and the patient's family

> *"...if we cannot treat the patient here, we will refer him to Medan. We will cover the flight for the patient and one of patient's family member as well as the health worker. We also give 500 thousand rupiah for the family and we built lodging near the hospital for the patient and patient's family to stay.... For 2012, we prepared more than 2 billion, apparently it was not sufficient ... For 2013 we prepared 3 billion. If a patient needs emergency and need to charter a plane, we will pay for it." (Head of DHO).*

c. *Height*: extra fee that must be paid by the patients

Not much information known about the out-of-pocket payment related to Jamkesmas and Jamkesda.

7. District preparedness to meet UHC implementation in 2014

Indonesian Universal Health Coverage (UHC) which will begin on January 2014 aiming at reducing financial barriers to healthcare to increase health service coverage and improve community health status.

(1) This section focuses on the preparedness of the health systems from the supply aspect of the health service. The preparedness of each district will be described and analyzed based on the situation of health facilities, health workers, and health systems for the upcoming UHC 2014, including: ratio of health worker to population and the relation to the national target (as stated in MoH Decree No.81/Menkes/SK/I/2004);
(2) availability of MCH-related specialists (pediatrician, obstetrician, anesthesiologist); and
(3) Availability of medical equipment for referral facility which is listed in the UHC regulation.

The qualitative findings in this section explore more about:

(1) the level of knowledge about the claim and reimbursement process under the UHC;
(2) the preparedness of health infrastructure; and
(3) the readiness of health systems to manage the new insurance scheme.

Availability of health workers

The figure 7.1 shows the nurse-to-population ratio. Only 2 out of 10 districts (Jayapura and Manokwari) comply with the national target, which is at 158 to 100,000. Timor Tengah Selatan has the lowest ratio among others, only about 20 nurses/100.000 population.

Figure 7.1 Nurse-to-population ratio (per 100,000 population) in the 10 districts, 2013

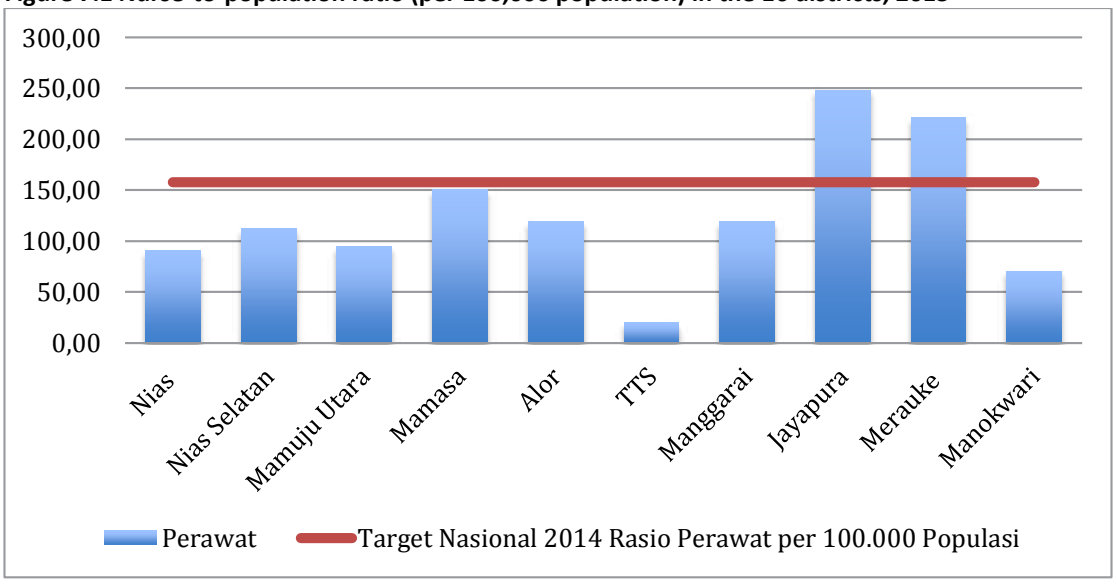


Figure 7.2 shows that the ideal ratio of midwives-to-population, that is 75 to 100,000 , have already achieved by 6 of 10 districts. Similar to the nurse-to-population ratio, Timor Tengah Selatan also has the lowest ratio compared to others, that is 8 to 100,000 population.

Midwives play an important role as the main caregiver for maternal-child health service, thus it is critical for each district to have adequate number of midwives. In addition, it is also important to ensure equal distribution of midwives, especially in remote areas.

Figure 7.2 Midwives-to-population ratio (per 100,000) in the 10 districts, 2013

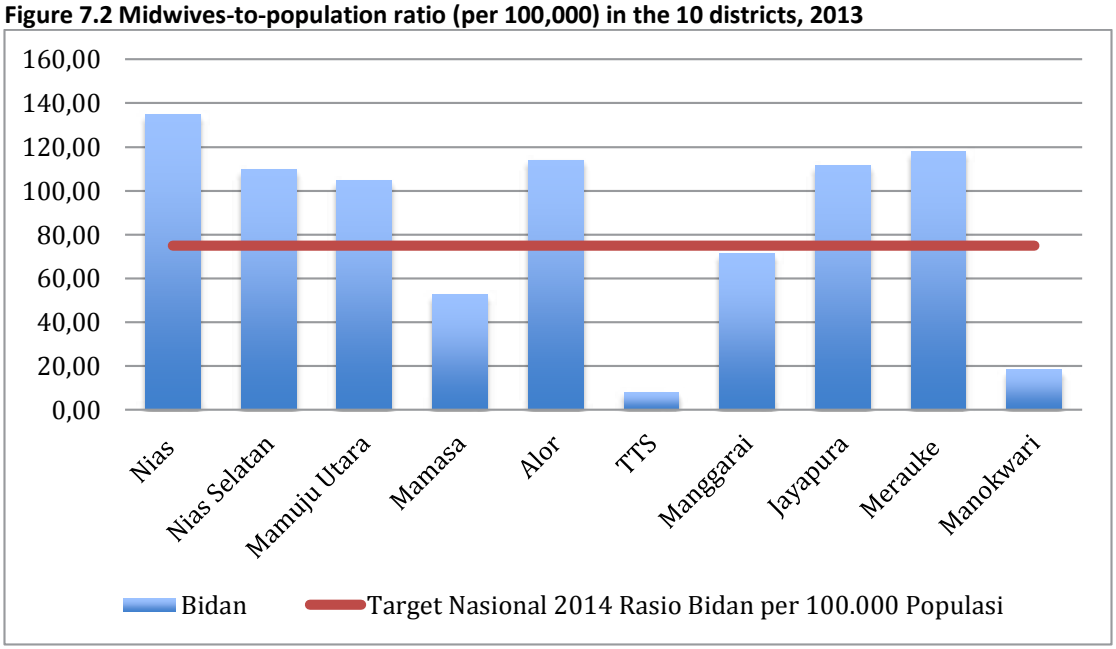
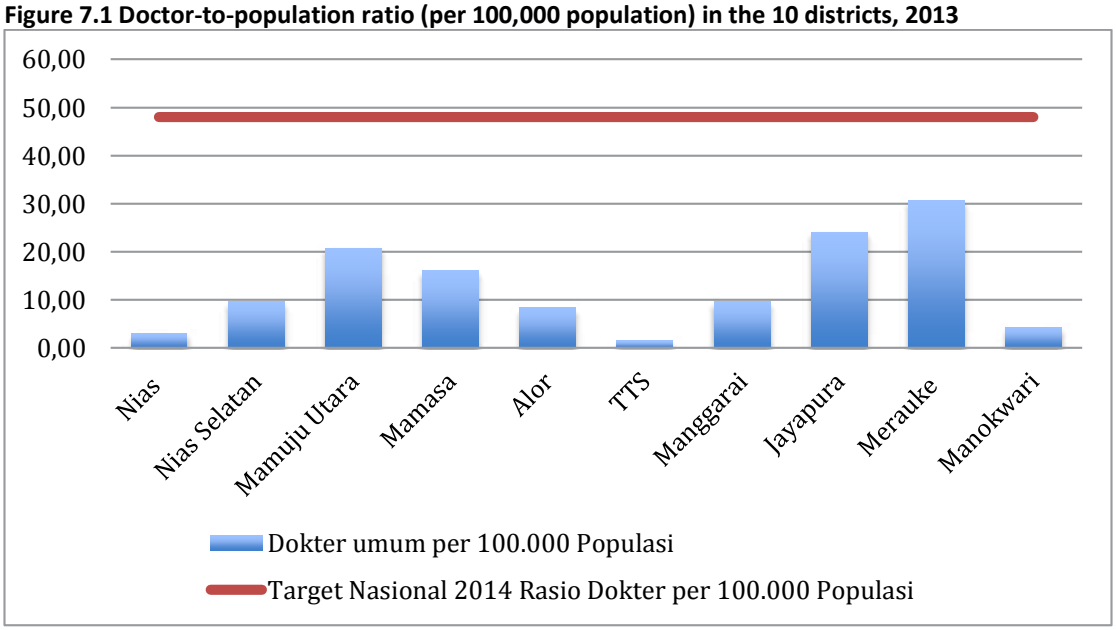


Figure 7.1 Doctor-to-population ratio (per 100,000 population) in the 10 districts, 2013



The figure 7.3 shows that none of the 10 district has achieved the national target for the ideal number of doctor, which is set at 48 doctors to 100,000. Timor Tengah Selatan, Nias and Manokwari are the three district with the lowest doctor-to-population ratio compared to the others.

The availability of specialists

Table 7.1 Availability of Specialists in the 10 districts, 2013

	Availability of Specialists					
	Obstetrician		Pediatrician		Anesthesiologist	
	Number	Ratio per 100.00 population	Number	Ratio per 100.00 population	Number	Ratio per 100.00 population
Nias	3	2.28	1	0.76	0	0
Nias Selatan	0	0	0	0	0	0
Mamuju Utara	1	0.65	1	0.65	1	0.65
Mamasa	0	0	1	0.80	0	0
Alor	4	2.24	0	0.00	0	0.00
TTS	1	0.23	1	0.23	1	0.23
Manggarai	1	0.34	0	0.00	0	0.00
Jayapura	1	0.89	2	1.79	1	0.89
Merauke	2	1.02	2	1.02	1	0.51
Manokwari	2	1.22	3	1.83	1	0.61
National target	**12 per 100,000 population**					

Table 7.1 displays the limited number of specialists that are critical for maternal-child health problems. Take for an example in Nias Selatan, none of the three specialists is available in 2013. Mamasa, Manggarai, and Alor also do not have all of the three specialists, which hinder these districts to have a complete and effective CEMOC facility.

The limited number of specialists could be a constraint to achieve better maternal and child health status. Related to the upcoming UHC implementation in 2014, lacking number of health workers could hamper its success in increasing health service coverage. Financial protection alone could be failed in improving health service coverage especially in the areas with limited health facility and health workers, because these areas do not have adequate facility to accommodate the increasing number of patients. As discussed in the previous chapter, many of the health staff felt that the existing health infrastructure is not sufficient to accommodate the patients, thus could reduce the quality of care as well. The implementation of UHC might be easier to succeed in the areas with adequate number of health workers and facilities. Hence, UHC could make areas like NTT, Papua, and West Sulawesi more marginalized in terms of healthcare utilization.

Availability of tertiary healthcare facility

Table 7.2 shows the completeness of tertiary-level health facility in the 10 districts. Hemodialysis equipment, X-ray, blood transfusion unit are necessary equipment in a tertiary-level health facility. Thus the availability of these units is expected to represents the readiness of the districts to provide treatment for advanced health conditions. Treatments in tertiary-level health facility, especially for advanced health conditions, need a much higher costs compared to treatments in primary-level facility. If the expensive treatment is only available in the capital or major cities, or even in Java, a higher budget to cover the cost of care from the UHC scheme will be allocated to these major cities rather than to the other less developed regions. Thus, there is an indication that the UHC will be a pro-rich program.

This situation will widen the equality gap across districts in Indonesia in terms of healthcare utilization.

Table 7.2 shows that some of the 10 districts have a limited tertiary-level health infrastructure. Take for an example, hemodialysis unit is not available in Mamasa, Alor, Timor Tengah Selatan, Manggarai and Manokwari. This means that patients who require dialysis must be referred to other cities where the hemodialysis unit is available. Considering the long-term and repetitive process of dialysis treatment, the high transportation cost and geographic barrier will be the significant issue and spend a lot of money as well. The UHC scheme should pay attention to such matters. Other example is the availability of blood transfusion unit, which only available in 5 out of 10 districts. The unavailability of this unit could become a constraint in treating many health conditions, thus the implementation of UHC could fail to improve health status in the district with limited infrastructure.

Table 7.2 Availability of hemodialysis unit, X-ray machine and blood transfusion unit in the 10 districts,

	Hemodialysis unit	X-ray machine	Blood transfusion unit
Nias	1	3	1
Nias Selatan	1	3	1
Mamuju Utara	1	0	1
Mamasa	0	0	0
Alor	0	2	1
TTS	0	2	1
Manggarai	0	5	0
Jayapura	3	1	0
Merauke	6	1	0
Manokwari	0	0	0

a. The level of knowledge about the claim and reimbursement process under the UHC

Most of DHO and district hospital staff feels that they haven't received a comprehensive information about the UHC implementation. In Manokwari, Jayapura and Merauke, the staff stated that the information they have received is mere conceptual without a more detailed guidelines of implementation at the district level. There was only socialization without special meeting to discuss the upcoming implementation of UHC.

> *"...no dedicated meeting for this (JKN) purpose. I also worried because the JKN will start soon..." (hospital director).*

> *"Yes I've heard (about JKN). PT ASKES gave socialization once, but it was just superficial. Then our director held a meeting once to discuss this JKN" (Financing director of the hospital).*

Different from Papua and West Papua, the health insurance manager in the DHO in Manggarai, TTS and Alor have already received official information from the government and PT Askes. Coordination meeting had been held which included Puskesmas as well. One of the important issues was about capitation system, but the district level will leave the discussion to the national level.

For the staff in Nias and Nias Selatan, what they knew about the UHC 2014 is that Askes, Jamkesmas and Jampersal will be merged into one insurance scheme. Some of the staff thinks that it will be like a "changed of clothes" or changing name. The only hospital in Nias, Gunung Sitoli hospital, haven't received any official letter or announcement regarding the UHC 2014, let alone about capitation system.

> *"...we haven't heard anything. We watched something on TV... we feel so confused that we haven't got the official letter or technical guidance.... it's lack of socialization..."*

Another source mentioned the socialization to the users.

> *"...they have socialiation for the people. Because the main problem here is that the people are not satisfied with the health care..."*

b. Perspective of the staff about the readiness of health infrastructure

As discussed previously, the number of midwives in the districts in NTT, West Sulawesi and Papua should be increased, especially those working in the community level (village midwives). Ideally, each village should have 1 midwife who stays in the village. The government also should concern on the equal distribution of midwives, especially in remote areas.

For the hospital level, in NTT, Alor haven't had 4 primary specialists, so the hospital is not ready yet. Should there an advanced case, it will be referred to Kupang. In NTT, the staff does not feel the need to add the number of the health worker. Contradictory, in Papua, the staff felt the need to add more obstetricians and pediatricians. Similar condition is also found in Nias and Nias Selatan, in which they already have some necessary equipment but no one can operate them.

> *"...we have USG but not the technician, no obstetrician. All we know is how to turn it on or off, see the display, but we don't know how to interpret it. The USG machine is so useless.... routine laboratory equipment is available in Puskesmas, but no human resource to use them..."*

The staff also mentioned that he didn't know anything about the requirement to comply with UHC.

> *"...the drug formulary is often late. It will be better if the technical guidance is disseminated at the initial phase. We really don't know whether the current drug formulary for Jamkesmas also applicable for UHC.."*

All of the staff could not clearly explain the UHC scheme, so they cannot explain the district readiness.

> *"…….we are so confused with JKN... we don't have any idea how to ask people to pay the premiums....."*

c. The readiness of health systems to manage the new insurance scheme

Most of the staff in the districts have superficial knowledge on UHC and it is quite difficult for them to describe the readiness of their health systems. The staff expects more health worker recruitment, especially in remote areas. The facilities also need to be improved, along with the drugs and equipment. None of them mentioned referral systems from the primary to tertiary-level health facilities.

Discussion

The program is intended to reduce maternal and neonatal deaths through increase in health care utilization. However, data collected in this study show that there has been no significant increase in health care service coverage even after the introduction of the Jampersal program. Some challenges include the low socialization for the community, disincentives due to the amount of reimbursable service fee, and out-of-pocket payments that reduce demand-side utilization.

The experience from Jampersal program implementation should be used to improve any future health insurance program, including the universal health coverage (UHC) that has taken place since early January 2014 in Indonesia. A number of challenges and opportunities found during the Jampersal implementation could serve as recommendations for the UHC. Firstly is the inclusion of transportation costs as part of the benefit package, where underutilization in geographically and economically challenged areas was found to be correlated with limited transportation fees coverage. Secondly is the importance of increased effort to socialize the program to both the health care providers and program beneficiaries. This recommendation should have greater emphasis in areas with limited information access or limited human resource capacities (both in terms of quality and quantity). Thirdly, insurance claims system would affect health care providers' performance; any late disbursement of funding or complicated claims system would serve as disincentive in providing critical health care services.

The fourth and fifth recommendations would be pivotal to ensuring that UHC program can improve equitable quality health care service. The fourth is the monitoring system that should be in place to ensure quality health care services. As was highlighted in this Jampersal study, MNH services under the Jampersal program were often provided as incomplete benefit package, showing lack of quality control system. In addition, referral system that could ensure accessibility to basic and comprehensive obstetric and neonatal care should also be in place. Such system is an important part of the quality improvement in the era of universal health care and should be available for all services covered under the scheme. The UHC implementation that covers more than just MNH services should be able to serve not only as a financial protection but also a program that could ensure complete and quality health care services for its beneficiaries. Hence, UHC should be closely monitored for its services provided, not only its reimbursement system.

The fifth recommendation would require a longer-term investment, that is human resource provision and health facility improvement in underserved areas. As was observed in this review, all of the study sites were not equipped with adequate human resource and there is evidence showing lack of health infrastructure and medical equipment. As the current UHC scheme is covering for most of health care services, including high-technology medical services that would incur high financial cost, there is a potential that insurance funds would be absorbed to more developed regions in Indonesia; leaving underserved areas with even lower utilization and could result in greater health inequity.

Conclusion

The Jampersal program is potentially a good program that would cover every woman throughout pregnancy and delivery and postnatal periods. However, due to problems with accessibility problem, health insurance only is not enough to increase demand-driven health

care utilization. Transportation costs, as was observed multiple of times during this study, serve as the sole strong reason for under-utilization of the MCH services.

Based on the challenges identified and that the goals of the program have not been entirely achieved, further improvement should be made on any future health insurance program. Challenges and opportunities that were observed during the Jampersal program implementation could serve as important inputs for the current universal health coverage program in Indonesia.