



## Aiming for a gender-transformative UHC agenda in Indonesia

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RESEARCH ARTICLE



## Aiming for a gender-transformative UHC agenda in Indonesia

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### ABSTRACT

At the 2019 High-Level Meeting on Universal Health Coverage (UHC), women's groups and their allies successfully lobbied for the recognition of gender equity and comprehensive sexual and reproductive health and rights (SRHR) as critical to UHC. Conservative opposition, however, remains, and realization of the then-approved political declaration will require their continued engagement to hold governments accountable and foster transformative reforms. This article, focusing on Indonesia's national health insurance or JKN, provides an illustration of possible interventions to advance a women's health and rights perspective in UHC in the context of existing barriers and opportunities for change. In particular, it presents women's groups' efforts, in part undertaken under the Australia-Indonesia Partnership for Gender Equality and Women's Empowerment or MAMPU before the COVID-19 pandemic, to promote women's participation in the national insurance scheme and improve its coverage of SRHR. Based on observational data, research findings and literature review, the article shows that these initiatives have contributed to the uptake of the scheme among disadvantaged women and brought significant gender biases to the attention of policy makers. However, much more will need to be done for the scheme to cover SRHR in a comprehensive and inclusive manner and recognize gender-responsiveness as a key element in improving women's health in Indonesia.

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## Introduction

Women have a significant stake in Universal Health Coverage (UHC) generally understood as access to all needed quality health services without financial hardship (World Health Organization [WHO], 2010). Women make up over half of the population, generally are in more underprivileged positions, their health needs are many and different from those of men, and they are usually held responsible for the health of their children and family. They are therefore highly dependent on health systems and are most affected by financial barriers and multiple inequities that reduce their access to health care. In middle-income countries, UHC has proven to be a powerful driver of achieving

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better women's health (Quick et al., 2014). It has been documented that maternal, new-born and child survival significantly increase with UHC (Gertler et al., 2014).

UHC schemes, however, like the health systems in which they are embedded, are not gender neutral and tend to reproduce biased views and structures present in society. In the words of Sen et al. (2020, p. v), they “exclude or marginalize gender concerns when framing problems, identifying and gathering data and evidence and designing programmes and policies.” Women, especially if disadvantaged, continue to experience barriers in trying to access health coverage and the offered essential packages often exclude or limit women-specific health services. Outside of maternal health, they generally tend to overlook women's realities and health needs, with the result that women have to shoulder a greater amount of out of pocket expenses than men in the same insurance scheme. Elements of sexual and reproductive health and rights (SRHR) that are very much needed by women, but often missing include contraception, safe abortion, prevention and treatment of HIV and reproductive cancers, adolescent health and treatment of health consequences of violence against women, including rape (Kowalski, 2014; Ravindran & Govender, 2020; Sen et al., 2020; Sen & Govender, 2015).

For UHC to remove barriers to women's access, it is crucial that the scheme's design and implementation adopt a gender-transformative approach that aims to “address and transform unequal gender norms, roles, and relations at all levels” (Waldman et al., 2018, p. 30) in order to contribute to gender equity in the health system and beyond. This would imply for UHC to tackle values and practices harmful to women, while supporting their participation, empowerment and choices including by investing more in SRHR. UHC should cover comprehensive SRH services that are “accessible and of high quality, and available without discrimination, coercion or violence” in order for “women and girls, who are often the most marginalised members of a community, to lead fulfilling and healthy lives” (Davies & Najmah, 2020, p. 3). To do so is feasible and effective. An example is Thailand, which from the very beginning of its national health insurance in 2002 foresaw a package that covered the promotion, early diagnosis and treatment of all SRHR components with no co-payment at the point of delivery. Besides technical interventions, block grants also support social action such as empowerment of women and the “no-tolerance to violence” movement and are inclusive of men's engagement and LGBTIQ+ services. This comprehensive approach has in turn resulted in tangible improvements in financial protection, access to services, equity with closing of the gap between income groups and in SRH outcomes (Tangcharoensathien et al., 2015; Cader, 2019; Panichkriangkrai et al., 2020).

To ensure more countries become committed to gender equity and comprehensive SRHR as critical to universal health, women's groups and their allies have successfully lobbied governments at the 2019 High-Level Meeting on Universal Health Coverage (UHC) on 23 September 2019. The adopted political declaration promises universal access to sexual and reproductive health-care services by 2030 and the mainstreaming of a gender perspective on a systems-wide basis in health policies and programs (United Nations General Assembly [UNGA], 2019). To realize this pledge and overcome the many obstacles to the actual implementation of the declaration, active engagement of women's groups and other SRHR advocates in public discussions, policy

planning and dissemination efforts remains a necessity (Gilby & Koivusalo, 2020; Sardana, 2019). In several low and middle income countries, women's movements have already engaged with this work, taking significant steps to reform UHC (Ravindran & Govender, 2020, Sen et al., 2020; Sexual and Reproductive Health Matters [SRHM], 2020). However, there has been little study of how such approaches are actually carried out and what are the implications and lessons for achieving universal access to SRH.

This article aims to present such a case study, exploring the concerted initiatives by women's groups in Indonesia facilitated or synergized by the Australia-Indonesia Partnership for Gender Equality and Women's Empowerment or MAMPU from 2014 to 2019 – thus prior to COVID-19 – to ensure that the then-introduced national UHC scheme or Jaminan Kesehatan Nasional (JKN) would adopt a women's health and rights perspective. At the time of the discussed initiatives many of Indonesia's SRH indicators were in dire need of improvement and failed to meet the set Sustainable Development Goals or SDGs (Republic of Indonesia, 2017). The maternal mortality rate of 305 deaths per 100,000 live births as reported by the 2015 Inter-Census Population Survey (BPS, 2015; Tejayanti et al., 2019) was high by all standards and its annual reduction rate too slow to meet the MMR global target of less than 70 per 100,000 live births in 2030 (Republic of Indonesia, 2017, p. 33). Unmet needs for effective contraceptives remained great and unsafe abortion and traditional harmful practices including female circumcision, early marriage and food taboos were widespread. Breast, ovarian and cervical cancers were growing and ranked as the leading causes of cancer for women in Indonesia as well as topping the new cancer cases for both men and women (Bruni et al., 2019). The feminization of the HIV epidemic was ongoing, with a growing number of "housewives" in heterosexual relations becoming HIV positive, but overlooked by prevention and treatment programs centered on so-called key populations (Fuspita et al., 2019). For pregnant women, HIV testing was not routine and anti-retroviral treatment to prevent mother-to-child transmission was not widely available (UNAIDS, 2018).

Aware of the possible contribution UHC could play in improving services related to women's health and particularly SRHR in the country, women's groups, in part with MAMPU support, have strived to address the gaps that ought to be bridged for Indonesia to fulfill its promise of comprehensive and inclusive health promotion, prevention and service delivery especially for the poorest and most marginalized women. As discussed in this article, through a multi-pronged approach consisting of community-based interventions, research and advocacy they have promoted women's participation and demanded the coverage of SRHR in the JKN scheme. The methodology to document and analyze their action consists of a combination of methods, namely direct observation of MAMPU-funded activities and other synergic efforts during the entire course of the program,<sup>1</sup> quantitative and qualitative assessments of the program as referred in the text, as well as a review of relevant grey and published literature covering the program execution time. The article shows that these groundbreaking initiatives have contributed to the uptake of JKN among disadvantaged women. Their engagement was further essential to bring crucial issues related to women's health and SRH to the attention of policy makers, by initiating discussion

that no other stakeholders on their own would start. However, much more will need to be done to enhance the degree of JKN's gender-responsiveness as a key element in improving women's health in Indonesia and fulfill their SRHR.

### ***JKN: moving toward UHC in Indonesia***

At the beginning of 2014, the Indonesian government started the much-hailed rollout of the country's single-payer National Health Insurance System or JKN with the promise that by 2019 all the country's 260 million people would be covered. This was in accordance with the 2004 National Social Security Law, which mandates a comprehensive National Social Security System or SJSN consisting of two main schemes, namely JKN and the Manpower Social Security scheme to be administered by the Social Security Management Agency (Badan Penyelenggara Jaminan Sosial or BPJS). Specifically, BPJS manages the national insurance's membership, collects premiums from contract providers and make direct payments to providers (Organization for Economic Development & Co-operation [OECD], 2019).

Building on past efforts, JKN integrates previous health schemes for the poor (Jamkesmas), public employees (Askes) and formal workers into a single pooled fund and makes participation of anyone in Indonesia (citizens as well as foreign residents) compulsory. Members are offered a broad benefits package, covering everyday concerns through complex treatments and surgeries, to be provided through a multi-level public health system and private providers accredited to join the scheme. Fees for the poor and disadvantaged groups, estimated at 86 million people when JKN was launched, remain the responsibility of the State, so these so-called *Penerima Bantuan Iuran* or *PBI* ("contribution beneficiaries" or "non-contributory members") do not have to shoulder any costs for the services covered by JKN. Instead "contributory" (non-PBI) members are responsible for their insurance premium. For employees, the premium is 5 percent of their monthly salary and it covers the entire household,<sup>2</sup> while self-employed and workers in the informal sector are required to pay set monthly premiums (Sciortino & Tjong, 2015). These were between 25,500 and 59,500 IDR (about 2–4 USD), according to three classes of care (wards) with different levels of room comfort, before being almost doubled with much uproar in March 2020 (The Jakarta Post, 2020).

The JKN scheme has grown rapidly and managed to cover 203 million people in 2018 (Agustina et al., 2019). Before COVID-19 struck there were growing indications that JKN was having a positive and equitable impact on access to health services and on reducing impoverishment due to ill-health, and that eventually better population health outcomes could be expected (Agustina et al., 2019; Mboi et al., 2018). Research findings consistently showed that JKN had improved access to care and use of services in lower-income groups, in rural areas and in the poorer regions more than in higher-income groups, urban areas and privileged regions respectively, and that health expenditures among different socio-economic groups were narrowing. There were also some indications of improvement of health outcomes for advanced medical interventions where lower-income groups had little access, suggesting that thanks to JKN they may have accessed care more promptly (Agustina et al., 2019).

At the same time, challenges have been rife. To start with despite the introduction of JKN, the health sector has remained neglected with spending constituting only 2.8 percent of GDP in 2018<sup>3</sup>—one of the lowest levels of per capita health spending relative to income among lower-middle income countries and well below the global average of 6 percent (Organization for Economic Development & Co-operation [OECD], 2016; Gildea, 2018). Besides financial sustainability concerns, major problems have included the insufficient number and skewed distribution of facilities, personnel and supplies across the country; mis-targeting of low-income and low-middle-income groups; poor quality of services for noncontributory and lowest premium members; malfunctioning referral system, and delayed contributions by paying members and employers. As also discussed here, the package is selective and insufficiently includes preventive diagnostic interventions (Agustina et al., 2019; Sciortino & Tjong, 2015).

Public and policy discussions have mainly focused on the scheme's annual deficits, which have tended to grow, without a comprehensive analysis of the functioning of JKN and the equity and health benefits. Proposed solutions, have narrowly revolved around increasing fees and reducing the package offered, with no in-depth examination of the overall health sector and the dismal finances allocated to it nor of the efficiency of the scheme and the waste, malpractice and poor governance of resources. Moreover, there has been too little discussion about how to expand health and social outcomes and how to make – as promised – UHC truly universal by ensuring the formulation of a benefits package that responds to the diverse health, gender and socio-economic conditions of a diverse population. This disabling context has greatly affected the coverage of women's health and more specifically sexual and reproductive health and rights (SRHR), a health area generally overlooked and lacking political commitment, other than for specific mother and child care components.

### ***Early recognition by women's groups of JKN's gender bias***

Soon after JKN was introduced, women's groups came to recognize that the scheme did not adequately identify and address the structural inequities that reduce women's access to health care and their specific needs and therefore in its targeting was prone to miss vulnerable women. Some of these women's non-government organizations (NGOs) and grassroots groups were partners in the MAMPU program launched in 2012 by the Government of Indonesia with the Australian Government. This eight-year bilateral program for a total value of AUD \$108.3 million supported, directly and indirectly, over 100 local women organizations at national and sub-national levels. Funded activities across 27 of Indonesia's 34 provinces strived to enhance gender equality and women's empowerment in and through improved access of poor women to essential services and government programs in five core areas, namely social protection, women's health and nutrition, violence against women, home workers' employment, and overseas labor migration.<sup>4</sup>

In relation to the topic of this article, women's and civil society groups supported by MAMPU, advocated for a health and social protection system that would be: (1) "inclusive" and provided to all in need regardless of sexuality, geography, religion, civil status, or disability; (2) "comprehensive" in addressing poverty, vulnerability,

inequality and marginalization; and (3) “transformative” in bringing change to inequitable power structures. For this to occur, it ought to be “gender aware”:

To be inclusive social protection requires specific identification of, and outreach to, women and other potentially marginalized groups; to be comprehensive, it must acknowledge and respond to life-cycle differences in women’s and men’s roles and opportunities and link people to the various services they need; and to be transformative, women can be involved as active participants, not just as passive recipients or channels for family assistance (Lockley et al., 2020, p. 2).

These advocacy efforts initially did not include JKN since MAMPU preceded JKN launching and because some of the women’s NGOs were ideologically against a social insurance scheme with fees. In their view, health care should be free and accessible to all given that health is stated as a citizen’s right in the Indonesian constitution. Yet, they gradually realized that their constituent communities had great interest in JKN as it could offer to them financial protection for much-needed health services, but encountered difficulties in accessing the scheme. Eventually, these NGOs felt that they had to engage to be responsive, but had first to acquire the necessary technocratic knowledge to bring women’s needs into the public discourse and plan specific interventions. A learning forum was eventually established to better understand JKN modalities. The leading women’s health organization in the country, Yayasan Kesehatan Perempuan or YKP (Women’s Health Foundation) facilitated a series of forum discussions among JKN experts, public health practitioners and activists on the challenges that could be expected with the launch and early implementation of JKN and possible responses. By September 2014, women’s NGOs partnering with MAMPU were already engaged in advocating a “gender aware” JKN. They had identified two main concerns, namely (1) mis-targeting i.e., excluding many women in disadvantaged position and their families from their entitlement as PBI noncontributory members; and (2) the lack of a comprehensive sexual and reproductive health package, and had initiated activities to address them as described in the following sections (Sciortino, 2018 [a]; Thamrin, 2016).

### ***Ensuring inclusion of disadvantaged women in the scheme***

Social protection programs in Indonesia employ targeting to identify people most in need of social assistance. In spite of significant reforms to reduce targeting errors – such as the introduction of the Unified Database (Basis Data Terpadu or BDT) and the launch in selected regions of the Integrated Referral System (Sistem Layanan dan Rujukan Terpadu or SLRT) – the centralized process has proven complex due to the large number of poor and near poor in the country; the cyclical and fluctuating nature of poverty; differences between national and regional poverty lines and data sets; and the time lags between identification and implementation of programs as well as between complaints and adjustments in the data set. Moreover, the gendered nature of economic and social risks has not received the due attention, with female-headed and –maintained households, single women or childless women overlooked, discriminated or excluded by programs based on male-headed households as unit of targeting and on gendered conventions about household heads or because of lack of identity

documents (Tohari et al., 2019; Kementerian Sosial Republik Indonesia [Kemensos], 2017; Lokley et al., 2013).

At the time of the JKN launch, women's NGOs working on social protection and health were already aware that a significant proportion of poor households, and especially female-headed and -maintained households, did not benefit from targeted poverty programs (see also Alatas et al., 2012; Cameron and Shah, 2014) and were seeking to improve this situation. Once they became interested in JKN, they could easily adapt their programs to include monitoring of its implementation and start to assess the extent of targeting in relation to women (and their households) entitled to noncontributory membership. Soon it became clear that there were significant exclusion and inclusion errors and that many disadvantaged women did not enroll as PBI, while people who were not entitled were considered noncontributory members. These field observations were in line with studies at the time that indicated that in 2016 only 30.4 percent of poor people and 25.2 percent of near poor were enrolled as PBI, while 12.1 percent of not poor and not vulnerable people, not entitled to PBI, did receive it (Badan Pusat Statistik Indonesia [PBS], 2017; World Bank, 2017; see also Satriana, 2018).

To address mis-targeting and enhance knowledge of JKN and its benefits among women villagers and disadvantaged women in urban slums, MAMPU-supported women NGOs and grassroots groups started a range of interventions. Broadly, their activities can be classified into four *modus operandi*:

1. providing support to eligible women to ensure their entitlements as PBI members are met and helping them to get necessary documents – both identity documents and the village government's recommendation letter stating the family's underprivileged economy conditions (SKTM or *Surat Keterangan Tidak Mampu*) that serves for PBI free health coverage;
2. questioning the membership criteria that tended to exclude single women and female-headed and -maintained households and the accuracy of the data in determining who is poor;
3. developing of public monitoring and complain systems to document every case of unwarranted exclusion and ensure that it is addressed as well as using case documentation to advocate policy change;
4. disseminating JKN rules and regulations related to enrollment among women in areas difficult to reach (adapted from Thamrin, 2016, pp. 25–26).

The main strategy was to integrate JKN-focused efforts into the organization's broader activities to maximize scarce human and financial resources. For instance, the Institute for Women's Alternative Education or Institut KAPAL Perempuan (KAPAL) and its grassroots partners devoted attention to JKN at their "*Sekolah Perempuan*" (Women Schools). These informal schools run by grassroots women in villages in the provinces of East Java, West Nusa Tenggara and South Sulawesi explore issues of particular interest to members, and raise awareness and understanding of key gender-related concepts. The program, composed of seven modules, comprises developing gender and socially inclusive data for community and policy advocacy and encouraging women's

leadership and participation in village decision processes and governance mechanisms, including those determining the allocation of public funds. In relation to JKN, the cadres of the Women's Schools performed multiple tasks. Among others, they socialized the scheme among disadvantaged women in isolated areas and provided support to village women to navigate the enrollment process for new members and overcome administrative barriers to get treatment under JKN. They also collected data on overlooked disadvantaged women to advocate for their inclusion and documented implementation problems to be communicated to policy-makers at local and national level (adapted from KAPAL Perempuan, 2020).

Monitoring of PBI enrollment and support to entitled, but not-yet-covered, non-contributory members was also the focus of two other women's organizations, the national women organization network KPI (Koalisi Perempuan Indonesia or the Indonesian Women's Coalition for Justice and Democracy) and the Women-Headed Family Empowerment (PEKKA) Foundation and its national federation of women-headed households across Indonesia with more than 60,000 members (Lockley et al., 2020). KPI member organizations established 74 Information, Complaints and Advocacy Centers (Pusat Informasi, Pengaduan dan Advokasi or PIPA) to monitor women's access to JKN and other social protection programs spread in eight provinces [MAMPU, 2018 [a]]. Similarly, PEKKA provided information and consultation services (Klinik Layanan Informasi dan Konsultasi) or "KLIK", a mobile initiative to guide village women on accessing JKN and other government social protection schemes as well as services to attain legal identity documents and to provide care for survivors of violence [MAMPU, 2018 [b]]. When the women could not be included into the scheme's national PBI portion, women's groups advocated with local authorities to devote funds from the district budget to ensure PBI membership for them. One of many locations was Bantaeng in South Sulawesi where in 2018 206 JKN-PBI cards were issued by the district social services office to poor women based on data collected by PIPA, who had been previously excluded by the national authorities (MAMPU, 2018 [a]).

Some of these innovative programs were replicated with government funding in order to expand their reach. For example, PEKKA received support to expand its mobile services in four villages in Sukabumi (West Java) and 5 sub-districts of Baubau City (Southeast Sulawesi). Most importantly, in 2018, the Head of Sukabumi District in West Java signed a regulation to integrate KLIK into the government's SLRT system in 386 villages to improve data and access to social protection (MAMPU, 2018 [b]).

## **From promoting enrollment to addressing underutilization**

The early programs mostly focused on promoting PBI enrollment among disadvantaged women and ensuring they would get the PBI registration card that enabled them to access health services free of cost. These efforts by women's organizations by complementing official government's socialization of JKN through national media and BPJSN delivery system, greatly contributed to increased numbers of PBI members among women and their families. In areas where the above-mentioned organizations worked, a longitudinal study with a sample of 1460 households showed that the 50 percent that did not have PBI membership in 2017, had acquired it by 2019 (SMERU,

2019). Efforts also contributed to address the gender gap in health insurance membership. A national level analysis found that there were no longer differences among male-headed and female-headed households at the lowest poverty levels. At middle levels of consumption, women-headed households were even more likely to be members than male-headed ones (Schaner & Theys, 2020).

Some exclusion and inclusion mismatches remained, particularly in rural areas, but the need for women's NGOs to provide assistance for expanding women's access to JKN became less urgent. Gradually, their program focus shifted from enrollment to providing information on how to make use of the JKN card. It had in fact become clear that many PBI members did not use the services because they did not fully understand the benefits they were entitled to. This was confirmed by observations of the MAMPU advisory team<sup>5</sup> during a field visit to women's groups in villages in Central Java. They remarked that most women they interacted with were not familiar with JKN processes and could not identify what was covered and what was not covered by the scheme (MAMPU Strategic Advisory Committee [SAC], 2018). Studies at the time also showed that the increase in the number of beneficiaries only partly translated into outpatient and inpatient utilization rates. Among others, it was highlighted that "only 55% of those covered by PBI accessed the health services they needed, raising concerns regarding awareness and insurance literacy in the target population" (OECD, 2019, p. 103). According to the Center for Financing and Health Insurance of the Ministry of Health, about half of the JKN members did not use entitlements for outpatient care, and about 20 percent did not do so for inpatient care (Center for Financing & Health Insurance [CFHI], 2016). Similarly, KAPAL research showed that in spite of a large majority of households in the sample having health insurance eligibility, members generally did not know for what JKN could be used. A poignant example was that 87 percent of the surveyed women did not have reproductive health checks – being unaware that JKN covered them (Kapal Perempuan, 2018, p. 8).

The causes for this underutilization were varied. Besides poor information and low understanding of JKN procedures among both patients and health professionals, there were significant complaints about long queues and low quality of services and drugs (if not bought at a cost). Members also complained about the poor attitude and malpractice of health personnel including charging for drugs and procedures and referrals to private facilities not (fully) covered by JKN thus causing unnecessary out-of-pocket payments. Hospital wards were often declared full for PBI members with precedence given to contributory members. For women, structural factors also played a role as gender norms and sexual taboos continued to limit availability of SRH services and women's access to health facilities even after financial barriers had been reduced. In disadvantaged provinces, women's access to essential services was further restricted by geographical distance of health centers and especially tertiary facilities, difficult transportation, or simply lack of facilities or specialists (Agustina et al., 2019; SMERU, 2019; KAPAL Perempuan, 2020).

Women's groups thus come to envision more wide-ranging approaches beyond advocating for inclusion in the JKN scheme. They set out to ensure that the overall scheme would be properly governed and implemented and social barriers and supply-

side constraints to the advancement of universal coverage and access to SRH services would be addressed.

## Ensuring coverage of maternal and child care

JKN covers SRH services selectively, with essential components overlooked or managed under separated arrangements and no attention for rights and diversity considerations at the cost of efficiency, effectiveness and justice. In the early days of JKN, questions centered on how far JKN supported maternal and infant care crucial to ongoing efforts to reduce maternal and infant morbidity and mortality. JKN provisions substituted the universal delivery care program (Jaminan Persalinan in short Jampersal), implemented from January 2011 by the Ministry of Health, which provided free antenatal, delivery, and postnatal care for women and their newborns at primary facilities, along with referrals for maternal and neonatal complications to secondary and tertiary hospitals (Teplitskaya and Dutta, 2018). While the services covered were similar and in some respect broader under JKN, users felt that the process was more cumbersome. They also complained about the restrictions to deliver only at assigned local facilities, being JKN, contrary to Jampersal, place-based and not portable.

Women's groups together with midwifery and public health specialists also expressed their worries that the exclusion of poor women due to mistargeting (as discussed in the previous section) would backtrack progress in maternal and child care that had been achieved in rural areas with Jampersal. To respond to these concerns, in 2017, a new iteration of Jampersal was introduced by the Ministry of Health for poor women who were still uninsured with a greater focus on costs associated with birth waiting homes (rent, food and care support) for those who live far from the health facility and have to stay until the delivery nearby. Concerns, however, have emerged about duplication of activities and inadequate coordination between JKN and Jampersal II leading to waste of resources and possibly also to stagnated outcomes (Teplitskaya and Dutta, 2018).

Women's groups also expressed concern that JKN was not inclusive of midwives in their private practices, even if often, especially in rural and remote areas, they are the closest and most skilled personnel available for deliveries, family planning and mother and child care. Midwives' practices are too small to meet the set criteria for BPJSN's contracting so they have to be sub-contracted by other facilities with unclear costs implications and potential tensions among health practitioners or they remain out of the scheme and thus not free for the users. Recent research shows that those concerns are valid and women encounter high out-of-pocket expenses to continue to use private midwives for antenatal care, delivery and family planning (Teplitskaya and Dutta, 2018; Siswanto et al., 2020). It was also pointed out that access to hospital care had become more taxing due to JKN referral system with health centers acting as gatekeepers (Mahendradhata et al., 2017). Women in need of specialist or hospital services, if not considered an emergency, had first to obtain a referral from a health center – this even for chronic diseases with long-term treatment – otherwise, they would incur out-of-pocket expenses at the hospital.

At the beginning, much public attention was also given to the failure to cover newborn babies with complications if not already registered as members, which was impossible to do before birth. Thanks to women and child health care advocacy groups, the rules were changed to automatically enroll newborn babies in JKN and cover their care since birth. Many issues, however, remained unresolved and this moved women's groups to more systematically assess JKN's coverage of SRHR to be able to propose the necessary changes based on evidence.

### **Evidence-based advocacy for comprehensive SRHR package and services**

In 2016, YKP launched in collaboration with a network of 15 women's organizations spread throughout Indonesia (Jaringan Perempuan Peduli Kesehatan or JP2K) a three-year multi-wave longitudinal (non-panel) survey assessing the SRHR coverage in the provinces where the organizations were based. The aim was to use the findings to advocate for improvements in access and quality of services for women and their families. More than 9000 respondents were interviewed annually, consisting of both users and health professionals. The findings showed that in spite of a gradual increase in knowledge, both users and health providers had limited understanding of the SRH package and of JKN procedures and coverage extent. Most of the respondents as well as the health professionals had experienced JKN coverage mainly in relation to mother and child health services, and mostly for delivery (YKP, 2018; Lestari and Sigiuro, 2019).

Moreover, the survey showed that JKN coverage of SRH was far from comprehensive and that organizational arrangements further limited access to quality SRH services. With regards to contraceptives, JKN only funds the provision of services while contraceptive methods are procured and provided by the National Family Planning Agency (BKKBN). Due to the lack of coordination between BPJSN, the Ministry of Health, BKKBN and local governments as well as logistical barriers, availability of the entire spectrum of contraceptives ranging from short-term commodities such as pills and condoms to long-acting reversible and permanent methods has been wanting. It also appeared that selected long-term contraceptives, namely intrauterine devices (IUDs) and implants, are prioritized according to population control priorities. Poor women also continue to be "compelled" to use IUDs or implants immediately after delivery (a practice already established under Jampersal) with no or minimum counseling and little regard for their choice and rights. The government's population control bias has also led to the exclusion of infertility treatment from JKN's benefit package, this in denial of the serious social and emotional implications for the women and couples who experience childlessness.

Regarding surgical abortion, even if the Law no. 61, 2014 allows abortion due to medical conditions and as a result of rape, neither women nor health professionals were aware that it could be covered by JKN. No clear provisions are also there for the coverage of *visum et repertum* for rape victims and for providing them with emergency contraception. For sexually transmitted diseases and HIV/AIDS financing is selective and does not cover diagnostic test and treatment fully. Funds for ARV treatment were provided mainly by the Global Fund for Malaria, HIV and TB and other

international donors and had been diminishing recently raising questions on how JKN planned to sustain such services (see also Davies & Najmah, 2020).

JKN covers in principle all types of cancer, but there have been debates on the treatment provided and whether it is timely and of quality for affected women. The JP2K survey found that screening for cervical and breast cancer was covered by JKN in observance of Ministry of Health decision 71/2013 (article 28), but only when there were clinical indications. This according to the same MOH decision foreseeing regular yearly testing only for type 2 diabetes mellitus and hypertension, and not for cervical cancer and breast cancer (Kementerian Kesehatan Republik Indonesia [Kemenkes], 2013). In view of the great public demand, BPJSN did at times fund Acetic Acid Visual Inspection Method (IVA) and pap-smear diagnostic screening events and more rarely mammography screening, but only on an *ad hoc* basis, depending on funds surpluses or short-term bureaucratic projects, which according to the women's groups lead to waste and mismanagement of resources.

The survey and successive qualitative research also singled out interventions that have been used in excess, most strikingly, the jumping of C-sections. This finding is consistent with BPJSN data recording that C-sections increased from 20 percent of all covered deliveries when JKN was introduced in 2014 to 45 percent in 2017, with no major differences across beneficiary groups (Yulianti, 2019, slide 20). What could have been regarded as a case of malpractice affecting the wealthy, somewhat perversely has become more diffuse with the introduction of blended public-private UHC without adequate monitoring (Sciortino, 2020).

The selective inclusion of SRH components was found to be closely related to the "sensitivity" of SRHR in a context increasingly affected by the rise of "populist morality" and politicization of religion (Afrianty, 2020; Aryanti & Widyantoro, 2019; Zaman & Shaheed, 2017). Judgmental pressure by vocal conservative groups has affected public resource allocation and has led to the exclusion of services and groups deemed not to be "entitled" to SRH services: for example, young people, unmarried women and LGBTIQ+ persons. In spite of the increasing number of early pregnancies in the 15–19 age group to this day there is no JKN coverage of SRH services for them except for generic SRH education when available at public facilities. There were also reports of unmarried women not been considered for IVA screening because of their being considered as not sexually active and thus at no risk (Waldon, 2017) and of people with HIV who were denied treatment and UHC coverage as their condition was seen as the result of "immoral" behavior and therefore "their own fault", even if there is no formal policy to this extent (Davies & Najmah, 2020). Those discriminated groups have thus become dependent on private practitioners for targeted care irrespective of their economic status (Sciortino, 2020).

Based on their research findings and analysis and other relevant information, JP2K and like-minded organizations formulated a common agenda to inform a joint program strategy to fill some of the gaps and advance a comprehensive SRHR package. Key areas of improvement were articulated and presented to BPJS and other relevant government units at both the national and district levels (JP2K, 2018; YKP, 2018; Lestari and Sigiro, 2019). Members of JP2K have also held dissemination and advocacy meetings with the media, health professionals and the general public in their

respective locations all over Indonesia. Among others the proposed reforms recommended that financing of contraceptive services be fully integrated, with BPJSN taking over funding of contraceptive methods purchase and logistics from BKKBN in order to reduce delays and waste of resources. Family planning further ought to be integrated with other vertical programs and expanded both to improve the services and to offer a greater and unbiased choice to women. Male contraceptives were to be encouraged and age and marital status no longer be set as criteria for providing services. Socialization of the RH Law about safe abortion and adolescent sexual education among both health professionals and the concerned target population was considered a must for making the covered services accessible, and pressure put on the Ministry of Health to complete the operational guidelines for training of health professionals. It was further recommended that appropriate infertility treatment be financed, while stricter rules should be employed to reduce unnecessary C-section deliveries and the associated risks and waste of resources.

The advocacy agenda also called for the urgent revision of Article 28 of the Ministry of Health decision 71/2013 in order to include pap smear and mammography on a periodic basis to address the growing trend of reproductive cancers in the country. Awareness that such reform would take time, moved women's groups like Aisyiyah, a large Islamic women's organization with a strong focus on health and education, to successfully promote and provide IVA and to a less extent pap smear screening and clinical breast examination in disadvantaged communities. They have provided reproductive cancer awareness education through innovative methods to address women's embarrassment at being examined and their fear of the unknown screening processes and the potential negative result, and have raised funds from local governments and health centers as well as private donors to cover diagnostic services (Tempo, 2015; MAMPU, 2018 [c]). A call was also made for HPV vaccination to be covered by JKN and provided by health services as a preventive measure for cancer-causing infections and pre-cancers, but to date opposition by conservative groups has been stronger than public health arguments.

Realizing that a more enabling environment was crucial to advance the "gender-aware" JKN agenda, women's groups and their allies have also made substantial efforts to promote consonant values among the public and key stakeholders and institutions. Among the regional initiatives, PERMAMPU, a consortium of eight women's organizations from across Sumatra, has advocated key stakeholders (religious and cultural leaders, health service providers, schools and local governments) to influence socio-cultural norms that support harmful practices such as female circumcision and child marriage, while hindering women's choices and rights to access information and services on SRHR (MAMPU, 2018 [d]). Aisyiyah and KUPI, a newly formed network of Muslim women preachers, have sought progressive theological interpretations about gender roles and SRHR. Kapal Perempuan (2020) has advocated across the country against female circumcision, child marriage and violence against women, and for the realization of SRHR.

National and sub-national efforts have further led to enhanced public knowledge on SRHR and to the reform and formulation of decrees and legislations to promote

inclusiveness and enhancing gender justice on interlinked issues related to access to services, adolescent sexuality, child marriage, medicalization of female circumcision and sexual violence among others.

### **A promising start to a challenging journey**

The multi-pronged strategy was still ongoing when COVID-19 struck at the beginning of March 2020. To that point, women's groups still persisted in their efforts to strengthen the grassroots constituency, while actively pressuring for the proposed agenda through media and policy advocacy. They were at a significant moment, having managed to hold direct conversations with the leadership of BPJSN, MOH, and other relevant agencies in Jakarta and with local governments in the districts and provinces. provided to women's groups strategic access to national planners and other relevant stakeholders, key to eventual reforms. An important component was the broadening of the coalition beyond the small number of NGOs traditionally concerned with health, to acquire more political significance in order to obtain the envisioned changes. COVID-19 and containment measures have put a halt to these promising endeavors, hampering face-to-face activities and moving SRH concerns to the background as the government and the health system are geared toward controlling the pandemic.

The long-term impacts of the described synergic efforts are difficult to judge in the present context, but there are indications that they have contributed to broadening women's access to JKN's membership and entitlements and to triggering a discussion on the framing of a SRHR package and its implementation. As mentioned before, research findings already show that women's groups have played a significant role in expanding the reach of the program among less privileged women and increasing their PBI-membership by socializing the JKN scheme and providing feedbacks to correct the significant exclusion errors and gender biases in targeting. There is also evidence that the increased participation of women's groups in wider collective processes in the village has increased the likelihood of accessing JKN and child and maternal health services (SMERU, 2019). Women's groups' monitoring of health services and coverage has also provided invaluable information to identify and assess to what extent JKN is women-friendly and SRH services are covered. Their data and observations have triggered public and policy discussions on the quality of the services and made the point that no care disparities should emerge for women, irrespective of whether they pay the insurance fee or it is paid for them by the government. Their pioneering research has provided an evidence base to improve SRH coverage and services and their proposals have had wide dissemination and reached relevant agencies. Discussions on SRHR have also been integral to the successful advocacy to raise the minimum age at which women can marry to 19 from previously 16 years old, to curb widespread child marriage and female circumcision and are advancing public awareness of much needed SRHR access and coverage for adolescents (Hamdi, 2019). These experiences demonstrate:

the dual role played by women's civil society organizations: as a bridge between central and district agencies and the communities they serve, and secondly, as monitoring

agents, increasing the accountability of, and providing feedback on the implementation of government policy (Lockley et al., 2020, p. 15).

That said, there is still ample room for improvement especially as coverage of SRHR and the full realization of the gender-transformative agenda are concerned. For a start, sex-disaggregated data for JKN and the gathering of data on priority women's health services, health outcomes and equity indicators are still lacking. The awakened greater interest for universal SRH care is still to translate into tangible reforms. As noted previously, the few concrete changes to the offered package have mainly concerned child and maternal health, and neglected other components of SRH. Support of public health specialists and sympathetic policy planners is being restrained by conservative views and financial considerations. Most pressing, discussions of rights are limited and there is scant talk of inclusive services outside of those related to women's reproductive function. The overall environment also remains hostile. The sexual violence eradication bill (RUU PKS) was finally approved by parliament after a decade from its submission, but only after the removing of two key sections concerning rape and safe abortion for victims of rape. It further remains a question when and how it will be implemented considering the persistent opposition of Islamist groups claiming the bill promotes amoral behavior (BBC News Indonesia, 2022; Tinessia, 2020).

While women's groups continue to work toward overcoming these barriers to a comprehensive approach to SRHR, they are further challenged by four evolving trends. Firstly, civil society groups, and even more women and health advocacy organizations, are operating in an increasingly restrictive environment and confronted with shrinking resources (Sciortino, 2018 [b]). MAMPU is unique among bilateral funding programs for its long-term support to women's organizations and for its clear focus on women's empowerment as central to development, but it ended in December 2020 and the follow-up program has been delayed by the pandemic and does not have the same focus on SRHR. Secondly, the increase of JKN premiums recently introduced by the Indonesian government may backtrack some of the gains in women's JKN's membership, access and participation and compromise the scheme's universality principle. Especially, the many women in the informal sector who have been impoverished by the pandemic may fall in the cracks. Thirdly, the far-reaching impact of COVID-19 on existing health institutions and infrastructures may affect overall quality of care and access in the years to come. And fourthly there is a growing occurrence of religious-based policy formulation that limits women's choices and gender inclusion (Afrianty, 2020).

To address these trends, women's engagement ought to be sustained and expanded. If it was not for women's groups and their allies, the issues of women's access and comprehensive SHRH package would not even have been raised, and to be pursued further will need their leadership. In the words of PERMAMPU executive coordinator, Dina Lumbantobing, more and more women "must be active, have a voice, and become agents of change. As subjects, instead of objects" (MAMPU, 2018 [e], 1). Efforts to date show that the empowerment of women at national, district and grassroots levels is essential for women to gain from national reforms that they might otherwise be at risk of missing out. Evidence shows that the empowering of previously excluded women in becoming aware and advocating for their health and social protection entitlements is key to increasing access and accountability in service provision

(Lockley et al., 2020). This will be even more the case in the days ahead for JKN to deliver on its potential to improve women's health for all.

## Notes

1. The author has been a strategic adviser (consultant) to the program since its inception and until its closing. She also provided technical advice in several program evaluations and research projects whose findings are presented in this article (see also Acknowledgment at end of article).
2. For private sector employees, the employer is responsible for 4 percent and the employee is responsible for 1 percent while the split, for public sector employees is 3 and 2 percent respectively.
3. <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=ID>
4. See further information on Mampu website <https://www.mampu.or.id/en/> and on the DFAT website at <https://www.dfat.gov.au/geo/indonesia/development-assistance/Pages/inclusive-society-in-indonesia>
5. Including the author.

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No potential conflict of interest was reported by the author(s).

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