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A STUDY ON THE IMPLEMENTATION OF JAMPERSAL POLICY IN INDONESIA

DISCUSSION PAPER **SEPTEMBER 2014**

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Health, Nutrition & Population

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September 2014

Health, Nutrition, and Population (HNP) Discussion Paper

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Health, Nutrition, and Population (HNP) Discussion Paper

A Study on the Implementation of Jampersal Policy in Indonesia

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Paper prepared by the World Bank Group and supported by funding from the government of Japan through the Japan–World Bank Partnership Program for Universal Health Coverage (P125669).

Abstract: Indonesia launched Jampersal in 2011, a nationwide program to accelerate the reduction of maternal and newborn deaths. The program was financed by central government revenues and provided free and comprehensive maternal and neonatal care with an emphasis on promoting institutional deliveries. Jampersal providers were public and enlisted private facilities at the primary and secondary levels. In 2013, the World Bank and the Center for Family Welfare, University of Indonesia conducted a qualitative and quantitative study to assess the implementation and impact of the program in Garut District and Depok Municipality in West Java Province. The study found that Jampersal utilization was highest among women who were least educated, poor, and resided in rural areas. Utilization was also high among women with delivery complications. The study showed Jampersal only had an impact where institutional delivery coverage was still low such as in Garut District. In this district, women were 2.4 times more likely to have institutional deliveries after Jampersal. The finding suggests implementation of Jampersal policy may have to be adjusted according to the utilization pattern for efficiency and effectiveness. The government discontinued Jampersal with the launching of the National Health Insurance Program (JKN) on January 1, 2014. The study's findings indicate the merit in reevaluating the policy to terminate the program, given that Jampersal helped increase institutional deliveries while voluntary participation in JKN remains low.
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Keywords: Jampersal, comprehensive maternal and neonatal care, national health insurance

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ACKNOWLEDGMENTS

This report is published by the World Bank Office, Jakarta, as part of the Japan–World Bank Partnership Program for Universal Health Coverage. Data management and analysis were conducted by Anhari Achadi, Endang L. Achadi, Trisari Anggodowati, Kamaluddin Latief, Fitri Nandiaty, Poppy Elvira, and Nurfitri Rachmadaniawati from the Center for Family Welfare, University of Indonesia (CFW-UI), and by Eko Pambudi from the World Bank. Report writing was led by Puti Marzoeki from the World Bank.

The team coordinated closely with, and benefited from, valuable inputs during consultations with the following representatives of the Indonesian government: Usman Sumantri (P2JK/ Center for Health Financing and Health Insurance, MoH) and Riskiyana Sukandi Putra (Dit Kesehatan Ibu/ Directorate of Maternal Health, MoH).

Valuable comments on the draft report were received from Ajay Tandon, Senior Economist, World Bank. The report was peer reviewed by Marjorie Koblinsky, International Maternal Health Expert, and Karima Saleh, Senior Economist, World Bank

The paper was written under the overall guidance of Toomas Palu, Practice Manager, GHNDR.

The authors are grateful to the World Bank for publishing this report as an HNP Discussion Paper.

PREFACE

In 2011, Japan celebrated the 50th anniversary of achieving universal health coverage (UHC). To mark the occasion, the government of Japan and the World Bank conceived the idea of undertaking a multicountry study to respond to this growing demand by sharing rich and varied country experiences from countries at different stages of adopting and implementing strategies for UHC, including Japan itself.

This led to the formation of a joint Japan–World Bank research team under the Japan–World Bank Partnership Program for Universal Health Coverage. The program was set up as a two-year multicountry study to help fill the gap in knowledge about the policy decisions and implementation processes that countries undertake when they adopt the UHC goals. The program was funded through the generous support of the government of Japan.

This country report on Indonesia is one of the 11 country studies on UHC that was commissioned under the program. The other participating countries are Bangladesh, Brazil, Ethiopia, France, Ghana, Japan, Peru, Thailand, Turkey, and Vietnam. A synthesis of these country reports is in the publication "Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies," available at http://www.worldbank.org/en/topic/health/brief/uhc-japan.

These reports are intended to provide an overview of the country experiences and some key lessons that may be shared with other countries aspiring to adopt, achieve, and sustain UHC. The goals of UHC are to ensure that all people can access quality health services; to safeguard all people from public health risks; and to protect all people from impoverishment due to illness, whether from out-of-pocket payments or loss of income when a household member falls sick. Although the path to UHC is specific to each country, it is hoped that countries can benefit from the experiences of others in learning about different approaches and avoiding potential risks.

ACRONYMS AND GLOSSARY

ANC	Antenatal Care
APBD	Anggaran Pendapatan dan Belanja Daerah/ *Regional Government Budget*
APBN	Anggaran Pendapatan dan Belanja Negara/ *State Budget*
APN	Asuhan Persalinan Normal/*Normal delivery care*
ARSADA	Asosiasi Rumah Sakit Daerah Seluruh Indonesia/*Indonesian District Hospital Association*
Askeb	Asuhan Kebidanan/ *Maternity Care Plan*
Askeskin	Asuransi Kesehatan Miskin/*Insurance for the poor*
Bappenas	Badan Perencanaan dan Pembangunan Nasional/*National Development Planning Agency*
BOR	*Bed occupancy rate*
BPK	Badan Pemeriksa Keuangan/ *National Finance Audit Board*
BPS	Badan Pusat Statistik/ *Central Bureau for Statistics*
Bumil	Ibu Hamil/*Pregnant woman*
Bupati	Kepala Daerah/*Head of district*
DTP	Dengan Tempat Perawatan/ Primary health center *with in-patient care*
Dinkes Kab	Dinas Kesehatan Kabupaten/*District health office*
Dinkes Prop	Dinas Kesehatan Propinsi/*Provincial health office*
EMAS	*Expanding maternal and newborn survival*
FGD	Diskusi Kelompok Terarah/*Focus group discusion*
GDON	Gawat Darurat Obstetri Neonatal/*Emergency Obstetric and Neonatal*
HDI	Indeks Pembangunan Manusia/*Human Development Index*
HRH	Sumber Daya Kesehatan/*Human resourches for health*
IBI	Ikatan Bidan Indonesia/*Indonesia Midwives Association*
ICU	*Intensive care unit*
IGD	Instalasi Gawat Darurat/*Emergency room*
INA-CBGs	*Indonesia case-based groups*
IUD	*Intrauterine device*
Jamkesda	Jaminan Kesehatan Daerah/*Local health insurance scheme*
Jamkesmas	Jaminan Kesehatan Masyarakat/*National health insurance scheme*
Jampersal	Jaminan Persalinan/*Universal delivery care*
Jamsostek	Jaminan Sosial Tenaga Kerja/*Social insurance for private sector workers*
JKN	Jaminan Kesehatan Nasional/*National Health Insurance Program*
Juknis	Petunjuk Teknis/*Technical guidelines*
KB	Keluarga Berencana/*Family planning*
Kemenkes	Kementerian Kesehatan/*Ministry of Health*
Kemendagri	Kementerian Dalam Negri/*Ministry of Home Affairs*
Kemenkeu	Kementerian Keuangan/*Ministry of Finance*
KK	Kartu Keluarga/*Family card*
KPPN	Kantor Pusat Perbendaharaan Negara/*State Treasury Office*
KTP	Kartu Tanda Penduduk/*Identity card*
K1	Kunjungan ANC Pertama/*ANC in first trimester*
K4	Kunjungan ANC keempat/*2nd ANC in third trimester*
Linakes	Persalinan oleh tenaga kesehatan/*Delivery assisted by health professional*
Linfaskes	Persalinan di fasilitas kesehatan/*Institutional delivery*
MoU/SKK	Surat Keterangan Kerjasama/*Memorandum of understanding*
MDGs	*Millennium Development Goals*
Menkokesra	Menteri Koordiantor Kesejahteraan Rakyat/*Ministry of People's Welfare*
NICU	*Neonatal intensive care unit*
Ob-gyn	Spesialis Kebidanan/*Obstetrics and gynecology*
Perbup	Peraturan Bupati/*Head of district regulation*
Perda	Peraturan daerah/*Local regulation*
Permenkes	Peraturan Menteri Kesehatan/ *MoH regulation*
PERSI	Perhimpunan Rumah Sakit Seluruh Indonesia/*Indonesian Hospital Association*
Perwali	Peraturan Walikota/*Mayor regulation*
PKH	Program Keluarga Harapan/*Conditional cash transfer program*
PNC	*Postnatal care*

PNBP	Penerimaan Negara Bukan Pajak/*Nontax payment*
PNPM-GSC	Program Nasional Pemberdayaan Masyarakat — Generasi Sehat dan Cerdas/*The National Program for Community Empowerment (PNPM). Smart and Health Generation*
PNS	Pegawai Negeri Sipil/*Civil servant*
PPH 21	Pajak Penghasilan/*Personal income tax*
PPM	Bidan Praktek Swasta/*Private practice midwife*
Polindes	Pos Bersalin Desa/*Village delivery post*
PONED/BEONC	Pelayanan Obstetrik dan Neonatal Esensial Dasar/*Basic essential obstetric and neonatal care (BEONC)*
PONEK/CEONC	Pelayanan Obstetrik dan Neonatal Esensial Komprehensif/*Comprehensive essential obstetric and neonatal care (CEONC)*
Posyandu	Pos Pelayanan Terpadu/*Integrated service post*
PP	Peraturan Pemerintah/*Government regulation*
PPS	*Probability Proportional to Size*
PPK1	Pemberi Pelayanan Kesehatan — Tingkat 1/*Primary health service*
PTT	Pegawai Tidak Tetap/*Contracted worker (temporary civil service)*
P2JK	Pusat Pembiayaan dan Jaminan Kesehatan/*Center for Health Financing and Health insurance*
Puskesmas	Pusat Kesehatan Masyarakat/*Primary health center*
Pustu	Puskesmas Pembantu/*Satellite puskesmas*
RB	Rumah Bersalin/*Maternity clinic*
Riskesdas	Riset Kesehatan Dasar/*National Basic Health Research*
RKA	Rencana Kerja Anggaran/*Budget work plan*
SBA	Persalinan oleh tenaga terlatih/ *Skilled birth attendance*
SC	*Sectio Cesarea* (Operasi Sesar)/*Cesarian section*
SIP	Surat Izin Praktek/*License to practice*
SK	Surat Keputusan/*Decree*
SP2D	Surat Perintah Pencairan Dana/*Disbursement letter*
TBA	Dukun Bersalin/*Traditional birth attendants*
UNFPA	*United Nations Population Fund*
Walikota	Kepala Daerah/*Mayor*
WHO	Organisasi Kesehatan Dunia/*World Health Organization*

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EXECUTIVE SUMMARY

Indonesia has made progress in reducing maternal mortality in recent years. Despite this progress, Indonesia's maternal mortality ratio (MMR) level remains high relative to its income, to regional peers, and for a country that has high utilization of maternal health services such as antenatal care (ANC) and skilled birth attendance rates. In 2011, the government launched the Jampersal program to accelerate the reduction of maternal and newborn deaths. The program was financed by central government revenues, and provided free and comprehensive maternal and neonatal care with an emphasis on promoting institutional deliveries. The beneficiaries were those without coverage from existing social health insurance schemes such as Askes, Jamsostek, and Jamkesmas/Jamkesda. Jampersal providers were public facilities and enlisted private facilities at the primary and secondary levels. The government reimbursed providers for Jampersal services through fee claims. The tariff for primary level services was set by the Ministry of Health (MoH), while the tariff for hospital services followed the INA-CBG (Indonesia case-based groups).

The World Bank in collaboration with the Center for Family Welfare, University of Indonesia (CFW-UI) conducted a study in 2013 to assess the implementation of Jampersal and the impact of the program on the coverage of maternal and neonatal health services. At the subnational level, the study involved Garut District and Depok Municipality in West Java Province. The study comprised qualitative and quantitative components and was funded through the Japan–World Bank Partnership Program for Universal Health Coverage.

Jampersal was implemented by the MoH and local governments, although other stakeholders such as the Ministry of Finance, Bappenas (National Development Planning Agency,) Office of the Vice President, Ministry of Home Affairs, and the coordinating Ministry of People's Welfare were involved in the policy formulation process. Awareness and socialization of Jampersal were lower than expected: even in the third year of implementation: 30 percent of respondents (women of child-bearing age) in both Garut and Depok were still unaware about Jampersal, in part due to limited involvement of other sectors during implementation. Even among those respondents who knew about Jampersal, most perceived Jampersal was a program that was limited to provision of free deliveries at puskesmas and public hospitals. Respondents doubted that the services really were for free, and some perceived that "free" meant lower service quality.

The percent of deliveries (last birth for each woman) financed by Jampersal in Garut and Depok were 28.1 percent and 10.3 percent, respectively. Jampersal utilization was highest among women who were least educated, poor, and residents of rural areas. Jampersal use was also high among women with delivery complications. Contrary to design, Jampersal use was higher among those who already had health insurance coverage, including Jamkesmas/Jamkesda beneficiaries. Respondents who knew about the program considered the requirements for using Jampersal services simple (identity card and MCH [maternal and child health] book) and were aware that, unlike Jamkesmas, the choice of providers at the primary level was not limited to public providers. Almost 60 percent of Jampersal users in both Garut and Depok reported paying additional out-of-pocket (OOP) costs for delivery services at health facilities, and about half of them could not explain the reason for the extra OOP payments. Among those that provided explanations for OOP costs, 16 percent reported paying for drugs and injections, even though these should have been covered by the program. In addition, respondents noted that private midwives sometimes requested extra payments for long-term contraceptives, as Jampersal fee reimbursement for family planning services was lower than the cost of long-term contraceptives. Households also reported paying additional OOP costs for referral transport.

Puskesmas was the main Jampersal provider at the primary level in Garut. In Depok, the private sector was the dominant maternal and neonatal care provider. However, although 67 percent of private practice midwives and all private hospitals have enlisted as Jampersal providers, their actual participation in the program was minimal. The reluctance for involvement in Jampersal was mostly due to dissatisfaction about service fees. Although the government increased the fees in the second year, the amount was still considered much lower than the regular private sector fees. Moreover,

Jampersal reimbursement processes were considered cumbersome because verification requirements and claim payments were often delayed. Private providers preferred non-Jampersal clients who paid OOP directly.

The qualitative study revealed that Jampersal resulted in a reported workload increase among public sector providers and that this affected the income of midwives, particularly those engaging in dual practice. Jampersal negatively influenced those dual practice midwives who had a high number of patients in their private practices before Jampersal. Conversely, private practice midwives with fewer patients before Jampersal reported benefitting positively from the program.

In Garut District, the institutional delivery increase after Jampersal was 54.4 percent, and the increase was statistically significant; women were 2.4 times more likely to have institutional deliveries after Jampersal. However, around 30 percent of deliveries in Garut were still assisted by traditional birth attendants (TBAs). Coverage of institutional deliveries in Depok was already high (92.3 percent) prior to Jampersal, and after almost three years of program implementation, the coverage remained the same. An interesting phenomenon was the slight shift of institutional deliveries in Depok from the private to the public sector, and from private midwives to private clinics/obstetricians after Jampersal.

There was almost no change in antenatal care (ANC) and postnatal care (PNC) visits after Jampersal, although the use of long-term contraceptives has increased. Delivery by Cesarean section (C-section) increased by 26.4 percent, but the increase was not statistically significant, and the study could not convincingly confirm that Cesarean sections were strictly for delivery complications. The odds of having a C-section were higher in Depok than in Garut, suggesting higher access to C-section services in Depok.

Recommendations

A program like Jampersal requires strong support from stakeholders beyond the health sector. Jampersal encompassed horizontal (across sectors within the same level) and vertical (between the central and local government) collaboration. Jampersal has brought sectors together during policy formulation, but sector collaboration is important for building the momentum during implementation as well. For example:

a. Given the decentralized system in Indonesia, the involvement of the Ministry of Home Affairs (MoHA) could help build local government commitment to the program. A strong buy-in from local governments may increase subdistrict and village government support in increasing community awareness and potentially in removing other barriers to care.

b. Joint collaboration between MoH, MoHA, and Ministry of Finance (MoF) in reviewing existing regulations would be helpful in finding ways to reduce the complexity of Jampersal (or other insurance) fund management and the reimbursement process.

c. Multisector involvement is required in planning and implementing long-term investment for improving road infrastructure, transportation, and health facilities in geographically difficult areas, to improve access to institutional deliveries.

Jampersal could help to increase institutional deliveries while National Health Insurance Program (Jaminan Kesehatan Nasional, JKN) voluntary participation is still low. The study has shown the potential of Jampersal to increase institutional deliveries where coverage was low, as in Garut. The government may want to consider this finding and reevaluate the policy to terminate Jampersal implementation with the launching of the JKN on January 1, 2014. Nevertheless, before continuing the implementation, it is important to review the cost-effectiveness of the program.

Addressing "nonservice" cost is important. The study reported families still pay additional OOP cost for referral transport, which might be a barrier to accessing care. Building linkages with other

programs such as PNPM GSC[1] might be an option for addressing this issue. Moreover, reducing OOP would also require better understanding about the reason for the OOP; for example, whether it is an issue of supply chain and drug shortages, an issue of exclusion of certain drugs from the basic benefit package, or an issue of provider prescription behavior. For the latter, it will be useful to monitor possible cream skimming.[2]

"Free" is not enough; service readiness and quality also matter. Women who experienced low quality of care tended to stop using the care, or even dissuaded other women from using care (Wairimu 2013). In Kenya, women's refusal to use free maternity care was due to poor quality of facilities and the rude attitude of health providers, among other factors. Continuous quality improvements should follow any effort to improve access to health care. Complementary work shows that maternal health supply-side readiness problems remain, especially in some parts of the country; these issues could deter patients from utilizing care, despite the removal of financial barriers via programs such as Jampersal.

Getting private providers on board requires a carefully designed provider payment system. In areas where private providers are dominant and demand for private provision is high, buying services from the private sector to improve access might be more efficient than expanding public sector investment. Obviously, this would require reasonable fees and quality assurance of service provision. The study also showed that the support from professional associations like the Indonesia Midwives Association (Ikatan Bidan Indonesia, IBI) could facilitate private midwife participation in Jampersal.

There is a need to explore more options to improve human resources for health (HRH) availability and distribution in remote areas. Skilled birth attendance in rural Garut increased after Jampersal despite the low presence of midwives, suggesting adding more midwives could increase skilled birth attendance even more if paying for service is not an issue. Experience shows that monetary incentives are often not enough for deploying HRH to "difficult" areas. Other attractive features, such as housing, children's education, continuing education, and a clearly defined time period of service need to be considered. In developing HRH policies, Indonesia would benefit from a labor market analysis to understand labor market dynamics influencing HRH supply and demand.

In areas with difficult access to hospitals, the presence of basic emergency obstetric and neonatal care (BEONC) is essential. Investment in BEONC should be followed by close monitoring and consistent support to ensure continuity of care as well as by introducing policies that deter high turnover of trained staff and increase utilization.

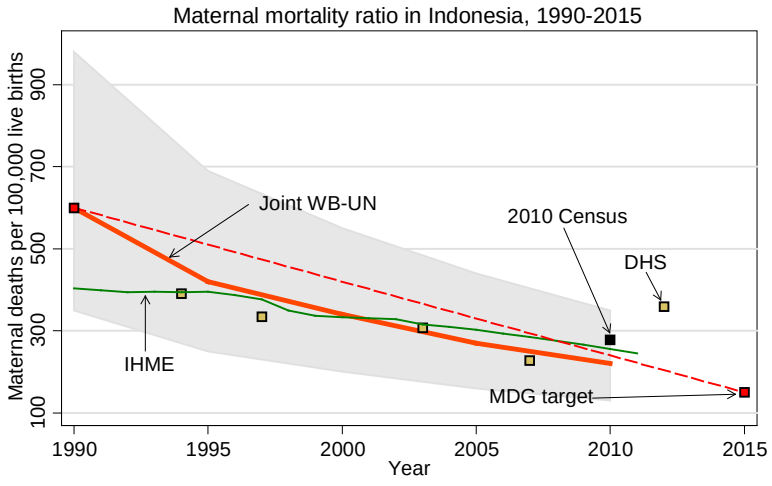
Implementation of Jampersal (or UHC) policy may have to be adjusted according to the utilization pattern for efficiency and effectiveness. The household survey conducted under this study showed Jampersal only had an impact in an area where institutional delivery coverage was still low, such as Garut. Further assessment is needed to translate this finding into future policy changes.

1. PNPM GNC is the government's community-driven development program, providing block grants to poor communities to attain selected health and education targets.
2. Midwives working in dual practice may decide to ask patients to come to their private practice as they can use the whole claim reimbursement for their own benefit, while in puskesmas they have to share with other staff.

PART 1: BACKGROUND

Indonesia has made progress in reducing maternal mortality. Although there is uncertainty about Indonesia's MMR level, all existing estimates show a decline of MMR during the last two decades with a recent plateau or even increase (figure 1.1). Despite the decline, Indonesia MMR level is still high for a country with good access to maternal health services.

Figure 1.1 Maternal Mortality Ratio in Indonesia



Sources: Joint WB-UN estimates; Indonesia census
DHS; Institute of Health Metrics and Evaluation (IHME)
Note: Shaded area represents joint WB-UN estimation uncertainty

By 2012, delivery by a skilled provider was 83.1 percent, although 36 percent of deliveries were at home, and 13.5 percent were assisted by traditional birth attendants (BPS et al. 2013). Many studies reported that possible reasons for maternal deaths included unskilled attendant during delivery, lack of knowledge of danger signs, and delayed referral. In addition, horizontal referrals have contributed to the delay in proper management of birth delivery complications.

To achieve MDGs 4 (reduce child mortality) and 5 (improve maternal health), the government has promoted institutional deliveries and improving the referral system, including access to referral services. In 2011, the government launched the Jampersal program to provide free delivery assistance to those who do not have insurance coverage for delivery services. Under this definition, Jampersal is an expansion of Jamkesmas coverage for delivery services and aims at achieving universal coverage for maternal and neonatal health services. Table 1.1 show the various social insurance schemes implemented at the same time as Jampersal, as well as prior to the merger of those programs under the National Health Insurance Program (JKN) on January 1, 2014.

Table 1.1 Comparison between Jampersal and Other Social Insurance Programs in Indonesia prior to January 2014

	Jampersal (established 2011)*	Jamkesmas[3] (established 2005)**	Askes (established 1960)***	Jamsostek (established 1992)***
Groups mandated	All women who were not covered by any type of health insurance	Poor and the near-poor	Civil servants, retired civil servants, retired military personnel, and veterans	Private employers with >10 employees or pay salary >Rp 1 million a month
Number enrolled	n.a.	76.4 million	16.6 million	5.0 million
Premium	n.a.	Rp 6,500 ($0.67) per capita per month	2% of basic + 1% government; no ceiling	3% of salary for bachelors; 6% of salary for married employees; ceiling Rp 1 million per month (not changed since 1993)
Contributor	Government 100%	Government 100%	Employees 66%; employer 34%	Employers 100%
Carrier	Ministry of Health	Ministry of Health	PT Askes (for profit)	PT Jamsostek (for profit)
Benefits	Maternal and newborn health care	Comprehensive; drugs are covered if prescribed within formulary; no cost-sharing	Comprehensive, no specific exclusion; drugs are covered if prescribed within formulary; Cost-sharing available when services fall outside basic benefit package	Comprehensive; cancer treatment, cardiac surgery, hemodialysis, and congenital diseases are excluded;[4] drugs are covered if prescribed within formulary; no cost-sharing
Dependents	n.a.	All family members	Spouse + 2 children under 21 years who are not working and not married	Spouse + 3 children under 21 years who are not working and not married
Providers	All puskemas and public hospitals and selected empanelled private clinics and private hospitals	All puskemas and public hospitals and selected empanelled private hospitals	Mostly contracted public health centers and public hospitals	Mixed: public and private providers
Provider payment mechanisms	Fee-for-service at puskesmas; diagnosis-related group (DRG)/case-based group (CBG) for hospitals	Fee-for-service at puskesmas; DRG for hospitals	Special fee schedules for civil servants; extra billing depending on negotiated fees	Fees are negotiated; extra billing depending on negotiated fees

Source: *Indonesia, Ministry of Health 2011; **Indonesia, Ministry of Health 2012; *** Harimurti et al. 2013.

3. Health insurance for the poor was introduced as Askeskin in 2005, which was expanded and renamed Jamkesmas in 2007.
4. Starting in 2012, Jamsostek expanded the benefits package to cover catastrophic cases as well.

Jampersal benefit package includes antenatal, delivery, and postnatal services at the primary care facilities, and referral services for maternal and neonatal complications at secondary and tertiary hospitals. Table 1.2 in the next section explains the details of the benefit package. The primary care facilities are public health centers (puskesmas) and their network, including the polindes (village delivery post). Enlisted private providers include private midwives, private midwifery clinics, and private hospitals. Referral/in-patient care is provided at class-3 hospital beds at public and enlisted private hospitals.

PART 2: OBJECTIVES

This study examined the financing, payment, and organization policies of the Jampersal program. Specific objectives of the study include the following: (i) a review of how Jampersal policy was formulated at the central level and implemented at the local level; (ii) a review of service provider and community response to the policy; and (iii) an assessment of the impact of Jampersal on the coverage of maternal services, particularly the impact on institutional deliveries at the primary level and Cesarean section (C-section) coverage at the secondary level (See annex 3 for study methodology).

PART 3: JAMPERSAL PROGRAM DESCRIPTION

3.1. PROGRAM TARGET

Jampersal is a government-supported program for maternity care, specifically targeting pregnant women who are not covered by any other health insurance scheme regardless of their socioeconomic status. The government of Indonesia is committed to improving the country's health system as stated in the Ministry of Health Strategic Plan 2010–2014 and the government's Roadmap to Accelerate the Achievement of the MDGs in Indonesia. The commitments translate into the provision of social health insurance for the poor, among others. Until the end of 2013, the main social health insurance for the poor in Indonesia was Jamkesmas, previously known as Askeskin, financed by the central government and targeting the poor and near-poor. Jamkesmas, which became operational in 2005, was managed by the MoH, and provided beneficiaries with free health services in puskesmas and hospitals. Another type of insurance for the poor is Jamkesda, which is funded by the subnational government (province/district level), and finances health care for the poor who are not covered by Jamkesmas. The aim of most social health insurance programs is to enable the poor and near-poor to gain access to health services to reduce mortality, morbidity and inequality. Jampersal provides comprehensive maternal health service coverage to those not covered by Jamkesmas, Jamkesda, or any other health insurance scheme. The government terminated the implementation of Jampersal in December 2013 with the launch of the National Health Insurance Program (JKN) on January 1, 2014.

3.2. BENEFIT PACKAGE

Jampersal covers pregnancy, delivery, and postpartum services including antenatal care, delivery care, postpartum care for mother and newborn, and family planning. The coverage includes standard drugs used in the national MCH program. Referral care is provided in hospital outpatient clinics and class 3 hospital beds, regardless of the income level of the user. The Ministry of Health released the Jampersal guidelines under Ministry of Health Regulation no.631/MENKES/PER/III/2011. This regulation was revised by Ministry of Health Regulation no. 2562/MENKES/PER/XII/2011 in 2012, to adjust the benefit package and the unit costs in response to findings from the evaluation of the first year implementation, indicating dissatisfaction among health providers with the service fees. Table 1.2 compares Jampersal 2011 with 2012 guidelines on services, frequency, and fees.

Table 1.2 Comparison of 2011 and 2012 Jampersal Guidelines

Type	Benefit package	Jampersal 2011 vs 2012	
		2011 (No.631/Menkes/PER/III/2011)	2012 (No.2562/Menkes/PER/X11/2011)
Antenatal care	Rate ANC in basic service	Rp 10,000/time	Rp 20,000/time
	Frequency	4 times only	Specifically for ANC with complications, the claim can be done according to the number of ANC provided as long as it is consistent with the standards (ANC can be more than 4 times)
Normal delivery	Fee for normal delivery in primary level	Rp 350,000/time	Rp 500,000/time
Maternal complication	Maternal complication is covered	Limited to obstetric complications (related to pregnancy, delivery, and postpartum)	Obstetric and nonobstetric complications (heart and other life-threatening pregnancy complications)
	Rate for management of hemorrhage, vaginal delivery with basic emergency care in BEONC facilities	Rp 500,000	Rp 650,000
	In-patient services for complications during pregnancy, postpartum in BEONC facilities	Not covered	Covered, rate based on standard rate for inpatient services
	In-patient services for sick newborns	Not covered	Covered, rate based on standard rate for inpatient services
	Postpartum care, e.g., placenta removal	Included in delivery package	Separate at a rate of Rp 150,000
Postnatal care	Fee for PNC in primary level	Rp 10,000/time	Rp 20,000/time
	Frequency	3 times only	4 times to achieve the target pof KF1,KF2,KF3&KN1, KN 2, KN3[5] For PNC with complications, according to the number of services given as long as consistent with standards (PNC can be more than 4 times)
	Contraception services[6]	Included in PNC component	Separate: a. IUD/implant Rp 60,000 b. Injection Rp 10,000
	Complication of contraception postdelivery	Not covered	Rp 100,000/time
Transport	Transport for referral	Covered	Covered
Newborn	management of sick newborn	Not covered	Covered

Source: Indonesia, Ministry of Health 2011–12.

5. KF = Postpartum visit
KN = Neonatal visit
First visit for KF1 and KN1 (6 hours to 2nd day); second visit for KN2 (3rd to 7th days); third visit for KF2 and KN3 (8th to 28th days); fourth visit for KF3 (29th to 42nd days
6. Although Jampersal also reimburses the use of short-term contraceptives, the guidelines emphasized prioritizing long-term contraceptives.

3.3. FINANCIAL SCHEME

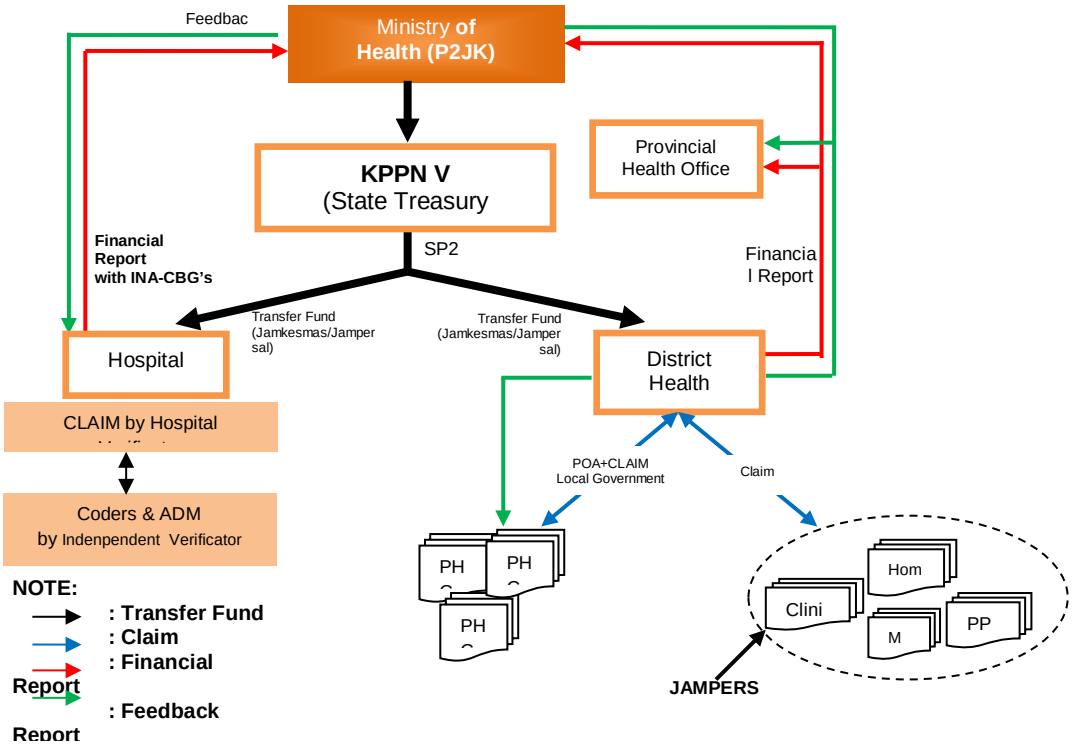
Jampersal is entirely financed through central government revenues. Figure 1.2 describes channeling of the Jampersal fund from the central to the district level. The fund was channeled directly from the State Treasury Office (Kantor Pusat Perbendaharaan Negara, KPPN Jakarta V) to the following:

The head of district/municipality health office (DHO) account. A Jamkesmas management team at the DHO manages the fund for puskesmas and participating private health facilities/providers at the primary level. The center makes the transfer periodically, three to four times a year. The amount is based on the number of pregnant women projection for the district, and adjusted according to fund utilization during the previous reporting period.

The hospital account for hospitals, which has a memorandum of understanding (MoU) with the DHO for Jamkesmas/Jampersal program. The center transfers the amount in advance based on service utilization in the hospital budget report.

As a measure to maintain continuity of care and equity among regions, P2JK (Pusat Pembiayaan dan Jaminan Kesehatan, the Center for Health Financing and Health Insurance, MoH) has the authority to reallocate funds among districts and municipalities according to district utilization and need, and depending on the availability of funds at the national level.

Figure 1.2 Jampersal Fund Channeing



Source: Modified from Ministry of Health Jampersal Technical Guidelines 2012.

Payment for the puskesmas is done through a transfer from the district treasury, while primary level private health providers receive payment directly from the DHO. The amount of payment is based on claims. The DHO verifies claims from primary level providers, while P2JK assigns independent verificators to verify hospital claims. Jampersal adopts the portability principle, allowing beneficiaries to get services from any Jampersal participating facility; the facility can make claims to the DHO

where it is located. The DHO must return unused funds to KPPN V at the end of the year, and submit the fund utilization report to MoH.

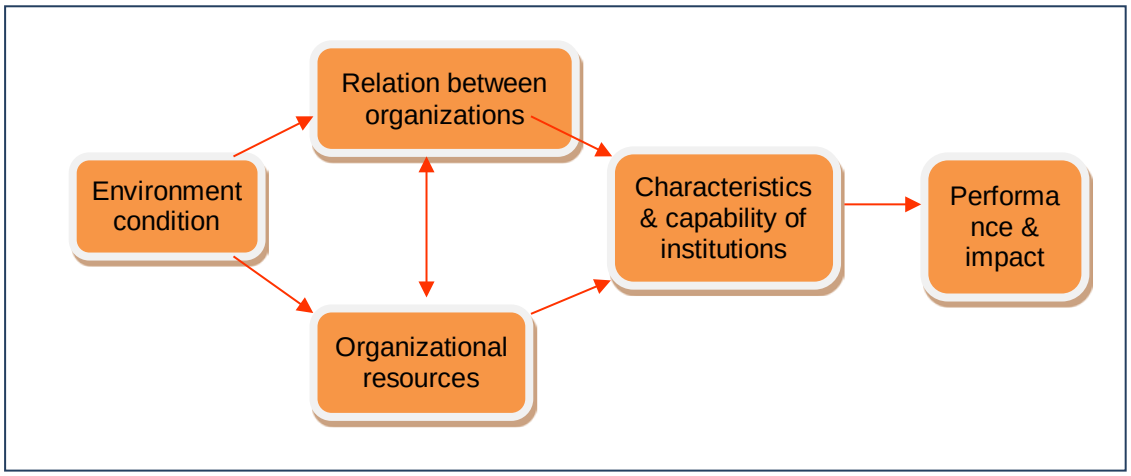
3.4. SOCIALIZATION

MoH invited DHOs and hospitals to the socialization workshops about Jampersal it held at each provincial health office (PHO); Jampersal technical guidelines were distributed to all attendees.

PART 4: STUDY FRAMEWORK

Policy Implementation Theory lists five factors influencing the success of policy implementation. The factors are **content**, **context**, **commitment**, client **capacity,** and **coalition** or the 5-C Protocol (Najam 1995). According to Cheema and Rondinelli (1983), policy performance and impact in a decentralized setting is affected by four variables as illustrated in figure 1.3 below:

Figure 1.3 Conceptual Framework of Policy Implementation



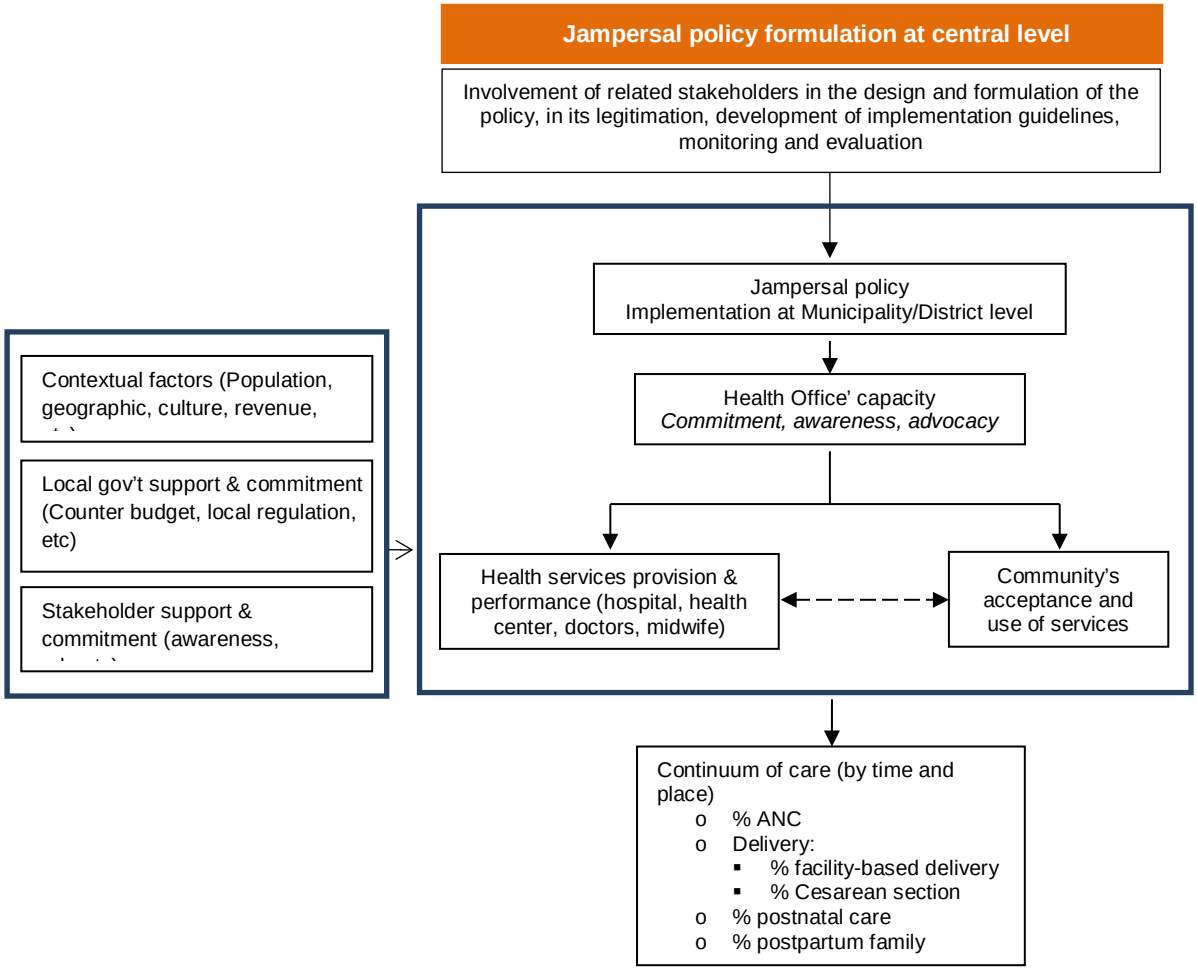
Source: Cheema and Rondineli,1983.

The study adopted the 5-C Protocol and the above conceptual framework to comprehensively analyze Jampersal implementation, focusing on the following:

Jampersal policy design at the national level: (a) policy formulation, (b) soliciting political support to improve policy acceptance, (c) development of implementation guidelines, and (d) monitoring and evaluation.

Jampersal implementation at the provincial and district levels: (a) policy implementation issues, including analysis of barrier and facilitating factors; and (b) impact of the policy on continuum of care and provider performance.

Figure 1.4 Study Framework



Source: Authors.

Jampersal policy is developed centrally and implemented by local governments to provide maternal and newborn health services at public health service delivery points and private institutions enlisted by the local government. Because of decentralization, implementation varied among the districts, depending on local government commitment, health service, and community factors. This study examined the implementation of Jampersal policy in Garut District (mostly a rural area) and Depok Municipality (an urban area) in West Java Province, covering contextual factors (geography, population, revenue, and cultural aspects); local government commitment and support; stakeholder participation and support; and the capacity of the lead implementing unit (that is, district health office) in implementing the policy. This study also looked at service provision by the responsible public and private health service institutions at the primary and secondary levels; human resources, particularly doctors and midwives working in the institutions, regarding their satisfaction toward Jampersal terms and conditions and financial incentives; and Jampersal utilization by the community, including involvement of the community leaders, client satisfaction, and reasons for not using Jampersal. The study analyzed Jampersal program output at the community level, covering the level of antenatal care, institutional delivery, Cesarean section, and postpartum family planning services.

In interpreting the impact of Jampersal, the study also identified other programs implemented at the national, provincial, or district level in health and other sectors that may influence program outcomes.

PART 5: METHODOLOGY

5.1. STUDY DESIGN

The team implemented the study during May to August 2013 in Garut District and Depok Municipality in West Java Province. The study applied qualitative and quantitative approaches. The study design was cross-sectional with pre/post assessment. The qualitative approach provided information about the financing, payment, and organizational policies of Jampersal and reviewed the impact of the policies on HRH performance. The quantitative approach examined whether Jampersal has an impact in improving the coverage of services, particularly institutional deliveries and Cesarean sections. The sample size provided statistically representative data for each area.

5.2. POPULATION AND SAMPLE SIZE

The qualitative approach used in-depth interviews and focus group discussions at the central, provincial, district/municipality, and community levels. A household survey measured the impact of Jampersal on maternity care utilization. The respondents were women of childbearing age (15 to 49 years). Women who delivered two years (the two-year cut-off point was used to reduce recall bias) before Jampersal implementation (2011) were the baseline/pre-Jampersal samples, and women who delivered after Jampersal implementation were the endline/post-Jampersal samples. The required minimum sample size was 453 households for each group (pre- and post-) in each study area. The sample size was 906 samples in total for each area, or 1,812 samples in the two study areas. The study collected information from 921 respondents in Depok and 918 respondents in Garut, or a total of 1,839 respondents. The households were randomly selected using a two-stage random sampling with Probability Proportional to Size (PPS) method. Inclusion criteria were mothers with a child/children who have lived in the study area at least since 2009 (See annex 3 for the full study methodology).

5.3. STUDY LIMITATIONS

The study may have been undertaken too early to evaluate the real impact of Jampersal. Further, since it covered only two districts, the study cannot represent the real situation of Jampersal implementation in the country.

PART 6: RESULTS

6.1. DESCRIPTION OF THE STUDY AREAS

The two study areas were widely different in factors influencing access to health care. The size of Garut District was approximately 3,000 kilometers,[2] with a population of over 2.4 million residing in 42 subdistricts. The majority of the district is rural/remote areas consisting of 403 rural-villages and only 21 urban-villages. In contrast, Depok Municipality is an urban area, with no geographical constraints and with a high availability of health care facilities. Depok encompasses an area of 200.2 kilometers^2 and has a population of approximately 1.8 million people. Depok is a rapidly growing city, located next to Jakarta, Indonesia's capital. According to the 2011 Human Development Index (HDI),[7] Depok had a high HDI score (79.36), higher than the HDI of West Java Province (72.73). The HDI of Garut for the same year was 71.70.

In 2012, 12 of the 65 puskesmas in Garut had no doctor. More than half of the midwives in two of the sampled puskesmas in Garut were temporary midwives, who were paid a monthly honorarium by the puskesmas. Around 52 percent of village midwives in Garut had completed Normal Delivery Care (Asuhan Persalinan Normal, APN) training while only around 29 percent of them had attended Obstetric and Neonatal Emergency Care training (Gawat Darurat Obstetrik Neonatal, GDON). In Depok, almost 91 percent of the midwives had completed APN training, and around 63 percent had attended GDON training.

The list of facilities and human resources for health at the beginning of the Jampersal program (2011) in the two locations is shown in table 1.3 below.

Table 1.3 Facilities and Human Resources for Health in Garut and Depok, 2011

Facilities	Garut District	Depok Municipality
	Number (*)	Number (**)
Public hospitals	2	1
Public hospital beds	504	71
Military hospitals	1	1
Private hospitals	1	14
Puskesmas (with in-patient care)	15	1
Puskesmas (without in-patient care)	50	31
Pustu (satellite puskesmas)	136	5
Private maternity clinics	7	25
Private physicians	2	158
Private clinics	89	19
Posyandu (integrated services post)	3,558	974
Human resources		
Specialist physicians	30	551
Obstetricians	5	35***
Anesthesia specialists	12	24
Physicians (general practitioners)	93	269
Midwives	586	377
Village midwives	431	–
Nurses	673	1827
Pharmacists	70	284

Source: *Garut District Health Profile 2011; **Depok Municipality Health Profile 2011; ***based on license.

7. Human Development Index is a composite of three indexes: life expectancy rate, education (based on illiteracy rate and average school years), and decent living index.

In 2012, there were 15 BEONC facilities in Garut, or double the number of 2010. Garut DHO had converted 14 Puskesmas in geographically difficult areas into BEONCs. There were far fewer BEONC facilities in Depok: only one BEONC in 2010 and four in 2012 (table 1.4).

Table 1.4 The Number of Health Facilities in Garut and Depok, 2010–12

Data	Garut District*			Depok Municipality**		
	2010	2011	2012	2010	2011	2012
Puskesmas (PHC)	64	65	65	32	32	32
BEONC[8] facilities	6	15	15	1	2	4
Midwives	930	1,074	1,074	108	109	109
CEONC[9] (public) facilities	1	1	1	1	1	1
CEONC (private) facilities	0	0	0	15	15	15

Source: *Garut District Health Profile 2010–12; **Depok Municipality Health Profile, 2010-12.

Less than half of Garut's population and around a quarter of Depok's population were covered either by Jamkesmas, Jamkesda,[10] or Askes.[11] In Garut, Jamkesmas, Jamkesda, and Askes covered around 33 percent, 6 percent, and 2 percent of the population, respectively. In Depok, the coverage was around 8 percent, 10 percent, and 6 percent, respectively (table 1.5).

Table 1.5 Population and Recipients of Social Health Insurance in 2012

	Garut	Depok
Total population*	2,485,130	1,813,612
Poor population**	969,924	321,012
Estimate number of pregnant women*	67,414	47,899
Estimate number of birth deliveries	64,701	45,722
Jamkesmas** (%)	33	8
Jamkesda** (%)	6	10
Askes** (%)	2	6

Source: *Health Profile of Garut District and Depok Municipality, District Health Office 2010–12;

** Provincial Health Office Estimates, 2012.

6.2. IMPLEMENTATION OF JAMPERSAL POLICY (FINDINGS FROM THE QUALITATIVE STUDY)

6.2.1. Organizational Arrangement

There were six main actors in Jampersal implemention: MoF, MoHA, Bappenas, MoH, PHO/DHO, and local government. In practice only the MoH and local governments were actively involved in Jampersal implementation. Both Garut and Depok collaborated with the Indonesia Midwives Association (IBI) to increase participation of private practice midwives.

8 BEONC is Puskesmas with ability to provide 24-hour Basic Emergency Obstetric and Neonatal Care (BEONC/PONED), including management of preeclampsia/eclampsia, shoulder dystocia, vacuum extraction, post-partum hemorrhage, puerperal infections, low birth weight, and other early neonatal conditions.
9 CEONC is hospital with ability to provide comprehensive emergency obstetric and neonatal care
10. Local government health insurance.
11. Health insurance for civil servants.

Table 1.6 Roles and Responsibilities of Actors under Jampersal

	MoF	MoHA	Bappenas	MoH	PHO/DHO	Local government
Oversight scheme				√		
Financing scheme	√		√	√		
Benefit package determination				√		
Accreditation/empaneling providers				√	√	
Financial management/planning		√		√	√	√
Setting reimbursement rates				√		
Claims processing/payment				√	√	√
Outreach/social marketing				√	√	
Service delivery				√	√	
Monitoring local utilization					√	
Monitoring national utilization				√		
Customer service				√	√	

Source: Modified from the Joint Learning Network 2012.

6.2.2. Financing

Utilization of Jampersal and disbursement of the allocated money for Garut increased gradually (table 1.7). In 2011, the absorption of the Jampersal budget was 43.5 percent (Rp 7.0 billion from the allocated Rp 16.2 billion), and increased to 57.0 percent in 2012 (Rp 15.2 billion from the allocated Rp 26.7 billion). By the end of the second quarter of 2013, the absorption was almost Rp 6.0 billion.

Table 1.7 Budget Allocation and Utilization of Jampersal in Garut, 2011–13

Year		Jampersal budget tranches				
		I	II	III	IV	Total
2011	Allocation	6,133,501,000	8,178,002,000	1.942,169,000	-	**16,253,672,000**
	Utilization					**7,076,388,000**
2012	Allocation	8,017,686,000	10,690,248,000	-	8.017,686,000	**26,725,620,000**
	Utilization					**15,258,030,000**
2013*	Allocation	8,390,279,000	8,770.560,000	-	-	**17,160,839,000**
	Utilization					**5,759,470,750**

Source: Garut District Health Office 2011-–13,

*Second quarter.

In 2013, the fund allocation in Depok decreased significantly (table 1.8). This was because the DHO reported utilization of Jampersal in 2012 was only around Rp 500 million, although not all services had been claimed. The study could not gain access to the disbursement data. The low utilization in Depok might be related to the high use of private providers for maternal care in Depok; many private providers did not participate in Jampersal.

Table 1.8 Budget Allocation of Jampersal in Depok, 2011–13[12]

Year		Budget allocation tranches				
		I	II	III	IV	Total
2011	Allocation	n.a.	n.a.	–	n.a.	n.a.
2012	Allocation	3,377,336,000	4,503,114,000	–	3.377,336,000	11,257,786,000
2013	Allocation	875,700,000	–	–	–	875,700,000

Source: Depok District Health Office, Technical Implementing Unit (Unit Pelaksana Teknis, UPT) Jamkesda, 2011–13.

According to the revised 2012 guidelines, disbursement of Jampersal funds should comply with the APBD (Anggaran Pendapatan dan Belanja Daerah, local government budget mechanism). The DHO prepared an annual Jampersal budget work plan (RKA, Rencana Kerja Anggaran) based on the yearly projection of the number of deliveries in the district. The amount had to be locally approved and recorded in the APBD and would be the reference for the Jampersal money available to the district for the year. The DHO could not pay for claims above the amount set in the APBD. If the total claim was higher, as experienced by Garut, the DHO could not cover the whole claim and had to delay payment until the subsequent budget year. The DHO must return any unused Jampersal funds to KPPN V, and submit a fund utilization report to MoH at the end of the budget year.

6.2.3. Verification, Claim, and Reimbursement System

6. 2. 3. 1. Primary Care Level

Jampersal used verificators to check the completeness and validity of Jampersal claims. There were seven verificators in the Garut DHO and five in the Depok DHO. In addition, at the puskesmas in Garut, a team consisting of the head of the puskesmas, the Jampersal treasurer, and the midwife coordinator verified the completeness of documents for services delivered through the puskesmas network (including the polindes) before submitting the claims to the DHO. One puskesmas did spot--checks to uncover any irregularities by conducting home visits to Jampersal users.

> *"I had an experience finding fictitious data. The woman turned out to be an elderly. Field verification is meant to confirm the accuracy of the claim."* (Puskesmas)

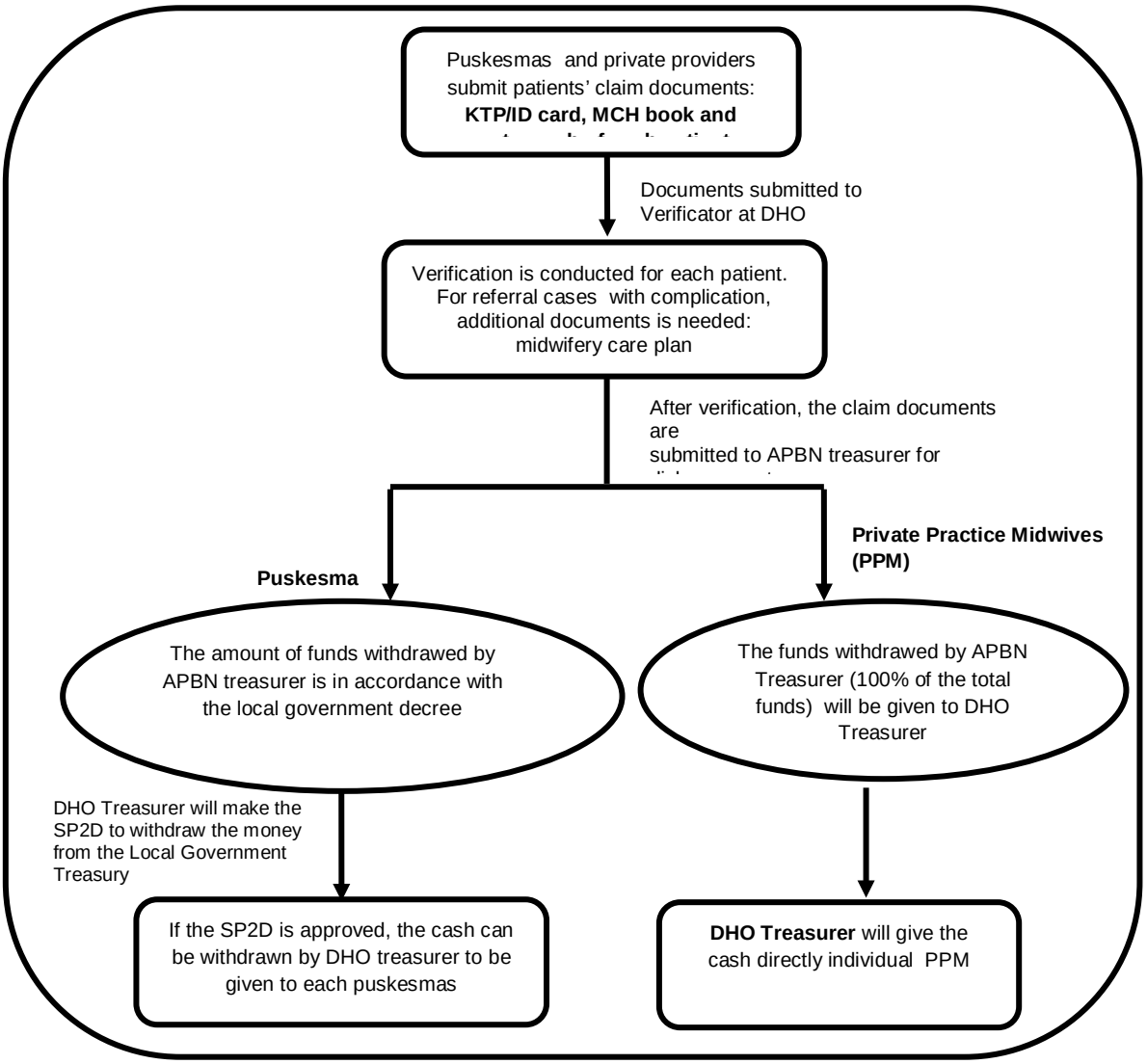
Staff involved in the verification process received some incentives from the local government. For delivery complications, the Maternity Care Plan (Askeb, Asuhan Kebidanan) was added to the requirements for service claims. The Garut DHO went further by introducing a local policy requiring submission of the Maternity Care Plan for all deliveries as a way to improve discipline in documentation of provided care. This local initiative was considered burdensome by the midwives, who thought the partograph[13] was a sufficient tool for recording normal as well as complicated birth delivery processes.

Puskesmas and private providers must submit the required documentation for fee claim processing at the DHO.

> *"It took between two or three weeks until one or two months to finish (verification of documents for Jampersal claims). There were so many...especially...when it has piled up for several months. Maybe for private providers there are not as many ...around two to three patients per month. But, for the puskesmas, there are tens up to hundreds for every single month. So it takes a longer time."* (DHO)

12. The researcher did not get any fund utilization data from Depok DHO.
13. Partograph is a composite graphical record of key data (maternal and fetal) during labor, entered against time on a single sheet of paper. Relevant measurements might include statistics such as cervical dilation, fetal heart rate, duration of labor, and vital signs.

Figure 1.5 Claim and Reimbursment Mechanism at Primary Care Level



Source: Authors.

The DHO verified Jampersal claims from the puskesmas and private providers (figure 1.5). Private providers at the primary level could send claims directly to the DHO verificators.

Puskesmas in rural/remote areas of Garut submitted claims every two to three months instead of monthly. On the other hand, urban puskesmas came frequently to the DHO for consultation during the verification process.

In 2011, after completion of the verification process, the verficators sent the documents to the DHO Jampersal management team leader for approval. The team leader forwarded the documents to the DHO treasurer of Jamkesmas/Jampersal with the claim amount to be paid. The puskesmas would receive payment in cash from the DHO verificators. In 2012, the center changed the puskesmas claim mechanism to follow MoF regulation on district financial management. The verificators submitted verified claims to the APBN treasurer, who had the authority to withdraw money from the district APBN account. The APBN treasurer transferred the money to the local government treasury at the DHO. Fund withdrawal from the local government treasury was based on a disbursement warrant letter (Surat Perintah Pencairan Dana, SP2D). The DHO treasurer would transfer the claim payment

to the puskesmas, while primary level private providers obtained the payment directly from the DHO treasurer (figure 1.5).

The deadline for the use of Jampersal funds in each calendar year was December 20. This was because MoH must return unused funds at the end of the year as nontax payment (Penerimaan Negara Bukan Pajak, PNBP) to the KPPN. Claims submitted after December 20 would be paid in the following year. The balance in the DHO account should be zero at the end of the year when the BPK (Badan Pemeriksa Keuangan, National Finance Audit Board) audits the DHO.

The DHO was also bound by Ministry of Home Affairs (MoHA) regulation no. 262/PMK.03/2010, regarding income tax, applying 6 percent income tax (Pajak Penghasilan, PPH 21) to fees received by civil servants level III and above. The tax would be deducted from the amount paid to the puskesmas.

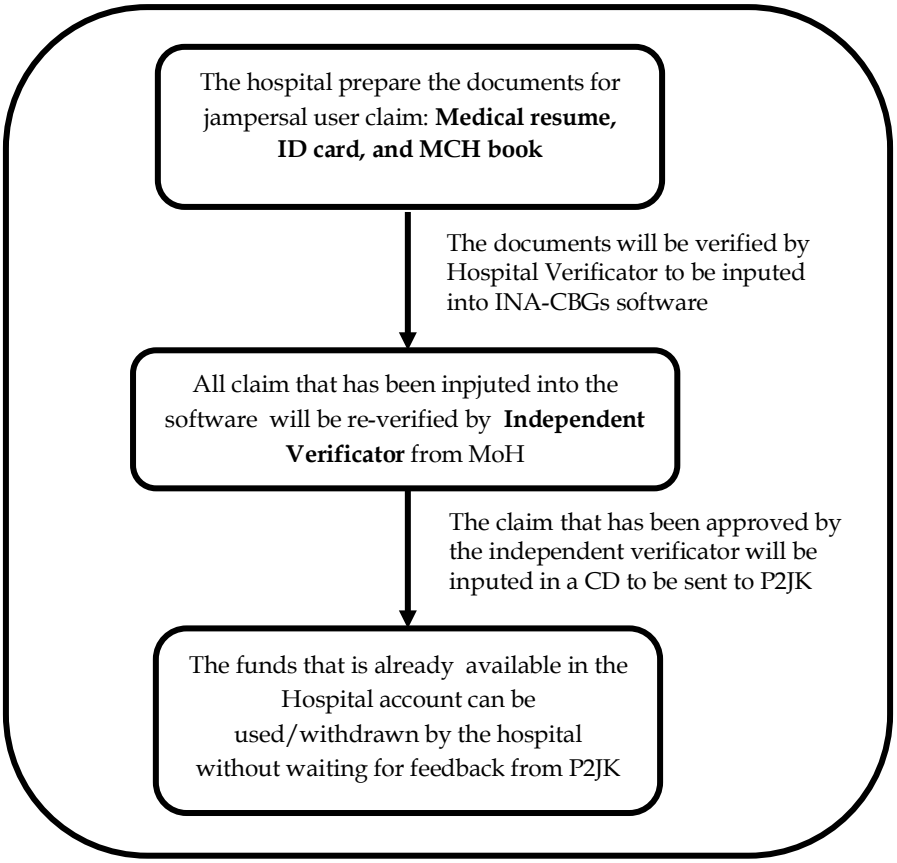
6. 2. 3. 2. Hospital Level

P2JK assigned independent verificators to verify Jampersal and also Jamkesmas claims at the hospital level. Each hospital may also assign its own staff to verify the documents before submission to the independent verificator.

Hospital Jampersal claims were based on the INA-CBGs [14] tariff (figure 1.6). Required claim documents included a copy of the medical record, including supporting examination results, family card, the mother's and the husband's ID cards, and the mother's MCH book.[15] The hospital would issue a statement letter for entering data into the INA-CBGs software and for verification by the independent verificator. Problems in the verification process were related mainly to software changes and broken computers.

14. Indonesia case-based groups or DRGs.
15. The MCH book records information from maternal services records (pregnancy, childbirth, and postpartum) and child services records (immunization, growth monitoring) and provides relevant information about maternal and child health care.

Figure 1.6 Claim and Reimbursment Mechanism at the Hospital Level



Source: Authors.

Because MoH has transferred Jampersal money to the hospital in advance, the claim payment process did not take long once the verification process was complete. So far, the amount transferred by MoH to the hospitals was enough to cover the claim payments. If all Jampersal money in the hospital account has been spent, the MoH would make another transfer to the hospital.

6.2.4. Provider Payment Scheme

6. 2. 4. 1. Primary Care

According to Jampersal guidelines, a minimum 75 percent of puskesmas claims were for service fees; the remainder (25 percent) could be used by the DHO for operational costs, such as program socialization, consumables, drugs, and monitoring and evaluation. Depok allocated only 15 percent for DHO operational costs.[16] Private providers were reimbursed 100 percent of their claims.

The puskesmas has the flexibility to decide on the fee amount for the providers. In some puskesmas in Garut, the amount received was shared by all puskesmas staff depending on the workload; therefore, the amount received by the actual provider was quite small even though the government had increased Jampersal service fees in 2012.

6. 2. 4. 2. Hospital Level

Payment to public and private hospitals was determined according to the same INA-CBG tariffs. Public hospital management reported that the service fee for medical staff was a very small proportion of the total claim per service. This was considered unfair, particularly for specialists who saw many

16. Depok Mayor Decree no. 903/99/KPTS/dinkes/Huk/2013.

hospital patients. One informant stated that the service fee received by a specialist from a public hospital per patient was only 5 percent.

For private hospitals, the INA-CBG payment was considered far below the private hospital tariff, even after the government increased the tariff. Cesarean section for third-class patients under INA-CBG was Rp 1.4 million, while non-Jampersal patients in a private hospital paid Rp 8 million. A private hospital informant stated 50 percent of the Jampersal payment was for the obstetrician, 30 percent for the anesthesia specialist, and 20 percent for the pediatrician. Other clinical staff such as the anesthesia assistant got Rp 50,000 to 100,000 per Jampersal patient from the hospital's own budget. Midwives and nurses in that private hospital were considered salaried workers and did not receive anything from the Jampersal claims.

6.2.5. Socialization

The study found that the central level socialization workshop preceded the distribution of Jampersal guidelines to the PHO/DHO and the health providers. The guidelines were available at the implementation level around three months after the start of the implementation or mid-2011. There were indications of some confusion at the beginning of program implementation, particularly regarding implementation procedures and the benefits package.

The DHO conducted socialization for all Jampersal providers through monthly workshops, meetings, and other activities. An informant from a private clinic stated there was no follow up from the DHO to discuss agreement on the Jampersal program.

In puskesmas, participants of the socialization workshop were the head of the puskesmas, the midwife coordinator as the technical implementer, and the treasurer of Jampersal. The DHO adjusted the socialization material according to participants' duties and responsibilities. Interviews during the study revealed that the general nature of the guidelines may have undermined the wide variation of implementation conditions.

> *"It is not suitable to the field condition. The technical guidelines are general, as if all health facilities are the same: having a doctor, midwives, complete tools, and infrastructure."* (Puskesmas)

The DHO reported that questions raised by the midwives indicated they did not have access to or had not read the gudeilines.

> *"….. Many midwives still ask questions…whether pills can be claimed. In fact, the answer is stated in the technical guidelines. Some midwives did not claim for family planning services because they did not know that postpartum family planning was covered."* (DHO)

Some midwives thought Jampersal information was clear except for information on payment to the providers. They also questioned the use of the 25 percent operational costs by the DHO.

Puskesmas and village midwives conducted Jampersal socialization for the community through mini workshop/meetings at the village office, posyandu, or puskesmas. In rural and remote areas, they also used community activities such as religious gatherings as venues. Socialization for Jampersal beneficiaries was done mostly by midwives for women seeking antenatal care.

Interviews with women and community leaders showed that community understanding about Jampersal was inadequate. Many women did not know about Jampersal. Some informants perceived that Jampersal only covered fees for birth delivery. Others thought that Jampersal required cost-sharing and patients would have to pay half of the service costs. Some women did not want to use Jampersal because they were not convinced that services were free, particularly for treatment of complications in the hospital. Some perceived Jampersal provided lower quality of service.

"… Have heard of Jampersal, but I hesitated to use, I am afraid that I still have to pay." (Mothers)

"I think the service is the same, but patient who pays get faster service, gets good and expensive medicine." (Mothers)

6.2.6. Monitoring and Evaluation

Jampersal monitoring and evaluation (monev) was conducted through a cascade process. The DHO conducted visits and regular meetings with the puskesmas head and with the verificators to discuss implementation issues, such as places eligible for birth delivery, claim schedule for puskesmas, disbursement schedule of Jampersal funds, and coverage report. A DHO informant reported that implementation of monev activities were not regular. At the puskesmas level, the discussion was mostly about program coverage, barriers, and problems. Overall, information gathered during the study seemed to indicate that the focus of monev was primarily on the utilization of Jampersal funds.

6.2.7. Supply-Side Capacity

6. 2. 7. 1. Human Resources

Unlike Depok, Garut had a serious shortfall in HRH numbers and distribution, especially for its rural and remote areas. The local government relied mostly on support from the provincial and central governments for HRH recruitment. However, most HRH sent by the province did not want to serve in difficult areas.

Recruitment of Bidan Honorer in Garut has somewhat helped the puskesmas in solving the HRH availability issue, but the compensation of Bidan Honorer has become a burden to the puskesmas. A puskesmas reported that the monthly fee of a Bidan Honorer was only Rp 100,000 per month, although they were eligible for receiving Jampersal service fees. The turnover of Bidan Honorer was higher than that of civil servants. The DHO considered this problematic because the high turnover affected puskesmas achievements.

"In puskesmas BEONC X, the PTT (contract) midwife has received BEONC training, but the building was not ready. When the building is finished, the midwife has moved out…the puskesmas recruit...volunteers…. In reality there are many Bidan Honorer in the BEONC, but they do not have BEONC competencies." (DHO)

In the public hospitals, the increasing number of patients due to Jampersal was not followed by a parallel increase in HRH. The hospital was lacking specialists and midwives for maternity care. Although there were obstetric interns in the hospital, the workload of the obstetricians was quite high.

"Now there are eight patients, a patient has not given birth, another one came in. The surgery has just finished; there is another one already in the waiting lists for the next surgery. Honestly we really want to refuse patients, but it is not allowed…. It makes us so tired…." (Hospital)

6. 2. 7. 2. Public Health Facilities

After Jampersal, all puskesmas in Garut were instructed to provide delivery services; while before Jampersal, only puskesmas with in-patients provided the services. Despite improvements to the puskesmas, for example by increasing the number of BEONC (basic essential obstetric and neonatal care) facilities, puskesmas in the rural areas of Garut were only open from 7 am to 2 pm. The midwives considered the presence of BEONC facilities in remote areas helpful, at least for stabilizing patients with complications before referring them to the hospital. Dr. Slamet Public Hospital in Garut could not fully function as a CEONC (comprehensive essential obstetric and neonatal care) hospital because it did not have sufficient staff and facilities. The neonatal intensive care unit (NICU) was available but not yet functioning.

> *"Referred obstetric patients go to emergency room where there is only one midwife per shift, incomplete equipment, and lack of facilities. If there are three referred patients ...will be a burden to the emergency room."* (Hospital)

One clinical staff stated that even before the Jampersal program, the district hospital has always had a high load of referred obstetric cases.

> *"What a pity …patients must be tired of waiting, and for us this did not make our performance optimal. If the Cesarean section was delayed, we could not go home to rest.... It was so tiring and make us angry."* (Obstetrician in a district hospital)

Both study areas faced problems in referring maternal complications. Depok has one public hospital with very limited capacity to provide maternal and neonatal care; as a result, the hospital often referred severe complications to other hospitals, including to public hospitals outside Depok and sometimes to private hospitals. Garut has two public hospitals, but only one could fully function as a referral hospital, causing a real burden to that hospital. The situation was exacerbated by geographical constraints. The referral hospital was difficult to access from the southern part of Garut with at least a three-hour travel time to reach the hospital.

6. 2. 7. 3. Private Providers

Private sector participation in Garut was low. Only 11 of 571 private practice midwives in Garut have signed the Jampersal memorandum of understanding (MoU) with the DHO. Jampersal guidelines stated services should be provided by competent staff. There is no accreditation process prior to enrollment of the providers. Most private practice midwives in Garut engaged in dual practice as they were public sector employees in the morning. In Depok, 67 percent of private practice midwives had Jampersal MoU with the DHO. The Indonesia Midwives Association (IBI) was instrumental in increasing the involvement of private practice midwives.

The acceptance of private practice midwives to Jampersal varies according to their perceived benefits. Many private providers in the two locations were dissatisfied with the service fees; this was the main reason for refusing to become Jampersal service providers. The regular tariff for delivery in puskesmas according to Garut District regulation was Rp 75,000 to Rp 125,000, depending on the type of the delivery provider.[17] Although the Jampersal tariff was already higher (Rp 500,000 for normal delivery), it was still lower than the private provider tariff. In Depok, the fee for normal delivery by a private provider was Rp 1 million, while in Garut it was Rp 850,000.

For midwives with a low visit rate or with a practice in areas where the majority of the community was of low socioeconomic status, Jampersal increased the number of deliveries in their private practice. A midwife who had few patients before Jampersal mentioned that Jampersal increased her income because she saw more Jampersal patients. On the other hand, midwives with a high number of patients paying out-of-pocket were reluctant to serve Jampersal patients. A private midwife with many patients, who did not sign up for Jampersal, reported a reduced income because Jampersal shifted some of her patients to the puskesmas or to other private practice Jampersal midwives. Other midwives reported that the additional workload due to Jampersal was not comparable to the compensation received.

Regardless of the midwife's perception of Jampersal benefits, almost all midwives interviewed consistently mentioned the problem of delayed reimbursement and troublesome claim processes. One private midwife interviewed reported she stopped providing Jampersal services for those reasons. Non-Jampersal clients paid directly out-of-pocket for services received, while in Jampersal, private providers had to submit claims, and payment was often delayed.

Based on DHO information, no private clinic in Garut provided Jampersal services. One private clinic owner stated the main reason for not joining Jampersal was the low reimbursement that did not cover service fees and operational costs. The tariff rate set out by INA-CBGs was much lower than the

17. Garut Local Government regulation no. 821/Kep.0006.A/Dinkes/2013.

usual obstetrician fee rate. Private clinics were concerned that a low fee would result in low quality, while service quality was the trademark of the private sector. Moreover, private clinics with low bed occupancy rates (BORs) could not exercise cross-subsidy.

> *"It does not cover at all. I have to pay the wages for my staff, and in the private sector the cost is borne by the patients."* (Private Clinic Owner)
>
> *"The specialist will get nothing…even the nurses will only receive 10 to 25 percent of the usual service fee. In the end I fear that it will affect the service delivery performance."* (Private Clinic Owner)

There was no private hospital in Garut. All private hospitals in Depok signed a Jampersal MoU, and demanded that each private hospital get an equal share of Jampersal patients. In practice, many private hospitals in Depok did not accept Jampersal patients, despite the MOU; or they limited the number of patients. In addition, not all facilities adhered to Jampersal portability principles. Some private hospitals rejected Jampersal patients from neighboring districts, while others refused referral from private practice midwives and demanded a referral letter from a puskesmas or public hospital.

The main reason for low participation of the private hospitals was the low Jampersal reimbursement. Another study found that the low involvement of private hospitals is due to unclear information about the program itself, including about the criteria of cases covered by Jampersal, the payment system, and the benefit package (Najib et al. 2012).

The DHO acknowledged difficulties in engaging the private sector to join Jampersal. There was concern in the DHO that if private clinics provided Jampersal services, most patients would prefer private clinics to public hospitals or puskesmas.

6.2.8. Commitment to Jampersal

Garut DHO acted to overcome some Jampersal implementation barriers, for example: (1) advocacy to district government to increase the allocation for service fees to public providers at primary care level; (2) advocacy to increase the ceiling of the Jampersal fund allocation in the APBD through a budget amendment to ensure that all claims could be covered within the ongoing year; (3) speeding up the verification process by providing incentives to the puskesmas verificators; (4) encouraging village midwives and private practice midwives to improve the quality of their practice sites for eligibility as Jampersal delivery facilities; and (5) developing a claim submission schedule for a puskesmas to better organize the verification system and prevent delays.

Village government contribution to Jampersal included the following: (1) socializing Jampersal information; (2) providing temporary ID cards or statement letters of domicile; (3) facilitating the provision of a village ambulance by encouraging a Corporate Social Responsibility Program of the private sector; (4) issuing village regulation on partnership between midwife and traditional birth attendants (TBAs); and (5) approving the construction of a village polyclinic financed by PNPM[18] as the village priority.

In 2013, the Depok DHO sought to improve Jampersal coverage by (1) adding a verificator at the DHO to accelerate the verification and claim payment process; (2) requesting Jampersal providers to send monthly claims to the verificator to avoid claim accumulation; (3) increasing the partnership with private practice midwives in serving Jampersal patients by providing reimbursement for consumables and drugs.

Low commitment of private hospitals to Jampersal in Depok compromised the effectiveness of the Jampersal referral system. Some hospitals refused to admit referred Jampersal patients, and the DHO often had to intervene and directly call the hospital to ensure that referred patients with government insurance were accepted by the hospital.

18. PNPM (Program Nasional Pemberdayaan Masyarakat) is a national community empowerment program for poverty reduction.

6.2.9. Garut's Dilemma in Implementing Jampersal Policy

In response to the lack of delivery facilities in rural and remote areas, Garut allowed skilled birth attendants to charge for home deliveries to Jampersal. This local policy was inconsistent with the Jampersal guidelines.

> *"Deviation still occurs in the Southern region and mountainous areas, please note and take this for input…. They give birth at home and still claim as Jampersal."* (DHO)

Another issue was that Garut had a decree from the DHO **(No 821/Kep.0006.A/Dinkes/2013)** for a Service Fee Target for Local Revenues, meaning that all puskesmas had an annual target of service fee earnings that would contribute to local government revenue. The fees were collected from in-patient services, deliveries, medical treatment, laboratories, and ambulances. The fee target was based on the number of villages, types of maternal care, and the number of pregnant women. The fee for birth delivery was Rp 75,000 to Rp 125,000 per patient depending on the type of birth attendant (midwife or doctor), and Rp 200,000 per patient for delivery in a BEONC facility.

The three puskesmas visited in the study had different fee targets for delivery care. The target for a BEONC facility in an urban area was Rp 12,075,000; for a BEONC facility in a remote area, Rp 7,350,000; and for a puskesmas without in-patient care in a rural area, Rp 12,700,000 per year.

The local regulation was a dilemma for providers in rural and remote areas. Although Jampersal patients did not pay for delivery services, a puskesmas still had the obligation to meet the district government's target.

Some puskesmas believed an unachieved target would be carried over to the next year and decided to request a contribution from the midwives. Each puskesmas and village midwife contributed about Rp 80,000 to Rp 150,000 per month. In contrast, puskesmas in urban areas with a high visit rate could cover the target from other services.

> *"You can imagine, the target in my puskesmas is 9 million per year, and we only have five midwives. Every month, how much do we have to contribute? There is Jampersal, but we still have to pay…."* (Puskesmas)

6.3. RESULTS OF THE HOUSEHOLD SURVEY

6. 3. 1 Respondent Characteristics

The household survey enrolled a total of 1,839 respondents, who are women of childbearing age (15 to 49 years): 921 sampled from Depok Municipality and 918 from Garut District. The sample size difference between the two locations was due to the rounding of samples per census block. The sample size per district for before and after Jampersal met the required minimum sample size.

Table 1.9 presents the respondent characteristics. The majority of the sample in both districts was in the two age groups: 21-to-30 and 31-to-40 years. The proportion of respondents less than 20-years old showed a different pattern: in Garut the percentage was much higher (3.9 percent among pre-Jampersal samples and 15.6 percent among post-Jampersal samples) than in Depok (0.4 percent and 3.0 percent, respectively).

Table 1.9 Respondent Characteristics

Characteristics		Garut		Depok	
		Before (*n*=462) %	After (*n*=456) %	Before (*n*=460) %	After (*n*=461) %
Age	≤ 20 years	3.9	15.6	0.4	3.0
	21–30 year	50.4	50.7	45.0	56.6
	31–40 year	36.8	30.5	47.2	36.9
	>40 year	8.9	3.3	7.4	3.5
	Minimum (years)	18	17	20	14
	Maximum (years)	49	49	45	45
	Mean (years)	30.3	28.1	31.6	29.7
Pregnancy	2–3 times pregnancy	48.9	46.9	52.6	54.9
	1 time pregnancy	31.6	35.3	35.2	32.3
	> 3 time pregnancy	19.5	17.8	12.2	12.8
	Minimum	1	1	1	1
	Maximum	10	11	7	9
	Mean	2.5	2.3	2.2	2.2
Completed education	No school/some primary	3.0	1.8	1.3	0.9
	Primary	46.5	43.4	14.3	12.6
	Secondary	47.0	49.3	72.8	73.8
	Academy/university	3.5	5.5	11.5	12.8
Occupation status	Working	25.1	14.0	26.7	20.4
	Not working	74.9	86.0	73.3	79.6
Urban-rural	Urban	45.0	45.6	100.0	100.0
	Rural	55.0	54.4	0.0	0.0
Health insurance	No insurance	48.3	56.1	55.4	57.5
	Insurance for the poor	46.5	38.4	15.9	14.3
	Other insurance	5.2	5.5	28.7	28.2

Most before and after Jampersal implementation respondents in Depok and Garut had two to three pregnancies. After Jampersal was initiated, the proportion of those with a first pregnancy was higher in Garut, but lower in Depok. For women pregnant more than three times, the proportion after Jampersal was lower in Garut, but was equal before and after Jampersal in Depok.

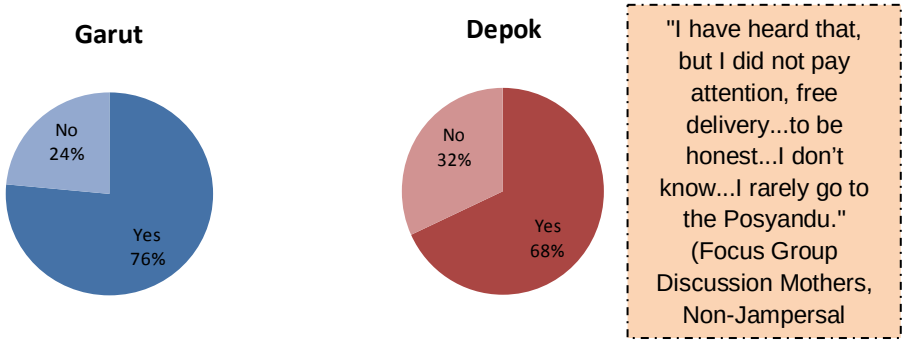
The educational background of respondents in the two locations was also different. In Depok, almost 75 percent of the respondents had completed secondary school and less than 15 percent attended only primary school, while in Garut about the same proportions attended primary and secondary schools. In both locations, only a quarter of respondents were working. By design, Depok Municipality was selected to represent urban characteristics, while Garut Distrct was selected to represent rural characteristics, although the district had some urban areas. The percentage of poor people in Garut

was higher than in Depok as indicated by the higher percentage of those having the insurance for the poor in Garut.

6. 3. 2 Community Understanding about Jampersal Program

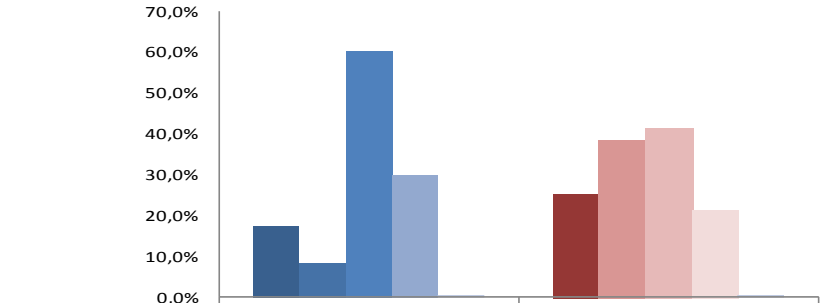
The study found a gap in women's exposure to information about Jampersal as it entered its third year of implementation. Approximately one-third (32 percent) and one-fourth (24 percent) of respondents in Depok and Garut, respectively, stated that they had never heard of Jampersal (figure 1.7).

Figure 1.7 Proportion of Women Who Have Heard of Jampersal



Among those who had heard of Jampersal, sources of information included health facilities and personnel, nonhealth providers, and mass media. Different sources provided the information in Depok and Garut. In Depok, a large proportion of women got Jampersal information from the health providers (38.3 percent) and/or the health facilities (25.2 percent); while in Garut the majority of women received information from nonhealth providers (60.3 percent), and only 8.3 percent and 17.4 percent got it from the health providers and the health facilities, respectively (figure 1.8).

Figure 1.8 Source of Jampersal Information in Depok and Garut

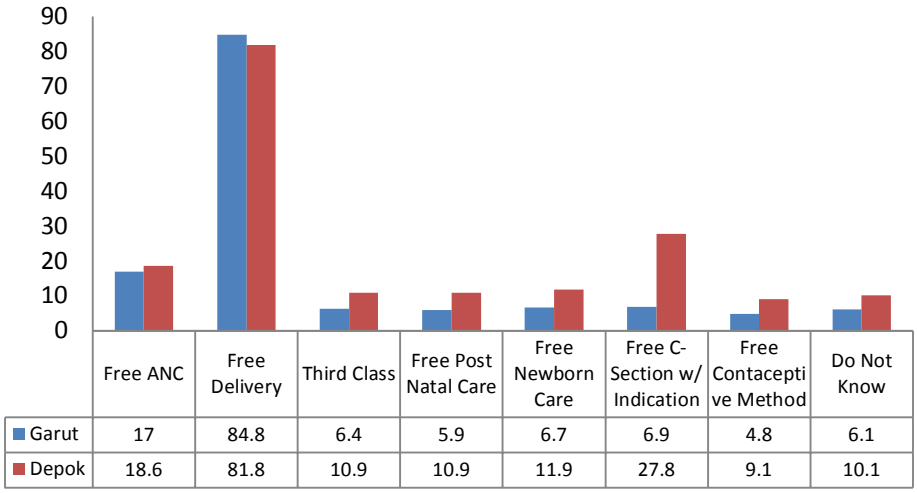


	Garut	Depok
Health facilities	17,4%	25,2%
Health provider	8,3%	38,3%
Non-health provider	60,3%	41,5%
Mass media	29,9%	21,4%
Community activities	0,5%	0,7%

For those who had heard of Jampersal, the study also measured their understanding about the program. Most women who had heard of Jampersal mentioned the program provided free delivery (mentioned by 81.8 percent of respondents in Depok, and 84.8 percent in Garut). The second most frequently mentioned benefit was free antenatal care. Only a few women mentioned the other benefits. Only 6.9 percent of women in Garut mentioned free Cesarean section as a Jampersal

benefit compared to 27.8 percent in Depok. Overall, the proportion of women who mentioned other Jampersal benefits apart from free delivery was lower in Garut than in Depok (figure 1.9).

Figure 1.9 Perception about Jampersal



	Free ANC	Free Delivery	Third Class	Free Post Natal Care	Free Newborn Care	Free C-Section w/ Indication	Free Contacepti ve Method	Do Not Know
Garut	17	84.8	6.4	5.9	6.7	6.9	4.8	6.1
Depok	18.6	81.8	10.9	10.9	11.9	27.8	9.1	10.1

Women were asked about health facilities eligible for Jampersal services. In both districts, the main response was public facilities. A small proportion of women mentioned that services at home were also free of charge under Jampersal.

6. 3. 3 Jampersal Utilization

Jampersal utilization for the last delivery post-Jampersal was 28.1 percent in Garut and 10.3 percent in Depok. Jampersal was used mostly by less-educated women (26.2 percent), who resided in rural areas (33.5 percent), and who were in the lowest and second-lowest wealth quintile (21.8 and 23.1 percent, respectively). Jampersal use was also high among women with delivery complications (29.1 percent) (see table 1.10).

Table 1.10 Utilization of Jampersal for the Last Delivery, by Respondents' Characteristics, Depok and Garut, Post-Jampersal (after 2011)

Women's characteristics	Jampersal utilization for last delivery								
	Garut			Depok			Garut and Depok		
	n	%	*p*-value	*n*	%	*p*-value	*n*	%	*p*-value
All	**456**	**28.1**		**458**	**10.3**		**914**	**19.1**	
District/municipality									
Garut							456	28.1	0.000
Depok							458	10.3	
Women's age									
20–34 years	325	27.4		352	10.2		677	18.5	
<20 years	43	30.2	0.874	9	22.2	0.472	52	28.8	0.185
>=35 years	88	29.5		97	9.3		185	18.9	
Women's education level completed									
No school/primary	206	30.6		61	11.5		267	26.2	
Secondary	225	25.3	0.434	338	11.2	0.176	563	16.9	0.001
Academy/univ	25	32		59	3.4		84	11.9	
Women's occupation status									
Not working	392	28.6	0.555	365	11.2	0.175	757	20.2	0.072
Working	64	25		93	6.5		157	14	
Number of pregnancies									
2–3 pregnancies	214	27.6		251	10.4		465	18.3	
First pregnancy	161	26.1	0.484	148	9.5	0.873	309	18.1	0.244
Multiple pregnancies	81	33.3		59	11.9		140	24.3	
Antenatal care to health provider									
No	9	0	0.058	2	0	0.632	11	0	0.104
Yes	447	28.6		456	10.3		903	19.4	
Complication during delivery									
No complication	367	22.1	0.000	286	6.3	0	653	15.2	0.000
Any complication	89	52.8		172	16.9		261	29.1	
Residence									
Urban	208	21.6	0.005	458	10.3	n.a.	666	13.8	0.000
Rural	248	33.5					248	33.5	
Insurance									
Other insurance	25	16		130	3.1		155	5.2	
Insurance for the poor	175	32	0.180	65	13.8	0.006	240	27.1	0.000
No insurance	256	26.6		263	12.9		519	19.7	
Wealth quintile (total)									
Lowest	90	26.7		89	16.9		179	21.8	
Second	90	33.3		92	13		182	23.1	
Middle	96	24	0.002	89	9	0.084	185	16.8	0.007
Fourth	89	41.6		93	6.5		182	23.6	
Highest	91	15.4		95	6.3		186	10.8	

6. 3. 4 Utilization of Maternal Health Services

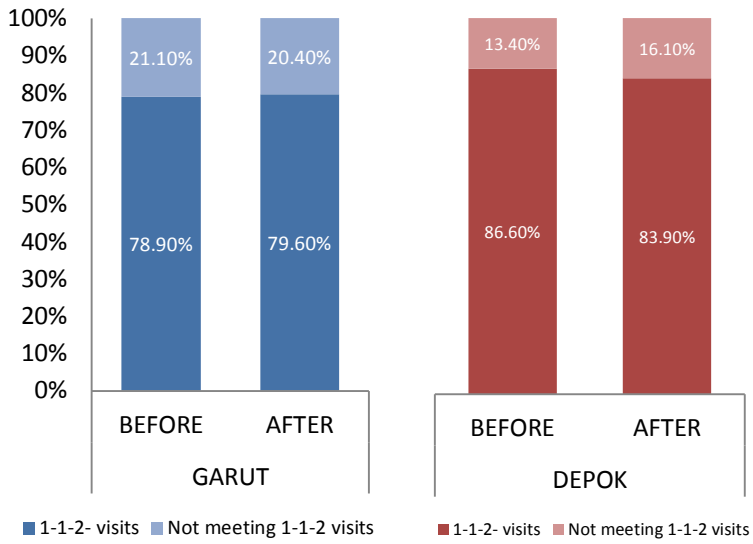
1.3.4.1. Antenatal Care

The total number of ANC visits and the MoH-recommended 1-1-2 visit pattern (at least one visit in the first trimester, one visit in the second trimester, and two visits in the third trimester) were the same before and after Jampersal implementation. This finding was consistent across the two study areas (table 1.11 and figure 1.10).

Table 1.11 Number of ANC Visits

Number of ANC	Garut		Depok	
	Before (*n*=462)	After (*n*=456)	Before (*n*=460)	After (*n*=461)
4 times or more	93.7	93.9	97.4	96.3
3 times	2.8	2.4	1.3	1.5
1–2 times	2.2	1.8	0.4	1.8
No ANC	1.3	2.0	0.9	0.4

Figure 1.10 ANC 1-1-2 Visit Pattern



1.3.4.2. Delivery

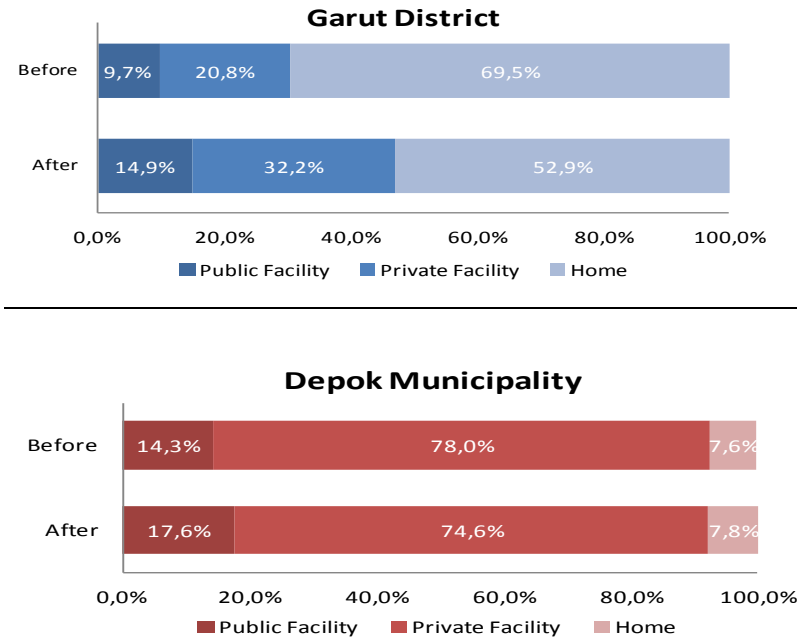
After Jampersal, institutional deliveries increased by 8.4 percentage points or 13.7 percent compared to before Jampersal (table 1.12).

Table 1.12 Place of Delivery by Time and by Women's Characteristics, Total Samples (Depok and Garut)

Variables	Place of delivery		Total	*p*-value
	Home	Facility		
	n=633	*n*=1206	*n*=1839	
Period				
Pre-Jampersal	356 (38.6)	566 (61.4)	922 (100)	0.000
Post-Jampersal	277 (30.2)	640 (69.8)	917 (100)	

Figure 1.11 shows that institutional deliveries in Garut increased 16.6 percentage points after Jampersal, from 30.5 percent to 47.1 percent. In Depok, institutional deliveries before Jampersal were already high (92.3 percent), and remained at relatively the same level after Jampersal (92.2 percent). However, there was a slight shift of place of delivery in Depok from private to public facilities. The change in choice of place of delivery before and after Jampersal was more apparent in Garut. Home deliveries declined by 16.6 percentage points after Jampersal, while delivery at public and private facilities increased by 5.2 percentage points and 11.4 percentage points, respectively.

Figure 1.11 Place of Delivery



"Free delivery is only for delivery in PHC, maybe it's called Jampersal"

(FGD)

Respondents who delivered at home were asked the reason/s for choosing home delivery. The reason most frequently mentioned was cost (34 percent), more convenient/more comfortable to deliver at home (27 percent), and delivery process started before the mother could be transported to a facility (20 percent). This pattern was the same for Garut and Depok, although in Garut a large proportion of respondents (21 percent) also expressed transport and distance to facility as reasons for choosing home delivery.

Table 1.13 shows the breakdown of preferred delivery facilities in the two study locations. In Garut, delivery at midwife/nurse practice increased from 19.9 percent before Jampersal to 31.8 percent after Jampersal. There was also an increase in delivery at a hospital from 8.0 percent to 11.2 percent. The proportion of deliveries at the puskesmas in Garut was very low (2.2 percent) and only increased slightly after Jampersal to 3.9 percent.

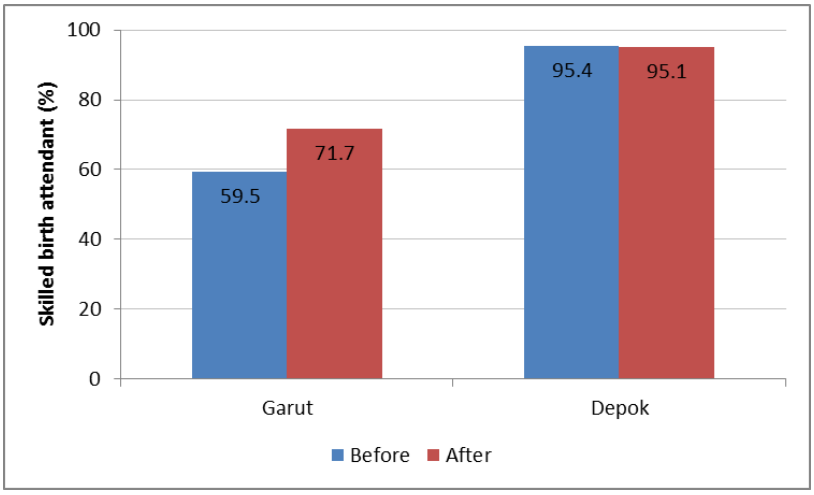
The preferred place of delivery in Depok before Jampersal was the midwife/nurse practice (43.9 percent) and hospital (36.1 percent). After Jampersal, birth delivery at midwife/nurse practice in Depok decreased slightly (40.6 percent), while delivery at hospital increased slightly (37.5 percent). Interestingly, delivery at private clinics/doctors/specialist practices in Depok after Jampersal increased by almost 4 percentage points from 6.3 percent to 10.0 percent, while delivery at the puskesmas declined from 6.1 percent to 4.1 percent.

Table 1.13 Breakdown of Preferred Birth Delivery Facilities

Birth delivery facilities	Garut		Depok	
	Before % *n*=462	After % *n*=456	Before % *n*=460	After % *n*=461
Home	69.3	52.9	7.6	7.8
Puskesmas	2.2	3.9	6.1	4.1
Midwife/nurse practice	19.9	31.8	43.9	40.6
Clinic/doctor/specialist practice	0.4	0.2	6.3	10.0
Hospital	8.0	11.2	36.1	37.5
Other	0.2	0.0	0.0	0.0

Figure 1.12 shows the proportion of deliveries by skilled birth attendants) in Depok and Garut. More than 95 percent of deliveries in Depok were by skilled birth attendants before and after Jampersal. In Garut the proportion of deliveries by SBAs was only around 60.0 percent before Jampersal, but increased to 71.7 percent after Jampersal.

Figure 1.12 Skilled Birth Attendance before and after Jampersal



The increased proportion of deliveries by skilled birth attendants in Garut was higher in rural than in urban areas. The increase in rural areas was around 14.5 percentage points, while in urban areas the increase was only around 9.1 percentage points (table 1.14).

Table 1.14 Skilled Birth Attendance before and after Jampersal, by Urban and Rural Areas, in Garut District

	Before	After
Urban (*n*=416)	*n*=208 69.7%	*n*=208 78.8%
Rural (*n*=502)	*n*=254 51.2%	*n*=248 65.7%

1.3.4.3. Cesarean Section

In Garut, the percentage of Cesarean sections more than doubled after Jampersal from 1.1 to 2.6 percent, although the increase is not statistically significant (*p*-value 0.092), and the level remains low. In Depok, the percentage of Cesarean sections after Jampersal also increased from 20.2 to 24.1 percent, which is above the WHO standard for 5 to 15 percent, but as in Garut, the increase was not statistically significant (*p*-value 0.159) (see table 1.15).

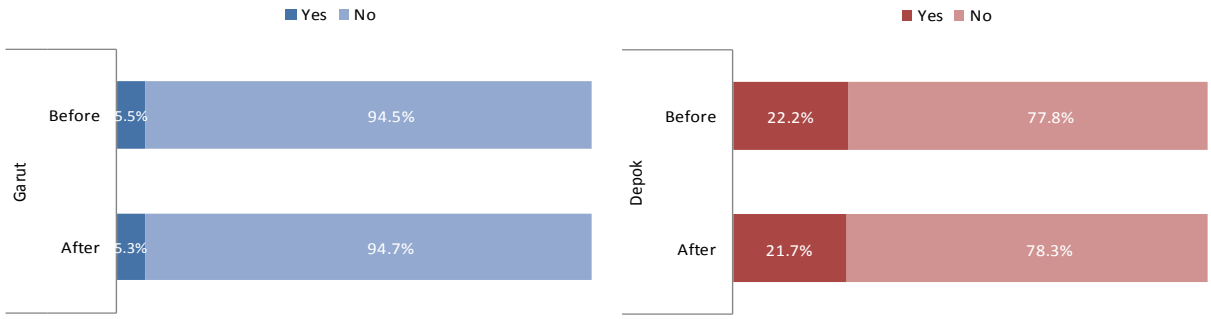
Table 1.15 Results of Bivariate Analysis on Association between Jampersal and Cesarean Sections

Variables	Garut			Depok		
	Cesarian section		*p*-value	Cesarian section		*p*-value
	No	Yes		No	Yes	
	n=901	*n*=17		*n*=717	*n*=204	
Before Jampersal	457 (98.9)	5 (1.1)	0.092	367 (79.8)	93 (20.2)	0.159
After Jampersal	444 (97.4)	12 (2.6)		350 (75.9)	111 (24.1)	

1.3.4.4. Postnatal Care

As with antenatal care, there was almost no change in the proportion of postnatal care before and after Jampersal (figure 1.13). The coverage of postnatal care was low in both areas, but the coverage in Garut was much lower (around 5 percent), while in Depok the coverage was around 22 percent. It should be noted that those percentages reflect the coverage of four visits of postnatal care, according to Jampersal guidelines introduced in 2012 (see table 1.1).

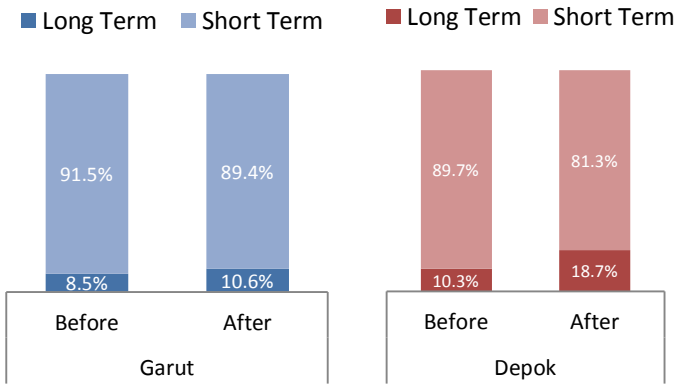
Figure 1.13 Percentage of Postnatal Care



1.3.4.5. Family Planning

Family planning services endorsed by Jampersal were the long-term contraceptive methods (IUD, implant, vasectomy, tubectomy[19]), although short-term methods were also eligible. Figure 1.14 below shows low coverage of long-term contraceptive methods in both locations, although there was a higher increase in Depok compared to Garut after Jampersal. The graphs also indicated that the increase was due to substitution rather than to new contraceptive users. The focus group discussion (FGD) with mothers revealed that they did not like long-term contraceptives because they were afraid of the side effects.

Figure 1.14 Percentage of Family Planning, before and after Jampersal, by Method



"…Most of the people are still afraid, especially in using spiral (IUD);" "…People are not free to choose."

(FGD Mothers, Non-Jampersal Users)

19. Vasectomy is a surgical procedure for male sterilization and/or permanent birth control. Tubectomy is a surgical procedure for sterilization in which a woman's fallopian tubes are clamped and blocked, or severed and sealed; both method prevents eggs from reaching the uterus for fertilization.

1.3.4.6. Source of Payment for Last Delivery

Table 1.16 Source of Payment for the Last Delivery

Source of payment for delivery	Garut (*n*=918)		Depok (*n*=921)	
	Before *n*=462	After *n*=456	Before *n*=460	After *n*=461
Out-of-pocket	93.3	81.6	92.2	86.3
Company	0.6	1.5	11.7	13.4
Private insurance	0.4	0.4	2.2	2.4
Askes[20]	0.4	1.1	1.5	0.9
Jamsostek[21]	0.0	0.7	3.0	4.3
Jamkesmas[22]	8.2	3.1	0.9	1.3
Jamkesda[23]	1.3	0.7	1.1	1.5
Jampersal	0.0	28.1	0.0	10.2
Others	8.4	10.3	16.5	12.8

Respondents were asked if they made any payment during the last delivery. If they made payments, they were asked to list all payment sources. Table 1.16 shows the percentage of out-of-pocket payment for delivery decreased in Garut after Jampersal from 93.3 percent to 81.6 percent, while in Depok the decline was from 92.2 percent to 86.3 percent. In Garut, the use of Jamkesda and Jamkesmas declined after Jampersal. Payment by Jampersal was higher in Garut (28.1 percent) than in Depok (10.2 percent).

Among respondents who used Jampersal, almost 60 percent reported additional out-of-pocket payments. This proportion was almost the same in Garut and in Depok. From those spending additional funds, more than 55 percent and around 30 percent of respondents in Garut and Depok, respectively, could not give detailed information on the purpose of the additional payment (table 1.16). Additional payment for drugs and injections was 13.5 percent in Garut and 22.2 percent in Depok, while that for delivery services was 6.8 percent in Garut and 3.7 percent in Depok (table 1.17).

20. Askes is health insurance for civil servants and retired armed forces personnel. Active and retired civil servants, retired military and police personnel, veterans, and national patriots, and their dependents are covered by this compulsory health insurance scheme managed by PT Askes.
21. Jamsostek is social insurance for private sector workers, health insurance for formal workers and social insurance for workers in large companies, providing four programs: employment injury, death, health insurance, and a provident fund–type old-age benefit.
22. Jamkesmas is a national tax-funded health insurance plan that targets the poor and near-poor through a proxy means test targeting method. The scheme provides beneficiaries with free health services in puskesmas and third-class wards in public and designated private hospitals.
23. Jamkesda is social health insurance provided by provincial or district governments. Jamkesda typically targets people identified by the local authorities as poor but not covered by Jamkesmas (because of mistargeting or because they recently became poor due to illness, etc), with some provinces (such as Bali and Aceh) heading toward universal health insurance. Schemes vary between provinces/districts, and benefits are normally only provided through health care providers in their respective provinces.

Table 1.17 Type of Other Payments during Last Delivery, among Jampersal Users

Utilities of payment for last delivery	Garut	Depok	Total
	%	%	%
	n=74	*n*=27	*n*=101
Registration	.0	3.7	1.0
Delivery service	6.8	3.7	5.9
Drug and injection	13.5	22.2	15.8
In-patient care	1.4	.0	1.0
Birth certificate	13.5	3.7	10.9
Volunteer	5.4	.0	4.0
Overall cost (could not be detailed)	55.4	29.6	48.5
Others (e.g., copying document)	5.4	25.9	10.9

6. 3. 5 Impact of Jampersal

The impact of Jampersal was estimated using logistic regression, controlling for other factors that may contribute to increased institutional deliveries. The distribution of the potential contributing factors was assessed before and after Jampersal in both locations to ensure that the two populations were comparable. The logistic regression was conducted with the total samples from both locations, and for the samples from each location.

6.3.5.1. Impact of Jampersal on Institutional Deliveries

Bivariate analysis of Garut showed significant association between Jampersal and institutional deliveries. The result remained significant after controlling for other contributing factors. The adjusted Odds Ratio (OR) was 2.40 (95% CI=1.74 – 3.33) (table 1.18 and annex 1). The result implied that women who delivered after the introduction of Jampersal had a 2.4 times higher chance of giving birth in health facilities compared to women who delivered before Jampersal. In other words, women who gave birth after the introduction of Jampersal had 87.7 percent probability of giving birth in health facilities.

For Garut, factors contributing to institutional deliveries other than Jampersal were delivery complications and residence. Women with complications around delivery were 5.3 times more likely to give birth in health facilities compared to those without complications. Furthermore, women living in rural areas had 15 percent lower probability of giving birth in health facilities compared to those living in urban areas.

For Depok, Jampersal introduction was not associated with institutional deliveries in bivariate as well as in multivariate analysis. The adjusted OR was 0.93 (95% CI=0.55 – 1.57). After controlling for other contributing factors, the strong predictor for institutional deliveries in Depok was a delivery complication (OR 3.22, 95% CI=1.59 – 6.51) (see annex 1).

Women who had any complication around delivery had an approximately 3.2 times higher chance of giving birth in health facilities as opposed to those who did not have any complication.

Table 1.18 Association between Jampersal and Institutional Deliveries

Variables	Garut District				Depok Municipality			
	Crude OR (95% CI)	*p*-value	Adjusted OR (95% CI)	*p*-value	Crude OR (95% CI)	*p*-value	Adjusted OR (95% CI)	*p*-value
Time of delivery*								
Pre-Jampersal (2009/2010)	Reference		Reference		Reference		Reference	
Post-Jampersal (2011 to 2013)	2.03 (1.55–2.66)	0.000	2.404 (1.74–3.33)	0.000	0.97 (0.60–1.58)	0.909	0.93 (0.55–1.57)	0.788

* Adjusted by age, education level completed, occupation status, gravida, complication during delivery, residence, insurance, and wealth quintile.

Results of the bivariate analysis also showed an increase in institutional deliveries in Garut after Jampersal among women who were least educated, poor, and lived in rural areas; while in Depok there was very little change in institutional deliveries before and after Jampersal across the same variables (table 1.19).

Table 1.19 Change in Institutional Deliveries by Mother's Education, Socioeconomic Status, Insurance Ownership, and Residence before and after Jampersal in Garut and Depok

(*percent*)

Women's characteristics	Garut				Depok			
	Before *n*=462	After *n*=456	Change	*p*-value	Before *n*=460	After *n*=461	Change	*p*-value
Institutional delivery	**30.5**	**47.1**	**54.4**	**0.000**	**92.4**	**92.2**	**-0.2**	**0.909**
Women's education level completed								
No school/primary	16.2	37.9	134.0	0.000	83.3	79.0	-5.2	0.525
Secondary	43.8	52.9	20.8	0.056	93.1	93.8	0.8	0.717
Academy/univ	56.3	72.0	27.9	0.303	100.0	96.6	-3.4	
Residence								
Urban	48.1	65.4	36.0	0.000	92.4	92.2	-0.2	0.909
Rural	16.1	31.9	98.1	0.000	n.a.	n.a.	n.a.	n.a.
Insurance								
Other insurance	37.5	84.0	124.0	0.002	95.5	98.5	3.1	0.177
Insurance for the poor	28.4	41.7	46.8	0.006	84.9	83.3	-1.9	0.797
No insurance	31.8	47.3	48.7	0.001	92.9	91.3	-1.7	0.494
Wealth quintile (total)								
Lowest	10.9	24.4	123.9	0.019	86.7	88.0	1.5	0.78
Second	19.4	34.4	77.3	0.023	89.4	91.3	2.1	0.655
Middle	31.9	53.1	66.5	0.004	96.7	95.5	-1.2	0.679
Fourth	38.3	57.3	49.6	0.011	95.9	93.5	-2.5	0.476
Highest	52.2	65.9	26.2	0.059	93.2	92.6	-0.6	0.885

In Garut, after Jampersal, institutional deliveries among women with elementary school education or lower increased by 134 percent, or by more than five times compared to the increase among women of other education levels. A very high increase (77.3 percent) was also observed among the second-lowest wealth quintile (Q2). Although institutional deliveries in the lowest wealth quintile (Q1) also increased by 123.9 percent, the increase was much lower than the increase in Q2. Institutional deliveries in rural areas showed an increase by 98.1 percent compared to only 36.0 percent in urban areas. Contrary to the purpose of Jampersal, although institutional deliveries among those without

insurance increased after Jampersal, the change was the lowest (48.7 percent) — compared to those covered by insurance for the poor (46.8 percent) — and other insurance (124 percent).

6.3.5.2. Impact of Jampersal on Cesarian Section

Bivariate analysis for Garut showed the percentage of Cesarean sections more than doubled after Jampersal implementation from 1.1 percent to 2.6 percent, but the increase was not statistically significant (*p*-value 0.092) (table 1.20). Other contributing factors did not show association except for education level and occupation status. Result of the multivariate analysis showed no significant correlation among the variables (table 1.21). This might be due to the small number of Cesarean sections in Garut.

Table 1.20 Change in Cesarean Sections by Women's Characteristics before and after Jampersal in Garut and Depok

(*percent*)

Women's characteristics	Garut				Depok			
	Before	After	Change	*p*-value	Before	After	Change	*p*-value
	***n*=462**	***n*=456**			***n*=460**	***n*=461**		
Cesarian section	1.1	2.6	136.4	0.092	20.2	24.1	19.3	0.159
Women's age								
20–34 years	0.6	2.5	316.7	0.073	19.4	22.0	13.4	0.406
<20 years	0.0	0.0	n.a.	n.a.	—	11.1	n.a.	n.a.
>=35 years	2.5	4.5	80.0	0.419	22.2	33.0	48.6	0.069
Women's education level completed								
No school/primary	0.4	4.4	1000.0	0.027	6.9	16.1	133.3	0.102
Secondary	1.4	0.9	-35.7	0.627	19.7	22.1	12.2	0.451
Academy/univ	6.3	4.0	-36.5	0.746	41.5	44.1	6.3	0.785
Women's occupation status								
Not working	0.3	3.1	933.3	0.022	19.3	21.3	10.4	0.781
Working	3.4	0.0	-100.0	n.a.	22.8	35.1	53.9	0.046
Gravida								
2–3 gravida	0.4	2.8	600.0	0.085	18.2	23.3	28.0	0.160
Primigravida	0.7	1.9	171.4	0.383	23.5	24.2	3.0	0.884
Multigravida	3.3	3.7	12.1	0.895	19.6	27.1	38.3	0.346
Antenatal care to health provider								
No	0.0	0.0	n.a.	n.a.	0.0	0.0	n.a.	n.a.
Yes	1.1	2.7	145.5	0.089	20.4	24.2	18.6	0.169
Complication during delivery								
No complication	0.5	0.8	60.0	0.639	5.5	5.9	7.3	0.840
Any complication	3.4	10.1	197.1	0.094	50.0	54.3	8.6	0.435
Residence								
Urban	1.9	3.4	78.9	0.365	20.2	24.1	19.3	0.159
Rural	0.4	2.0	400.0	0.133	n.a.	n.a.	n.a.	n.a.

Insurance								
Other insurance	4.2	4.0	-4.8	0.976	26.5	32.3	21.9	0.304
Insurance for the poor	1.4	1.1	-21.4	0.826	13.7	24.2	76.6	0.115
No insurance	0.4	3.5	775.0	0.048	18.8	20.0	6.4	–
Wealth quintile (total)								
Lowest	0.0	0.0	n.a.	n.a.	16.7	13.0	-22.2	0.493
Second	1.1	5.6	409.1	0.127	16.0	27.2	70.0	0.065
Middle	0.0	3.1	n.a.	n.a.	20.9	24.7	18.2	0.539
Fourth	2.1	3.4	61.9	0.609	15.5	34.4	121.9	0.003
Highest	2.2	1.1	-50.0	0.574	33.0	21.1	-36.1	0.071

Cesarean section percentage in Depok increased after Jampersal implementation from 20 to 24 percent, but as in Garut, the increase was not statistically significant (*p*-value 0.159) (table 1.20). For the multivariate analysis, after controlling for other contributing factors, the result did not show significant association between Jampersal implementation and Cesarean sections. The adjusted Odds Ratio (OR) was 1.15 (95% CI=0.78 – 1.69), meaning the probability of delivery with Cesarean section was not different before and after Jampersal implementation (table 1.21).

Table 1.21 Association between Jampersal and Cesarean Sections

Variables	Garut				Depok			
	Crude OR (95% CI)	*p*-value	Adjusted OR (95% CI)	*p*-value	Crude OR (95% CI)	*p*-value	Adjusted OR (95% CI)	*p*-value
Period of delivery*								
Pre-Jampersal (2009/2010)	Reference		Reference		Reference		Reference	
Post-Jampersal (2011 s/d 2013)	2.470 (0.863–7.069)	0.092	2.45 (0.77–7.78)	-	1.252 (0.916–1.710)	0.159	1.15 (0.78–1.69)	0.479

* Adjusted by age, education level completed, occupation status, pregnancy, ANC, complication during delivery, residence, insurance, and wealth quintile (see annex 2 for more detailed information).

Table 1.22 shows the result of multivariate analysis on association between wealth quintiles and Cesarean section. Results from both locations did not show significant association between wealth quintiles and Cesarean section. The difference among the wealth quintiles was also not significant. However, the OR for the second quintile to the highest quintile was more than one, while the OR for the lowest quintile was less than one. ta

Table 1.22 Results of Multivariate Analysis on Association between Wealth Quintiles and Cesarean Section

Variables	Garut				Depok			
	Crude OR (95% CI)	*p*-value	Adjust OR (95% CI)	*p*-value	Crude OR (95% CI)	*p*-value	Adjust OR (95% CI)	*p*-value
Wealth quintile								
Lowest	0.000	0.995	0.000	0.995	0.495 (0.293–0.835)	0.008	0.524 (0.280–0.980)	0.043
Second	1.676 (0.395–7.118)	0.484	2.854 (0.627–12.992)	0.175	0.795 (0.491–1.289)	0.353	1.179 (0.648–2.148)	0.589
Middle	1.333 (0.294–6.043)	0.709	1.841 (0.387–8.765)	0.443	1.029 (0.655–1.616)	0.902	1.120 (0.640–1.959)	0.693
Fourth	1.676 (0.395–7.118)	0.484	1.999 (0.451–8.854)	0.362	0.827 (0.504–1.357)	0.453	0.770 (0.422–1.404)	0.394
Highest	Reference	0.959	Reference	0.761	Reference	0.055	Reference	0.080

* Adjusted by Jampersal period, age, education level completed, occupation status, pregnancy, ANC, complication during delivery, residence, and insurance.

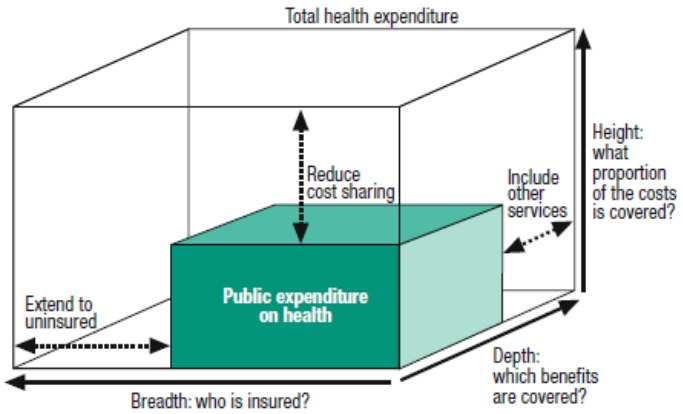
PART 7: DISCUSSION

Over the past few years, there has been a global movement to provide universal health coverage (UHC) to reduce financial barriers to health care. In 2005, the 58th World Health Assembly encouraged countries to plan health financing systems to achieve the goal of UHC such that “all people have access to services and do not suffer financial hardship paying for them” (WHO 2010). Indonesia started on the path to UHC in 2005 when Askeskin was introduced as a health insurance for the poor. Two years later, Askeskin was expanded into Jamkesmas, covering not only the poor, but also the near-poor (Harimurti et al. 2013). The local government contributed by providing Jamkesda not long after Jamkesmas was introduced to increase the coverage of insurance protection for the poor and near-poor. Substantial challenges in meeting MDGs 4 and 5 targets have led to the initiation of Jampersal policy in 2011. The formulation of Jampersal policy started in 2010 involving Bappenas (National Development Planning Agency), the Office of the Vice President, Ministry of Health, Ministry of Finance, and Ministry of People’s Welfare. The policy was launched nationwide in 2011 and aimed to cover uninsured pregnant women and newborns, irrespective of their economic strata. Thus by design, Jampersal could be considered universal coverage for maternal and newborn care. The program ended in December 2013, and the National Health Insurance Program (JKN) was launched in January 2014.

The Three Dimensions of Universal Health Coverage

The challenge for countries in moving toward universal health coverage is to expand the breadth, depth, and height of coverage (figure 1.15). The first dimension highlights the importance to progressively expand the coverage to include all uninsured populations, thus leading to equity across wealth, education, age, place of residence, and other population attributes. The second dimension is about expanding the range of essential health services to meet the health needs of the population, taking into consideration demand and expectations. The last dimension points out that the health care cost coverage should increase to reduce out-of-pocket copayment at service points (WHO 2010).

Figure 1.15 Three Dimentsions of Universal Health Coverage



Source: WHO 2010.

7.1. BREADTH OF THE COVERAGE: WHO IS INSURED?

Who benefits the most from Jampersal. Overall, Jampersal utilization was higher among marginalized women — those with low education (26.2 percent of no school/primary school compared to 11.9 percent of academy/university graduates), poor (around 22 percent and 23 percent of the lowest and second-lowest wealth quintiles, respectively, compared to only around 11 percent of the highest wealth quintile), and from rural areas (33.5 percent of rural respondents compared to 13.8 percent of urban rspondents). Furthermore, women experiencing complications during delivery were more likely to use Jampersal. The study data show an inverse association between Jampersal use and education, as well as between Jampesal use and socioeconomic status: Jampersal use increased as the level of education decreased; similarly, the poorer the woman, the higher the Jampersal utilization. This indicates the positive influence of Jampersal in alleviating barriers to care for the most vulnerable group of women (table 1.19).

Complications during pregnancy appear to be a significant factor affecting the use of Jampersal, as 29 percent of those who reported complications used Jampersal, compared to 15 percent who did not report any complication. This finding provides evidence of the positive influence of Jampersal in improving access to complication management. Another study in West Java Province, including Garut District, found perceived need was one reason for institutional delivery, meaning that women would be transferred to health facilities only if they perceived they had problems (Titaley et al. 2010), although it is not clear whether they were first told they had a complication, and hence were transferred.

Jampersal targets uninsured deliveries estimated at 41.5 percent of total deliveries or, according to MoH, around 2.8 million deliveries in 2011 and in 2012. An interesting finding was the higher use of Jampersal among those who were covered by insurance for the poor, compared to uninsured women. Among Jampersal users, approximately 32 percent already had other insurance protection, indicating an overlap between Jampersal and other insurance schemes. In practice, health providers tended to claim deliveries to Jampersal, perhaps because Jampersal was specifically covering deliveries. On the demand side, Jampersal requirements were considered easy. Unlike Jamkesmas, women could obtain services without any eligibility card. They only had to bring their ID card and the MCH book. Jampersal also provided wider access to services, as benefiaries could obtain services not just from public facilities, but also from any private providers/facilities that had signed an agreement with the DHO to accept Jampersal clients. This finding was consistent with another study reporting that most Jampersal users had previously been covered by another insurance scheme, such as Jamkesda, and there was a tendency to charge Jampersal rather than Jamkesda for maternal care at district/municipality level (Rachmawati et al. 2012).

The low awareness about Jampersal may have contributed to the relatively low utilization of Jampersal for the last delivery after three years of program implementation. Results of the household survey showed that around a third of women had not heard of Jampersal (32 percent in Depok and 24 percent in Garut). Most women who were aware of Jampersal did not understand the continuum of care that is covered through Jampersal. Many only knew that Jampersal was for delivery. There was also a gap in understanding about facilities providing Jampersal services. Women who did not use Jampersal expressed they were concerned that the service was not really free. Some perceived that a visit to the health facility might result in additional cost for examination or treatment. Another concern was the notion that the Jampersal service would be of lesser quality than service to patients who pay. Fear of coercion to use long-term contraception was also mentioned. Low awareness about Jampersal may be due in part to the low participation of other nonhealth sectors in socializing Jampersal during its implementation.

The qualitative study showed that most women who used Jampersal were pleased with the Jampersal program, and this seemed due primarily to the free nature of the service. Some reported they received less attention from health providers compared to non-Jampersal patients, but did not mind because the service was free. Some were aware that Jampersal also covered Cesarean sections, while others considered eligibility requirements for Jampersal were easy to meet.

An interesting finding was Garut local government's decision to claim home deliveries to Jampersal in areas with low availability of health workers and difficult access to delivery facilities as long as the delivery was assisted by a skilled birth attendant. Another study reported similar findings and suggested a special policy for districts with geographical challenges and limited facilities (Febriany et al. 2011).

7.2. DEPTH OF THE COVERAGE: THE BENEFIT PACKAGE

The services covered within a health insurance scheme is fundamental to how the scheme affects health outcomes and financial protection (Lagomarsino et al, 2012). The success of UHC requires expansion of services, at least to meet essential care. Jampersal covers essential services within the continuum of maternity and newborn care, that is, antenatal care, delivery care, postpartum and postnatal care for mother and newborn, and family planning. MoH expanded Jampersal service coverage further by (1) increasing antenatal and postpartum care frequency for complication cases to more than the regular four times; (2) including treatment for nonobstetric, life-threatening maternal complications; (3) covering in-patient care in BEONC facilities for pregnancies with complications; (4) covering in-patient care for sick newborns; and (5) covering the management of sick newborns. Service coverage may have been lower than expected because not all providers understood the scope of Jampersal services, indicating the need to improve the clarity of the Jampersal guidelines and to encourage the use of the guidelines as a reference point. Some health officers have a negative perception of Jampersal and considered the program a threat to the success of family planning. According to them the free services might encourage people to have more children.

Service availability. The capacity to deliver Jampersal primary and secondary health service in Garut may have been constrained by the relatively low availability of delivery facilities and the fact that only one hospital could provide comprehensive maternal health services. The situation in Depok was entirely different, as the city had a large number of private providers, but they were unwilling to join the Jampersal scheme. Nevertheless, the low private provider participation in Jampersal at primary level did not affect the level of institutional delivery in Depok, which was already very high before Jampersal — suggesting Jampersal did not have an impact in Depok. There were reports of difficulties in gaining access to referral care in Depok because most hospitals in the city were private and their participation in Jampersal was low, but since there were participating facilities in nearby Jakarta, access to referral care appeared not to be an issue for Depok.

Coverage of MCH services. The household survey showed minimal change in the utilization of antenatal and postpartum care in the two study areas before and after Jampersal implementation. The minimal change in antenatal care coverage after Jampersal was not surprising as the coverage was already high in both locations before Jampersal. The policy to have four instances of postpartum care was relatively new, and this might explain the low coverage even after Jampersal (5.5 percent in Garut and 22.2 percent in Depok). The use of long-term contraceptives, on the other hand, increased after Jampersal in both locations, consistent with Jampersal endorsement for long-term contraceptive use. The proportion of skilled birth attendants and institutional deliveries in Garut increased after Jampersal, but there was relatively no change to both indicators in Depok. Despite the low number of midwives in rural areas, the increase in use of SBAs was higher in rural than in urban areas, suggesting Jampersal impoved access to skilled birth attendants in rural areas because the service was free.

Despite Jampersal, around 30 percent of birth deliveries in Garut were still assisted by TBAs. Alleviating the risks for adverse maternal outcome may require reducing deliveries by the TBAs, among other efforts (Titaley et al. 2010). A study in West Java Province including Garut reported five main factors influencing the preference for home delivery and having the TBA as the delivery

assistant: economic, trust and tradition, perceived need, access to service, and the community member's perception of the knowledge and skill of the care provider. The findings of the qualitative study in Garut confirmed the five factors. Tradition, belief in the skill of the TBAs, previous experience, fear of health care (for example, injection), difficulty in finding transportation, perception that a midwife was only for emergencies, practicality and comfort of giving birth at home, and costs were the reasons expressed by women. Jampersal may have removed the economic barrier, but there are behavioral and cultural factors that are beyond Jampersal. Moreover, there has to be trust that the delivery is really free of charge, and further that, although free, the quality of care is the same.

Institutional deliveries. The multivariate analysis confirmed the impact of Jampersal in Garut after controlling for other contributing factors. The two-fold increase in institutional deliveries was statistically significant (OR 2.4; 95 % CI=1.74–3.33). This finding was consistent with the evaluation of the Delivery Fee Exemption Policy in Ghana, Senegal, and Nepal, although the latter two studies used secondary data. A population-based survey in two regions in Ghana reported evidence of institutional delivery increase by 11.9 and 5.0 percentage points after implementation of the fee exemption policy. In Senegal, facility data showed an increase in institutional deliveries from 40 to 44 percent (*p*-value <0.001) after one year of implementation of the policy. Health facility registers in Nepal showed a 19 percent increase of institutional deliveries after one year of implementing free delivery (Penfold et al. 2007; Witter et al. 2008; Witter et al. 2011).

On the contrary, Jampersal did not have an impact on institutional deliveries in Depok (OR 0.93; 95% CI=0.55–1.57). This was because even before Jampersal, institutional delivery in Depok was already very high (92.4 percent). Nevertheless, it was interesting to find some shift of place of delivery from the private to the public sector; and a shift from delivery with private practice midwives to a higher level of care with hospitals and the private clinics/doctors/obstetricians. For policy makers, the findings in Depok were important as they suggest in urban areas with high availability of and demand for the private sector, introducing Jampersal might be irrelevant and inefficient. Many local governments, including in cities like Depok, have responded to Jampersal policy by investing in public health facilities. For example, despite the large number of hospitals in Depok, the city invested in converting three puskesmas into BEONC facilities since the introduction of Jampersal, even though there was little information on the use of these. Moreover, the shift to a higher level of care, like the specialist clinics during the last two years in Depok, indicates that for the city, service cost was not a barrier to accessing institutional delivery.

Cesarean section coverage. There was a slight increase in incidence of Cesarean sections in Garut and Depok after Jampersal implementation, although the effect was not statistically significant (Garut OR 2.45; 95% CI=0.77–7.78; Depok OR 1.15; 95%=CI 0.78–1.69). Interestingly, the odds of Cesarean sections were much higher among women in Depok, compared to Garut (OR 11.257; 95% CI=6.555-19.333), suggesting a higher access to Cesarean sections in Depok compared to Garut. It should be noted that Cesarean sections in Depok were already high before Jampersal — 20 percent of all deliveries — and increased to 24 percent after Jampersal. The study could not convincingly confirm that all Cesarean sections were due to pregnancy or delivery complications, although most respondents perceived their Cesarean section was due to a complication. The low use of Cesarean sections in Garut may be related to the limited availability of Cesarean section services in the district. Another explanation for limited impact is the short implementation period of the program.

7.3. THE HEIGHT OF THE COVERAGE: FINANCIAL PROTECTION

Almost 60 percent of respondents who used Jampersal in Garut and Depok reported paying for other delivery-related costs. About half of those who paid additional out-of-pocket expenses could not explain the reason for having to pay extra. Around 16 percent reported paying for drugs and injections, and 11 percent reported paying for a birth certificate (birth certificates were not a part of the benefit package). If the needed drug was not available in the health facility, the patient had to buy it from outside the facility. Some hospitals charged the patient for blood transfusion. Private practice midwives sometimes requested extra payment for long-term contraceptives because the price of the contraceptives was higher than the Jampersal fees.

PART 8: CONCLUSION

8.1. POLICY FORMULATION AND IMPLEMENTATION

The formulation of Jampersal policy involved not only MoH but other sectors such as Bappenas, Office of the Vice President, Ministry of Finance, and Ministry of People's Welfare. During implementation, MoH and the local governments implemented Jampersal with little engagement with the other sectors. The study revealed that some local government regulations (Perda) were not supportive of Jampersal implementation. Ministry of Home Affairs' regulations regarding local government planning and budgeting, for example, affected Jampersal implementation, as payment for Jampersal claims could not exceed the amount allocated in the local government budget (APBD), despite the notional amount allocated by the central government. This regulation has contributed to delayed claim payments.

8.2. HEALTH SERVICE PROVISION AND PERFORMANCE

After more than two years of implementation, the supply side was not entirely ready to respond to an increase in the demand for services. Limited facilities in rural and remote areas may have influenced the coverage of institutional deliveries despite Jampersal. Their condition, for example, triggered the Garut DHO policy to allow claiming home deliveries to Jampersal in areas with difficult access to birth delivery facilities as long as there was an urgent need of assistance and the delivery was by a SBA. Access to referral care in rural/remote areas was an issue in Garut because the district only had one fully functioning hospital and the hospital's workload increased after Jampersal. The number of private facilities in Garut was very small, although most public sector midwives also had private practice office hours (dual practice).

In an urban area like Depok, although there were many delivery facilities such as maternity clinics and hospitals, most of them were run by the private sector, and they were reluctant to participate in Jampersal. Although the government increased the amount of service fee in the second year of implementation, the private providers were still dissatisfied with Jampersal fees. Low hospital participation in Depok resulted in frequent referral to public hospitals outside Depok. The study noted the number of BEONC facilities in Depok increased from one to four after Jampersal. There has been no evaluation of the efficiency of investing in BEONCs compared to introducing financing policies to increase private sector participation, which was dominating health care in Depok.

Other sources of provider dissatisfaction were the lengthy reimbursement process and confusion about the benefit package, for example about family planning services and coverage of complications. The issues found were not specific to this study as they were also reported in other studies conducted during the earlier period of Jampersal. There seems little change to those issues after more than two years of implementation.

Moreover, Jampersal has resulted in a workload increase for public sector providers, and this has affected the income of midwives, particularly those doing dual practice. Jampersal has negatively influenced dual practice midwives who had a high number of visits to their private practice before Jampersal. On the other hand, private practice midwives with fewer patients before Jampersal have positively benefited from the program.

Both Depok and Garut health offices were supportive of Jampersal implementation as indicated by the provision of consumables and medicines for private practice midwives in Garut, and by the increase in the share of provider fees from puskesmas' claims from 75 to 90 percent, among other factors.

8.3. COMMUNITY ACCEPTANCE TO JAMPERSAL POLICY

The community has not fully understood Jampersal. The study found that a third of women respondents had not heard of Jampersal. Among women who knew about Jampersal, most perceived Jampersal was only for free deliveries, and service was limited to puskesmas and public hospitals. Utilization was affected by uncertainty that the services were indeed free. There was also perception that "free" meant lower quality of service compared to that received by clients paying out-of-pocket. Low awareness about Jampersal may be due in part to the low participation of other nonhealth sectors in Jamperal implementation.

8.4. IMPACT OF JAMPERSAL ON MCH SERVICE COVERAGE

There has been no change in antenatal and pospartum care utilization in the two study areas before and after Jampersal implementation. However, Jampersal resulted in a relative increase in the use of long-term contraception.

The study observed increased use of skilled birth attendance (SBA) in Garut. The increase of SBA was higher in rural than in urban areas of Garut. There was almost no change in SBA use in Depok. However, the study found a shift of the type of preferred providers in Depok from the private to public sector providers; and from lower to higher type of providers.

The study found Jampersal had a statistically significant impact in increasing institutional deliveries in Garut but not in Depok. In Garut, there was approximately 2.4 times higher likelihood of institutional deliveries after Jampersal. Nevertheless, in Garut the proportion of home deliveries was also higher than in Depok. Women's preference for home-based delivery in Garut was influenced by values, practicality, and the comfort of home delivery, and geographical as well as transportation barriers in reaching delivery facilities. There was the perception that free service meant lower quality service, although others felt quality did not matter that much as long as the service was free.

Increase in deliveries by Cesarean section was not statistically significant. Nevertheless, the likelihood to deliver by Cesarean section among women in Depok was higher than Garut (OR=11.257; 95% CI=6.555–19.333). This might be due to the easy access to hospitals in Depok.

Jampersal showed higher impact in areas with low coverage and greater challenges for accessing institutional deliveries. The challenges shown in Garut were geographical and socioeconomic constraints, low availability of health facilities, and low insurance coverage. In urban areas such as Depok with easy access to health facilities — albeit private facilities — the impact of Jampersal was minimal.

PART 9: RECOMMENDATIONS

A program like Jampersal requires strong support from stakeholders beyond the health sector. Jampersal encompassed horizontal (across sectors within the same level) and vertical (between the central and local government) collaboration. Jampersal has brought sectors together during policy formulation, but sector collaboration is important for building the momentum during implementation as well. For example:

Given the decentralized system in Indonesia, MoHA's involvement could help in building local government commitment to the program. A strong buy-in from local governments may increase subdistrict and village government support in increasing community awareness and potentially in removing other barriers to care.

Joint collaboration between MoH, MoHA, and MoF in reviewing existing regulations would be helpful in finding ways to reduce the complexity of Jampersal (or other insurance) fund management and the reimbursement process.

Multisector involvement is required in planning and implementing long-term investment for improving road infrastructure, transportation, and health facilities in geographically difficult areas to improve access to institutional deliveries.

Jampersal could help to increase institutional deliveries while JKN voluntary participation is still low. The study has shown the potential of Jampersal in increasing institutional deliveries where coverage was low, as in Garut. The government may want to consider this finding and reevaluate the policy to terminate Jampersal implementation with the launching of the National Health Insurance Program (JKN) on January 1, 2014. Nevertheless, before continuing the implementation, it is important to analyze the cost-effectiveness of the program.

Addressing "nonservice" cost is important. The study reported families still pay additional OOP costs for referral transport, and this might be a barrier to accessing care. Building linkages with other programs such as PNPM GSC (he National Program for Community Empowerment, Smart and Health Generation) might be an option for addressing this issue. Moreover, reducing OOP would also require better understanding about the reason for the OOP; for example, whether it is an issue of supply chain and drug shortages, an issue of exclusion of certain drugs from the basic benefits package, or an issue of provider prescription behavior. Regarding provider behavior, it will also be interesting to monitor the possibility of cream skimming.[24]

"Free" is not enough; service readiness and quality also matter. Women who experienced low quality of care tended to stop using the care, or even dissuaded other women from using care (Wairimu 2013). In Kenya, women's refusal to use free maternity care was due to poor quality of the facilities and the rude attitude of health providers, among other factors. Continuous quality improvements should follow any effort to improve access to health care. Complementary work shows that maternal health supply-side readiness problems remain, especially in some parts of the country, and this could deter patients from utilizing care despite removal of financial barriers via programs such as Jampersal.

Getting private providers on board requires a carefully designed provider payment system. In areas where private providers are dominant and demand for private provision is high, buying services from the private sector to improve access might be more efficient than expanding public sector investment. Obviously, this would require reasonable fees and quality assurance of service provision. The study also showed that support from professional associations like the Indonesia Midwives Association (IBI) could facilitate private midwife participation in Jampersal.

24. Midwives working in dual practice may decide to ask patients to come to their private practice as they can use the whole claim reimbursement for their own benefit, while in puskesmas they have to share with other staff.

There is a need to explore more options to improve human resources for health (HRH) availability and distribution in remote areas. Skilled birth attendance in rural Garut increased after Jampersal despite the low presence of midwives, suggesting adding more midwives could increase skilled birth attendance even more if paying for service is not an issue. Experience shows that monetary incentives are often not enough for deploying HRH to “difficult” areas. Other attractive features such as housing, children’s education, continuing education, more definitive and specific terms of services period need to be considered. In developing HRH policies, Indonesia will benefit from a labor market analysis to understand labor market dynamics influencing HRH supply and demand.

In areas with difficult access to hospitals, the presence of BEONC facilities is essential. Investment in BEONCs should be followed by close monitoring and consistent support to ensure continuity of care by avoiding high turnover of trained staff and by increasing utilization.

Implementation of Jampersal (or UHC) policy may have to be adjusted according to the utilization pattern for efficiency and effectiveness. The household survey showed Jampersal only had an impact in an area where institutional delivery coverage was still low, such as Garut. Further assessment is needed to translate this finding into future policy changes.

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ANNEXES

ANNEX 1: ASSOCIATION BETWEEN JAMPERSAL AND INSTITUTIONAL DELIVERIES

Table 1A.1 Association between Jampersal and Institutional Deliveries

	Garut				Depok			
	Adjusted OR	*p*-value	CI 95% Lower	CI 95% Upper	Adjusted OR	*p*-value	CI 95% Lower	CI 95% Upper
After Jampersal	2.40	0.000	1.74	3.33	0.93	0.788	0.55	1.57
Women's age								
20–34 years	Ref							
<20 years	2.03	0.046	1.01	4.06	1.06	0.957	0.11	9.95
>=35 years	1.16	0.542	0.72	1.85	1.66	0.176	0.80	3.47
Women's education level completed								
No school/primary	Ref							
Secondary	1.72	0.003	1.21	2.44	2.53	0.002	1.39	4.57
Academy/univ	2.83	0.015	1.22	6.54	5.92	0.027	1.22	28.64
Women's occupation status								
Not working	Ref							
Working	1.00	0.983	0.66	1.51	0.86	0.657	0.44	1.67
Gravida								
2–3 gravidas	Ref							
Primigravida	0.97	0.855	0.66	1.41	1.30	0.407	0.70	2.40
Multigravida	0.78	0.334	0.48	1.29	0.80	0.596	0.35	1.83
Complication during delivery								
No complication	Ref							
Any complication	5.34	0.000	3.54	8.04	3.22	0.001	1.59	6.51
Residence								
Urban	Ref							
Rural	0.31	0.000	0.23	0.44	1.00	n.a.	n.a.	n.a.
Insurance								
Other insurance	Ref							
Insurance for the poor	0.97	0.927	0.46	2.03	0.30	0.01	0.12	0.75
No insurance	0.79	0.513	0.38	1.61	0.53	0.125	0.24	1.19
Wealth quintile (total)								
Lowest	Ref							
Second	1.36	0.287	0.77	2.38	0.98	0.946	0.48	1.98
Middle	2.01	0.013	1.16	3.48	2.20	0.091	0.88	5.52
Fourth	2.82	0.000	1.62	4.92	1.56	0.299	0.67	3.61
Highest	3.57	0.000	1.98	6.43	1.03	0.937	0.47	2.26
Obs		**918**				**921**		
Pseudo R2		**0.22**				**0.11**		

Source: Household Survey.

ANNEX 2: ASSOCIATION BETWEEN JAMPERSAL AND CESAREAN SECTION

Table 2A.1 Association between Jampersal and Cesarean Section

	Garut				Depok			
	Adjusted OR	*p*-value	Lower	Upper	Adjusted OR	*p*-value	Lower	Upper
After Jampersal	2.45	0.128	0.77	7.78	1.15	0.479	0.78	1.69
Women's age								
20–34 years	Ref							
<20 years	1.00				0.85	0.898	0.08	9.60
>=35 years	2.61	0.159	0.69	9.96	1.32	0.265	0.81	2.17
Women's education level completed								
No school/primary	Ref							
Secondary	0.41	0.182	0.11	1.51	1.82	0.083	0.93	3.57
Academy/univ	2.08	0.517	0.23	19.11	3.92	0.002	1.66	9.29
Women's occupation status								
Not working	Ref							
Working	1.17	0.826	0.30	4.56	1.22	0.413	0.75	1.99
Gravida								
2–3 gravida	Ref							
Primigravida	1.01	0.990	0.26	3.98	1.00	0.993	0.64	1.55
Multigravida	1.34	0.682	0.33	5.43	1.00	0.990	0.52	1.91
Complication during delivery								
No complication	Ref							
Any complication	11.93	0.000	3.80	37.41	18.35	0.000	12.00	28.06
Residence								
Urban	Ref							
Rural	0.46	0.193	0.14	1.49	1.00	n.a.	n.a.	n.a.
Insurance								
Other insurance	Ref							
Insurance for the poor	0.22	0.139	0.03	1.64	0.85	0.627	0.44	1.65
No insurance	0.35	0.267	0.05	2.24	0.87	0.550	0.56	1.37
Wealth quintile (total)								
Lowest	n.a.	n.a.	n.a.	n.a.				
Second	n.a.	n.a.	n.a.	n.a.	1.97	0.043	1.02	3.80
Middle	n.a.	n.a.	n.a.	n.a.	1.44	0.273	0.75	2.78
Fourth	n.a.	n.a.	n.a.	n.a.	1.71	0.107	0.89	3.29
Highest	n.a.	n.a.	n.a.	n.a.	1.68	0.120	0.87	3.21
Obs	**865.00**				**921.00**			
Pseudo-R2	**0.26**				**0.30**			

Source: Household Survey.

ANNEX 3: METHODOLOGY

The study applied cross-sectional design with pre/post assessment, using both qualitative and quantitative approaches. The qualitative approach provided information about the overall financing, payment, and organizational policies of the Jampersal program, and specifically the impact of the policies on HRH performance; while the quantitative approach examined whether Jampersal implementation has impact on improving coverage of services, particularly on institutional deliveries (primary level) and Cesarean section coverage (secondary level).

1. Qualitative Study

The qualitative approach used in-depth interviews and focus group discussions, collecting information from central, provincial, district/municipality, and community levels. At each level stakeholders were asked particular questions about the following aspects:

1. Central and provincial levels: role in policy formulation, implementation, and evaluation, including analysis on the sustainability
2. District/municipality level: process of implementation, its barriers and enabling factors
3. Community: community leaders' involvement; satisfaction, barriers, and enabling factors in utilizing Jampersal

Table 3A.1 Informants in the Qualitative Study

Institution	Method	Informants	Note
Central level			
MoH	In-depth interview	• Directorate General for Nutrition and MCH • Directorate General for Health Effort, include primary health and referral • Center for Health Financing and Insurance/P2JK • Planning Bureau • Board for Development and Empowerment of Human Resources in Health/BPPSDMK	
MoHA		• Directorate General for Regional Autonomy/Ditjen Otoda	
MoF		Ministry of Financing	
Legislative		Commission IX, which handles health issues Commission D, DPRD Garut	
PHO	In-depth interview	• MCH Unit • Unit for Health Insurance/Administration Unit/Tata Usaha	
Garut District			
DHO	In-depth interview	• MCH Unit • Primary Health Care Unit • Referral Health Care Unit • Unit for Health Insurance/Administration Unit/Tata Usaha	
Board for Regional	In-depth interview	Unit for Community Welfare	

Institution	Method	Informants	Note
Development Planning (Bappeda)			
District hospitals	In-depth interview	• Vice Director/Head of Health Service Unit • Vice Director of Finance /Head of Finance Unit • Ob-Gyn • Head of delivery room	
Maternity clinic with Cesarean section facility	In-depth interview	• Ob-Gyn/ Owner of maternity clinic	
Health center	In-depth interview	• Head of Health Center/Coordinator Midwife • Administration Unit/JKM Unit	• Tarogong PHC • Padaawas PHC • Peundeuy PHC
Village midwives	Focus Group Discussion	Midwife who has worked for at least 2 years and currently still works as village midwife. Midwives will be formed to represent urban-rural setting in Garut	• Tarogong PHC • Padaawas PHC • Peundeuy PHC
Private midwife/dual practice	In-depth interview	Midwife who has practiced as private practice midwife for at least 2 years and currently is still in practice. This will cover pure private and dual practice midwives.	• Jati Village • Karyamekar Village
Head of village, community leaders (TOMA)	In-depth interview	Lurah or TOMA per village	• Jati Village • Padaawas Village • Pangrumasan Village
Community (group of mothers who gave birth after the implementation of Jampersal)	Focus Group Discussion	• Mothers of at least 2 children who born before and after Jampersal	• Jati Village • Padaawas Village • Pangrumasan Village
	In-depth interview	• Mothers of children born after Jampersal and USED the Jampersal scheme • Mothers of children born after Jampersal and DID NOT USE the Jampersal scheme	• Jati Village • Padaawas Village • Pangrumasan Village
Depok Municipality			
DHO	In-depth interview	• MCH Unit • Primary Health Care Unit • Referral Health Care Unit • Unit for Health Insurance • Financial Treasurer	
Board for Regional Development Planning (Bappeda)	In-depth interview	Unit for Community Welfare	
District hospitals	In-depth interview	• Vice Director/Head of Health Service Unit • Vice Director of Finance /Head of Finance Unit • Ob-Gyn	

Institution	Method	Informants	Note
		• Head of delivery room	
Private hospitals	In-depth interview	• Vice Director/Head of Health Service Unit • Vice Director/Head of Finance Unit • Ob-Gyn/ Head of Obstetric Ward	• Sentra Medika Hospital • Hasanah Graha Afiah (HGA) Hospital
Health center	In-depth interview	• Head of Health Center/Coordinator Midwife • Administration Unit/JKM unit	• Sukmajaya PHC • Duren Seribu PHC
Village midwives	In-depth interview	Midwife who has worked for at least 2 years and currently still works as village midwife. Midwives will be formed to represent urban-rural setting in Depok	• Mekarjaya Village
Private midwife/dual practice	In-depth interview	Midwife who has practiced as Private Practice Midwife for at least 2 years and currently is still in practice. This will cover pure private and dual practice midwives.	• Mekarjaya Village
Head of village, community leaders (Tokoh Masyarakat – TOMA)	In-depth interview	Lurah or TOMA per village	• Mekarjaya Village • Bojongsari Lama Village
Community (group of mothers who gave birth after the implementation of Jampersal)	Focus group discussion	• Mothers of at least one of whom was born before and one after Jampersal	• Mekarjaya Village • Tirtajaya Village • Bojongsari Lama Village • Duren Seribu Village
	In-depth interview	• Mothers of children born after Jampersal and USED the Jampersal scheme • Mothers of children born after Jampersal and DID NOT USE the Jampersal scheme	• Mekarjaya Village • Bojongsari Lama Village

2. Quantitative Study

Sample Size

The population of this study were mothers and children as beneficiaries of the Jampersal package, that is, antenatal, delivery, postnatal care, and family planning in the two areas. Women who delivered two years before Jampersal implementation (this cut-off point is defined to reduce recall bias) were considered part of the sample for the baseline/pre, and women who delivered after Jampersal implementation will be considered as the sample for the endline/post. The sample size is calculated using a sample size formula for hypothesis testing between two population proportions for each group (Lemeshow et al. 1990).

$$n = \frac{\left\{z_{1-\alpha}\sqrt{2P(1-P)} + z_{1-\beta}\sqrt{P_1(1-P_1)+P_2(1-P_2)}\right\}^2}{(P_1-P_2)^2} * deff$$

Note: n = number of sample size

$Z_{1-\alpha}$ = Z-score for significance level of α in one-sided hypothesis testing
$Z_{1-\beta}$ = Z-score for 1-β power of statistical test
P = average of P1 and P2
p_1 = estimated proportion at baseline survey
p_2 = estimated proportion at evaluation survey
deff = design effect

Sample was selected using cluster sampling, instead of Simple Random Sampling (SRS), mainly due to financial and time limitations. Thus, calculation of sample size uses correction of design effect. We have anticipated that there is a wide variation of number of households per village within and between study areas. Population size in Depok Municipality is around 1.7 million located in 63 villages; while population in Garut District is approximately 2.4 million located in 424 villages. This condition results in un-comparability between the study areas. Thus we used census block as the cluster. Census block (CB) is the enumeration area developed by Indonesia Central Bureau of Statistics (BPS); the latest was used for the 2010 national census. In average, each census block consists of 80 to 120 households. Since all main indicators are measured through the household survey, the sample size is calculated for each main indicator to be assessed. The largest sample size was chosen.

Estimated proportion used in the sample size calculation is based on data from the 2010 National Basic Health Research (Riskesdas) using data for West Java Province. Estimation of difference coverage between pre-Jampesal and post-Jampersal implementation is 15 percent for all the main indicators, except for Cesarean section, which is estimated at 10 percent. This assumption is based on the increase of coverage data between the 2002–03 and 2007 IDHS (where no massive program is implemented), inflated by estimation of increase due to Jampersal program.

Table 3A.2. Sample Size Calculation for Each Group (pre/post) for Each District

Indicators	Estimated % at preintervention	Estimated % at postintervention	Sample size for group indicated under "indicators" column*	Total sample with 10% nonresponse rate	Total sample size for women with 10% nonresponse rate
Delivery at facility	53.7	68.7	179	269	**296**
Skilled birth attendants	78.3	93.3	91	137	**151**
Cesarean section	15.1	25.1	274	411	**453**
Antenatal care according to the standard**	67.2	82.2	142	213	**235**
Postnatal care	**75.1**	**90.1**	**108**	**162**	**179**

Source: Authors' calculation.
*Significance level at 5 percent, one-side hypothesis testing; power of test 0.9; design effect=1.5.
**1 time during 1st trimester, 1 time during 2nd trimester, 2 times during last trimester.

According to the above sample size calculation, the highest sample size is 453 for each group (pre and post) in each study area. In total there were 906 samples for each area, equal to 1,812 samples in the two study areas. The study has collected 921 respondents in Depok and 918 respondents in Garut, a total of 1,839 respondents.

Sampling Procedure

In each district, a number of census blocks/CBs (here, this refers to clusters) were selected randomly as the Primary Sampling Units/PSUs. The sampling process was followed by selection of households with the designated criteria (mothers of children born either before or after Jampersal

implementation). The table below presents the estimated number of under-five children within each CB (born either before or after Jampersal implementation).

Table 3A.3 Estimated Number of Eligible Population per Census Block

# of household per census block	# of population[α]	Estimated # of households with at least one U-5 in each CB (assumption 30%)
80–120	320–480	30 (24–36)

Source: Authors' calculation.

[α]The number of population in each household is estimated at four per household.

Based on the above table, we expect that there will be at least 24 under-five children within each CB. To control variation between CBs, the target is to enroll 18 samples in each CB.

The sample has been targeted in 61 CBs per districts. In situations where the number of eligible population is the same as the needed sample size per block, all the population were enrolled as the samples. When the number of eligible population is more than the designated sample size, random selection was applied. If the eligible population is less than the sample size per cluster, additional sample was taken from the neighboring census blocks (within the same village); thus, in such situations more than 61 clusters were visited. Samples of the pre-Jampersal and post-Jampersal may come from the same household, for example, a household with a child born before Jampersal and a child born after Jampersal implementation.

In each CB, the study team listed all eligible population residing within the CB area. The listing process used information from either cadres or head of the neighboring unit, who is most knowledgeable and can help prepare a list of children in the area. The sample is mother with child/children who has lived in the study area at least since 2009.

3. Data Collection

Qualitative Study

Qualitative data collections were conducted from May to August 2013 at district, province, and national levels. All informants were successfully interviewed except two informants in Depok — the regional representative council (DPRD) member and the Ob-Gyn of a private hospital. In Garut District, since there is no private hospital, we have replaced informants from private hospital with informants from a private maternity clinic that performed Cesarian sections.

Quantitative Study

Data collections for the quantitative survey were conducted from April 20, 2013, to May 25, 2013, in Depok and Garut. There were 921 respondents in Depok and 918 respondents in Garut who were interviewed. The study team visited 53 CBs in Garut and 52 CBs in Depok. The distribution of CBs in Garut was 28 in rural areas, and 25 CBs in urban area; while in Depok, all CBs were in urban area.

Data collection processes of quantitative study were as follows:

1. In each district, the team consisted of a field coordinator, assistant coordinator, data collectors (nine in Garut and eight in Depok), and two data entry personnel.
2. Before data collections were started, census blocks (CBs) were already selected. Field coordinator and assistant coordinators worked on respondent sampling using household listings. In each CB, 18 respondents were selected, consisting of 9 mothers with babies born by year 2009 to year 2010, and 9 mothers with babies born by year 2011 until the study time.

3. In conditions where the number of informants was not enough in one CB, the field coordinator and assistant coordinator went to the nearest CB for the household listing.
4. In conditions where selected respondents were not available during home visits, a second home visit was made by data collectors. If selected respondents were not available on the second visit or refused the interview, data collectors replaced the respondents with alternate respondents who had been identified prior to data collection.
5. Spot-checks to a sample of respondents (10 percent) were randomly conducted by the field coordinator and assistant coordinator.

Study Limitations

1. It is still too early in the program to evaluate and assess its impact.
2. The study is only conducted in two districts, so it is difficult to represent real conditions in Indonesia.

4. Data Analysis

Qualitative Study

All in-depth interviews and FGDs were audio-recorded and transcripted. All transcripts were collated into matrices to identify the main findings, which were then grouped based on the themes of interest.

Quantitative Study

Data were entered in the field on a daily basis: (1) to identify and correct any inconsistencies of data and other problems; (2) to minimize the risk of losing data during data management. Data were entered using EPI-Info program, and transferred to SPSS for further analysis.

Characteristics of the study participants were assessed to see whether the population of the preintervention and of the postintervention were comparable. Furthermore, this study examined factors and variables, either quantitatively or qualitatively, that may influence/confound the relationship between Jampersal implementation and the outcomes assessed, such as access to health services, urban-rural setting, sociodemographic characteristics of user, and existence of other related programs. Socioeconomic status was assessed using the wealth index, developed based on household assets ownership.

Quantitative analysis is aimed to assess the impact of Jampersal on the coverage of institutional deliveries and Cesarean section, as well as other maternal services within the framework of the continuum of care. Changes in the outcome were examined by comparing preintervention and postintervention population. The changes were also examined by comparing Depok Municipality and Garut District to explore whether there is difference on the impact of Jampersal between districts and municipalities, in relation to urban and rural settings as well as policy implementation.

5. Data Quality

Initial Test and Revision of Questionnaire

Questionnaires were tested for format, wording, sequence, time needed for each questionnaire, sensitive questions, difficult/unclear questions, flow of questions, use of local terms, and problems with responses (unexpected answers, inconsistencies). Any modifications and corrections were immediately applied to adjust the questionnaire for suitability for pilot testing.

Development of Manuals

Manuals were developed to assist the standardization of the data collection procedures in the field.

a. The General Manual consisted of the following:
   - The background, purpose, and rationale of the study to make sure each member of the study team had a good understanding about the study, including the questions in the questionnaires.
   - Explanation of the design of the study and sample selection.

- Organization and job description of each member of the study team, to help each member understand his or her role and responsibility in the study, especially during data collection.
- Guidelines for the interviewers in finding and approaching respondents, and a description of the supervisory mechanism.
- Interview techniques (quantitative and qualitative) were also included in the manual. The technique includes how to ask questions, including ethical considerations in how to avoid bias and the like.

b. Questionnaires/Instrument Manual, which explains each question in the questionnaires.

Training

All field staff received training about the questionnaire and sampling procedures so they would have a good understanding about the study being conducted. At the beginning, all field staff participated in the general training covering all procedures of data collection in the field. Subsequently, all field staff were trained in their specific duties on the basis of their skills, experience, and educational background. The training took place over two days in classes that encompassed explanations on questionnaires, guidelines, interview techniques, and one day for pilot testing in the field.

Pilot Test

The pilot test was conducted in the area identical to the main study area, with the following objectives:

a. To assess whether the sampling mechanism was working well, including the process of finding the households, finding and selecting respondents, and understanding the pattern of community activities.
b. To identify problems and find solutions, including in the process of administering the questionnaires, and other logistical arrangements.

Supervision Mechanism during Data Collection:

a. Daily review of all questionnaires and reinterview of some selected respondents were done by the supervisor to secure reliability of questions filled out by interviewers.
b. Regular meeting of the team took place in the base camp to check the consistency and the completeness of the questionnaire, and to prepare activities for the next day. Any problem will be identified and solved on a daily basis.
c. Spot-checking or supervision visit by supervisor.

Data Management

a. Testing of data entry template before and after pilot test, including data entry quality check.
b. Cross entry: 10 percent of sample data were reentered by different data entry staff. Consistencies were checked against the two data entries, and compared with the filled-in questionnaires.
c. Data cleaning.

6. Ethical Considerations

The research proposal and all related documents, including instruments, were submitted to the Institutional Review Board (IRB) of Public Health Faculty, University of Indonesia for ethical approval and clearance. Consent has been sought from selected institutions for qualitative study and from all respondents of the household survey. All key informants have been provided with information about the study. Names of key informants and respondents were kept confidential.

Indonesia launched Jampersal in 2011, a nationwide program to accelerate the reduction of maternal and newborn deaths. The program was financed by central government revenues and provided free and comprehensive maternal and neonatal care with an emphasis on promoting institutional deliveries. Jampersal providers were public and enlisted private facilities at the primary and secondary levels. In 2013, the World Bank and the Center for Family Welfare, University of Indonesia conducted a qualitative and quantitative study to assess the implementation and impact of the program in Garut District and Depok Municipality in West Java Province. The study found that Jampersal utilization was highest among women who were least educated, poor, and resided in rural areas. Utilization was also high among women with delivery complications. The study showed Jampersal only had an impact where institutional delivery coverage was still low such as in Garut District. In this district, women were 2.4 times more likely to have institutional deliveries after Jampersal. The finding suggests implementation of Jampersal policy may have to be adjusted according to the utilization pattern for efficiency and effectiveness. The government discontinued Jampersal with the launching of the National Health Insurance Program (JKN) on January 1, 2014. The study's findings indicate the merit in reevaluating the policy to terminate the program, given that Jampersal helped increase institutional deliveries while voluntary participation in JKN remains low.

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