FINAL REPORT

FAMILY PLANNING SITUATION ANALYSIS IN PAPUA AND WEST PAPUA

(Case Study in Jayapura, Jayawijaya, Manokwari and Sorong District)

BADAN KOORDINASI
KELUARGA BERENCANA NASIONAL

Australian Government
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ACRONYMS and LIST Of TERMINOLOGY

ABT	:	Anggaran Belanja Tambahan – Additional spending budget
AIDS	:	Acquired Immune Deficiency Syndrome
APBD	:	Anggaran Pembangunan dan Belanja Daerah – Local development and spending budget
APBN	:	Anggaran Pembangunan dan Belanja Nasional – National development and spending budget
ARH	:	Adolescent Reproductive Health
BKKBN	:	Badan Koordinasi Keluarga Berencana – National Family Planning Board
CBR	:	Crude Birth Rate
CPR	:	Contraceptive Prevalence Rate
FGD	:	Focus Group Discussion
HIV	:	Human Immuno Deficiency Virus
IEC	:	Information Education and Communication
IUD	:	Intra Uterine Device
Cadre	:	Village-based volunteers
KPA	:	Komisi Penanggulangan AIDS – AIDS Commission)
PPLKB	:	Pengawas Petugas Lapangan Keluarga Berencana – Supervisors of family planning field officers
PLKB	:	Petugas Lapangan Keluarga Berencana - Family planning field officers
PKB	:	Penyuluh Keluarga Berencana – Family planning counselor
Polindes	:	Pondok pesalinan desa – village health posts
Posyandu	:	Pos pelayanan terpadu – health centres
PPKBD	:	Pembantu Pembina Keluarga Berencana Desa – Village based family planning healthcare providers
Puskesmas	:	Pusat Kesehatan Masyarakat – Community health centre
Pustu	:	Puskesmas Pembantu – Community health centres that provide additional assistance
Rp	:	Rupiah
SDKI	:	Survey Demografi dan Kesehatan Indonesia – Indonesian Demographic and Health Survey
STI	:	Sexually Transmitted Infection
TFR	:	Total Fertility Rate
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children's Fund

FOREWORD

Family Planning (FP) is a cost effective health intervention that saves women and children's lives. It contributes to the wellbeing of women and children and help with long-term benefits to national development and poverty reduction. With the support of UNICEF, UNFPA conducted Family Planning situational analysis assessment in Papua and West Papua during July – September 2008. This analysis is one of the Fund's supports to provincial/ district administrations' population programme where the assessment findings highlighted the need for serious attention and strong involvement of local actors to address the unmet need, the high use of traditional contraceptive methods and the low prevalence of modern contraceptives. Improving local FP programme would increase reproductive health status of women and children in the provinces where maternal and infant deaths are among the highest in the country. UNICEF deserves high credit for supporting this initiative.

Quality FP and reproductive health (RH) as basic human right is highlighted at the 1994 International Conference on Population and Development (ICPD) and in its Plan of Action. Effective RH and FP programme is key for the achievement Goal 5 of the Millennium Development Goals of the World Summit: reduce by three quarters maternal mortality ratio between 1990 and 2015. FP contributes to reducing unwanted pregnancies that according to data, accounts for 11% of the maternal deaths.

For improved RH and FP services in Papua and in other parts of Indonesia, development actors-- governmental institutions, civil society organizations and international organizations-- need to work closely in order to build local capacity for effective quality RH and FP services, to secure adequate FP supplies, stimulate demands for services and to foster stronger political commitment to RH and FP. All this requires intensive advocacy and continuous public awareness efforts involving all elements of the society.

At UNFPA, we believe in the importance of population researches/surveys and the use of reliable data for well-targeted development interventions. I am sure the findings and recommendations of this assessment are useful to help decision makers and development planners in Tanah Papua to properly design FP programme aimed at improving the reproductive health status and the overall wellbeing of Papuan women and men for their optimal roles in boosting local development efforts.

Ms. Yenni Siswantini, UNFPA consultant and Dr. Melania Hidayat, UNFPA RH Officer have worked tirelessly to make this FP situation analysis study possible and I thank them for their dedication and hard work. I also thank Ms. Chaya Murli of UNAIDS for editing of the English version of the report. My special gratitude goes to the officers and staff of BKKBN, Dinas Kesehatan of the four study districts and the study puskesmas. Finally, my deep gratitude goes to the people in the community who graciously supported this study.

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EXECUTIVE SUMMARY

The objectives of this analysis is to document and analyze the present situation of family planning programs in Papua and West Papua, identify opportunities and challenges in promoting and implementing family planning methods in supporting reproductive health, and identify family planning services based on the needs of the local situation.

Data collection was conducted through a desk study and field study. Secondary data was collected from relevant family planning bodies at the provincial and district levels, such as the Dinas kesehatan, BKKBN, and BPS. Determining the study locations was done in stages (multistage purposive sampling). The first stage was to choose 2 districts from each province, areas in which UNICEF operates. Based on that criteria, Jayapura and Jayawijaya were chosen as study location in Papua and Sorong and Manokwari were chosen as study districts in West Papua. The second stage involved sub district selection through stratified purposive sampling , where the stratum was areas where UNICEF operates, and areas where UNICEF does not operate. Based on the criteria, 4 sub districts within each district were selected, including 2 sub districts where UNICEF operates, and 2 districts where UNICEF does not operate. Puskesmas at the sub district level were selected as study locations.

Development data on the population in Papua and West Papua shows an increase from year to year. Population based on age group in 4 study districts shows that the composition of females and males aged 15-49 years is similar, 52% of the whole population. Only in Jayawijaya the percentage of females (52%) is higher than males among the same age group. This data indicates that there is a high opportunity for the development of family planning programs in the 4 districts.

Based on the SDKI, the level of knowledge among married females aged 15-49 on at leat one type of modern contraceptive is relatively high, 61.5% in Papua and 92% in West Papua. Apart from knowledge on modern contraceptives, 65.7% of married females in Papua and 43.6% in West Papua have knowledge on traditional contraceptives.

The high knowledge level does not automatically translate to a high coverage of family planning in the 2 provinces. The CPR in Papua based on the SDKI 2007 is only 24.5%, whereas this figure in West Papua is 37.5%, a very low coverage as compared to the national level. This low coverage is also evident in the high TFR in the 2 provinces; 2.9 in Papua and 3.4 in West Papua. Unmet needs, or family planning needs that are not met, are still high; 15.8 in Papua and 16.5 in West Papua.

Popular contraceptives among married females in Papua and West Papua is the contraceptive injection and the pill. SDKI data also shows that the use of traditional contraceptives is high in Papua, the highest as compared to other provinces in Indonesia. This indicates that with a high knowledge on modern contraceptives, the opportunity for the development of family planning programs in Papua and West Papua is high.

The CPR in the 4 study districts shows that based on type of contraceptive, coverage for the injection and the pill in Jayapura is higher than that of Papua; whereas in Jayawijaya the coverage for all types of contraceptives is below the average in the same province. In West Papua, in Sorong the coverage for the pill, IUD and implant is above the provincial average. In Manokwari only the coverage for the implant is higher than in West Papua. For the other types of contraceptives, it is lower than the provincial level.

Policies on family planning institutions have changed significantly since the decentralisation era, where the BKKBN as an institution handled the development of family planning programs, and were spread accross Indonesia. Now the status of the institution differs in every district, and largely depends on the local government policies. In 2007, family planning institutions, through the PP no. 41/ 2007, on local organization, has been organized more specifically. In Article 22 verse 5 on Government Affairs section (i), issues on the empowerment of women

and family planning are mentioned. This means that existing institutions responsible for the development and implementation of family planning programs will be an official body or a department combined with women's empowerment.

Nomenclature in 4 family planning study locations in Jayapura and Manokwari are part of the office for Demographics, the Civil notes and Family Planning, whereas in Jayawijaya it stand sindependently as a family planning department and in Sorong it is part of the department for community empowerment and family planning. This institutionalization directly affects the coordination mechanism from the central level down to the district/city. The institutional change has also had an impact on the number and competency of staff that manage family planning programs. Since it has become part of the district/city government, the BKKBN staff can be placed within various bodies based on the needs of local government, and vice versa. If family planning management officials are not from the BKKBN, it is often the case that that family planning programs are not developed based on the needs of the community.

One indication of local government support for family planning programs is the availability of budgets. In the 2 provinces, local government support is still relatively low. Budgets for the development of programs largely comes from the central government through the APBD and DAK. In each ditrict, budget availability is not consistent. This indicates that family planning programs have not become a priority for local governments.

Based on the National Strategic Plan for family planning programs in the BKKBN and the National Strategic Plan for family planning programs in the Department of Health, it is shown that family planning institutions at the district/city level, along with the Department of Health, focus on family planning services, supporting and strengthening the BKKBN implementation of such services at the district/city level.

At the provincial and district level, there is no written document that outlines the role of the BKKBN, Dinas Kesehatan, and community and private institutions. Observations and results of interviews at family planning bodies and Dinas Kesehatan in the 4 districts visited sindicate that the BKKBN focuses more on promotion, advocacy, provision and distribution of contraceptives, whereas the Dinas Kesehatan focuses more on services. The Dinas Kesehatan in the 4 districts visited do not yet have policies and specific strategies on family planning programs. In addition, it is hoped community and private institutions play a role in maintaining the quality of family planning programs by developing the services.

In relation to the structure of services, family planning services are provided in a number of government and private health centres. Family planning services are available at hospitals at the district and city level. Apart from most puskesmas accross the districts, services are also provided at the polindes, and by private doctors and midwives. Secondary data shows tht 86.84% of the community in Papua and 95.55% in West Papua access family planning services provided by the government. At the district level, based on data from the Dinas Kesehatan in 4 districts, family planning services are provided by specialist doctors, general practitioners, midwives and nurses. Contraceptive supplies at the district level are mostly provided by the central government through the provincial BKKBN, and only a number of districts receive supplies from the APBD. Nationally, there exists policies on free contraceptives for 3 provinces; Nangroe Aceh Darusalam, West Nusa Tenggara and Papua; where contraceptives available should be provided free of charge to the entire community. From the provincial level down to the district level adequate contraceptives are available. At the provincial BKKBN there are storage units for contraceptive supples with a good security system, however notes using cards are only done at the BKKBN in West Papua. At the district level, not all districts visited have a storage unit for adequate contraceptive supplies. Physically, the storage unit for contraceptives in Manokwari and Sorong are not adequate, where storage shelves are not available and supplies are not organized based on expiry dates. In addition, at the 2 storage units, there are no notes available through the provision of cards, and individuals who manage the storage units in Manokwari have not been trained in management of supplies.

For distribution from the district level to the service level, puskesmas facilities are often unable to distribute supplies

evenly due to geographical barriers, availability of funds, and of health personnel to assist with distribution. At the time where PLKB/PKB were available in every sub district, distribution of supplies was conducted through them. At present, distribution from the district level to puskesmas facilities is based on demand. Administration fees are often applied when contraceptive supplies are collected. Request for contraceptive supplies can be made if the puskesmas provides documentation and data on the use of supplies from the previous period. Reporting of family planning services is done by the puskesmas with a form provided for MCH services, whereas reporting mechanisms on the use of contraceptives is provided by family planning bodies. In reality, reporting is not always done routinely due to a number of reasons. At the district level, reporting mechanisms are not always done in an integrated manner due to various factors such as insufficient coordination between family planning agencies and the Dinas Kesehatan.

Supervision of family planning services is conducted both by the Dinas Kesehatan as well as other family planning bodies. However, due to geographical barriers and limited funds available, monitoring of programs on the field can only be done in areas that are easily accessible and through reporting mechanisms. Meanwhile family planning services in puskesmas facilities are often included in meetings that discuss MCH services.

The level of knowledge among the community in Papua and West Papua according to the SDKI 2007 Report is relatively high, and field results indicate the same. Among married females, almost all FGD participants know of at least one method of contraception, except in Jayawijaya where results show that almost all FGD participants do not know of any contraceptive methods.

Among adolescents and young adults (unmarried) results show that almost all participants have heard, seen or used a condom, but most recognize the condom for STI and HIV prevention rather than for birth control. Married males and females believe that the condom is not suitable for use with permanent partners, and should only be used for engaging in sexual behaviour with other partners. A number of married females also believe that using a condom with permanent partners within the household results in a lack of trust between partners.

Sources of information on family planning in communities in Papua and West Papua are similar. FGD and interview results with community and religious leaders show that sources of information on family planning come from formal and informal sources, including health personnel (midwives, doctors and/or nurses), family planning field officers, family planning cadres, religious figures (pastor, sister, priest), education in schools, books, media (television, radio, newspapers, and external media such as billboards, as well as from families and parents. Among married females, knowledge on family planning is often received from health personnel, family planning field officers and posyandu cadres and/or PPKBD; whereas among adolescents and young adults knowledge on family planning is often obtained from parents, the media, books, and education in schools.

Apart from knowledge on modern contraceptives, a number of male ad female participants, particularly married males and females, also have knowledge on traditional contraceptives and a number of them also demonstrated it. Traditional contraceptives used by married women include abstinence. Apart from that a number of traditional contraceptive methods often used by the community in villages include prayers, mixtures made of wood, flowers and leaves.

The level of knowledge on family planning also differs. Most FGD participants and a number of religious and community figures who have limited knowledge in family planning, have a similar level of understanding that family planning is a government program that emphasizes no more than 2 children. However among respondents and FGD participants who are educated and have access to family planning information, most understand that family planning is a program that helps improve maternal health by spacing births and increasing a family's welfare.

The group with a low level of understanding of family planning issues, and believe it is a program only to limit the number of children one has, is generally not supportive of family planning programs implemented in Papua.

Related to condom use, almost all participants know of the condom for HIV prevention and in general participants do have good knowledge of HIV prevention.

Interview results with a number of community/cultural figures, religious figures and representatives from district offices, as well as FGD results with married males and females, unmarried males and females, and male and female adolescents indicate that community attitudes towards family planning is similar. From interview and FGD results it is evident that the community in Papua and West Papua can be categorized into the following groups; Those who support and participate in family planning programs, those who support but do not participate in family planning programs, those who do not support family planning programs due to geographical reasons, those who do not support family planning programs due to conflict with religious beliefs, those who do not support family planning programs due to conflict with traditions and cultural norms, and those with conflicting opinions.

Among the group who support and participate in family planning programs, most participants believe that such programs can help with increase maternal health levels by spacing births, increase the economic status of a family, and provide an opportunity for children to be educated. This opinion was common among married females and a number of religious figures, who are active participants in family planning and/or encourage their partners to be.

Those who support but do not participate in family planning programs are generally male and female adolescents, unmarried males and females, as well as a number of married males and females.

A lack of support for family planning programs is usually due to a number of reasons. For example, there are individuals who do not support family planning programs due to geographical reasons, including the belief that Papua is vast and needs human resources to manage their land many do not want to be a minority in their own land. Other reasons include not support family planning programs due to conflict with religious beliefs. Majority of Papuans and West Papuans are Protestant, and a number of them believe that there are a number of interpretations of family planning but within the church, family planning is regarded as “The family is responsible”. This means managing the number of children is the responsibility of one’s family. The belief that individuals are meant to reproduce should be complemented with the belief that these children are the responsibility of the family and if their welfare and future is not taken care of, families will sin. Meanwhile Islam religious leaders, a minority religion in Papua and West Papua, support the implementation of family planning programs.

A small number of respondents also believe that family planning should not be implemented in Papua as it may have a negative impact on the lives of women and families. This is related to the cultural norms that have developed within Papua. This opinion was common among unmarried males in Jayawijaya. A number of respondents believe that by adopting family planning methods, males and females are free to have multiple partners, as it may have a negative impact on the husband-wife relationship. Family planning can also lead to domestic violence. In Jayawijaya, results from group discussions with married males and females as well as unmarried males indicate much discussion on domestic violence. From a cultural perspective, lack of support for family planning programs is a result of the high number of children that families in Papua often desire. If a family does not have children, or do not have children of both sexes, husbands are allowed to leave their wives or remarry. In Jayawijaya, polygamy was found to be common if partners are not allowed to engage in sexual relations as they have young children. Therefore husbands often choose to remarry or have other partners.

Despite the lack of support for family planning programs as a result of the benefits of such programs, in-depth analysis of FGD results show that the need for family planning is still high within the community. Field data shows that married females are the ones who need family planning programs, however their needs are still unmet. This is due to the unavailability of services, the minimal provision of contraceptive supplies in the nearest health services, as well as the high costs associated with it. The high number of clients reverting to the use of traditional contraceptive methods supports this. Access to accurate information can also affect one’s decision to

use contraceptives.

The main complaint from the community on family planning services is the availability of contraceptives required. The availability of contraceptives has a direct impact on the costs associated with it. Almost all puskesmas facilities do not incur costs, however if there are contraceptives required by the client that are not available at the puskesmas, clients have to wait or obtain them from the pharmacy. Even though these contraceptives are provided by midwives, if they are not from the BKKBN/family planning offices, clients have to pay a fee for them.

Apart from the puskesmas, family planning services are also provided at the polindes and posyandu, and according to a number of respondents, they are also provided by individuals who provide the contraceptive injections.

Deciding to use a type of contraceptive as a method of spacing births or to limit the number of children one has, according to all married males and females, must be with consent from husbands. Agreement from a husband is required to avoid any misunderstanding between husband and wife, including the possibility that the wife will engage in sexual relations with other partners if they are on contraceptives. A number of married females stated that if they do not discuss this with their husbands, they will not understand why their wives are not getting pregnant again. In addition, husbands will believe that if their wives do not discuss family planning issues with them, they do not understand their wives' needs. A number of married male respondents also stated that even after discussing family planning with their wives, most of them often do no want to wait too long to have more children and they hope that these family planning methods are not long term.

A number of respondents also stated that if it is difficult to obtain consent from their husbands, they will adopt family planning practices without the husband's knowledge and methods adopted will be based according to those suggested by health personnel, usually for those wanting to receive the contraceptive injection.

In the traditional methods, involvement of the husband is also important because apart from abstinence and interrupting intercourse, a number of other methods also require the cooperation of the husband such as prayers and consuming mixtures between husband and wife.

From the above examples, it is evident that the role of the husband in helping decide involvement in and use of family planning methods is very important. A number of male respondents also hope that future socialization on family planning involves husbands to a higher extent.

Observation of family planning services was conducted in 14 puskesmas and 1 polindes. 1 puskesmas that a visit was planned for was not accessible due to renovations; however data from this puskesmas was obtained through interviews with the head of the puskesmas and the coordinator midwife who were available.

The study on the facilities and contraceptive supplies at the puskesmas refers to the instrument book "Independent Study on the quality of Services" Module I publishes by the Department of Health. This includes the availability of human resources trained in providing family planning services. Training for midwives and services providers includes family planning counseling, prevention of infections, as well training on implants, IUD and vasectomy.

Results from observations in 14 puskesmas and 1 polindes indicate that the puskesmas studied are divided into those with beds and those without beds. Family planning services in the puskesmas visited are provided by doctors in majority of facilities, midwives in all facilities, and in 4 facilities visited, services were also provided by nurses. From the 15 puskesmas where data was obtained, 8 of them did not have personnel trained in providing family planning services. The shortage of health personnel in the puskesmas results in limited services available, often only including the contraceptive injection and the pill.

Based on observation, not all puskesmas visited have complete basic equipment for family planning. Almost all

puskesmas facilities visited do not have family planning protocol, and family planning services are often combined with MCH services, with separate schedules. Due to the low number of clients in most of the puskesmas visited; an average of less than 10 every month; observation was only conducted in 5 puskesmas with 8 clients, including clients requesting for the contraceptive injection, the pill and the implant based on observation of family planning counseling services, it is evident that competence of health personnel is not yet optimal, particularly in puskesmas facilities where the midwives are not trained.

In terms of provision of contraceptives, puskesmas facilities usually receive supplies from family planning offices/ agencies at the district level. Almost all puskesmas have contraceptive supplies, mostly the injection and the pill. Only 1 puskesmas provided the IUD, and a number of others provided the implant and male condoms. Supplies are often stored in the family planning units, and although they are not stored in a special storage unit due to their limited supply, storage is usually safe and adequate. Family planning services in puskesmas facilities have not become a priority, and therefore according to a number of puskesmas heads visited, these facilities do not have a specific strategy to promote and increase family planning services, even though such services are free of charge. However if contraceptive supplies are not available and midwives provide them or buy them from the pharmacy, clients will be required to pay a fee, often between Rp. 15.000 – Rp. 150.000, depending on the type of contraceptives used.

In all puskesmas facilites, family planning services have been integrated with MCH services, therefore family planning services have been promoted along with MCH services, particularly for pregnant women or those with a high number of children.

In relation to the satisfaction of clients towards family planning services, observation results and those collected from FGD discussions show that in general, the community complain of a limited supply of contraceptives, as well as the high costs of services. There were no clients that were not satisfied with the attitudes of health staff. The limited number of trained health personnel and services available results in many clients deciding to stop the use of modern contraceptives and revert to traditional contraceptive methods, for example in cases where modern contraceptives lead to side effects.

Results of the observation at the puskesmas visited in 4 districts visited indicate that the mechanism for supervision at the district level and below is not structured. Supervision activities seem to be ad hoc and managed through notes and reports. Even when supervision is conducted through meetings and discussions, family planning issues are often not a priority for discussion. Supervision from the Dinas Kesehatan at the district level is usually conducted by staff from the sub offices for family health and nutrition (Sub-Kesga).

Community groups that have limited access to information and family planning services are referred to the marginalised groups here. They include communities who cannot afford services, communities in remote areas, unmarried individuals, and adolescents.

Family planning services for community groups who cannot afford as well as those in remote communities, according to officials at the Dinas Kesehatan, are provided through mobile puskesmas facilities, pustu, polindes and posyandu services that are available accross villages in Papua and West Papua.

Although FGD results show that premarital sex among adolescents and unmarried young adults in Papua and West Papua is high, there has not been any policies that ensure access to family planning services for sexually active adolescents. Most FGD participants and other interviewed agree that it is important that sexually active adolescents have access to family planning services, particularly condoms. Most do not agree that adolescents should have access to other contraceptives as it might lead to sterility. Access to condoms for adolescents and young adults in Papua and West Papua is relatively good, as they often recieve supplies from institutions that conduct HIV prevention prorams. Condoms are often recognised for HIV prevention by these group of individuals rather than a type of contraceptive.

MAIN RECOMMENDATIONS

1. To increase the quality of coordination between the BKKBN and/or family planning bodies and agencies, as well as the provincial and district Dinas Kesehatan, there should be a working group or quality management team to conduct routine coordination meetings.

2. Implementation of Government Regulation No 41 on family planning institutions need to be implemented immediately, and supported by an increase in the number of field staff based on the needs of the situation.

3. The quality and frequency of advocacy for family planning programs and policies should be increased. This should focus on the availability of budget allocation, particularly at the district level. Advocacy should also be tailored to the specific needs of the local situation in Papua.

4. Distribution of contraceptives should be done through more intensive cooperation between the BKKBN and Dinas Kesehatan at all levels, including storage of contraceptive supplies.

5. To increase community appreciation for family planning programs there should be IEC materials available as well as an effective information channel that focuses on the local needs in Papua.

6. Increasing the quality of family planning services in puskesmas facilities can be done by increasing the frequency of training on IUDs, implants and counseling for medical personnel.

7. Increasing the quality and frequency of information provided on ARH issues in school and outside school by involving religious, cultural and community leaders can be an alternative in addressing the issue of premarital sex among unmarried adolescents and young adults.

8. There should be a mechanism to ensure that all guidelines on family planning services and implementation of services are available at health services and consistently implemented.

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Chapter I

BACKGROUND OF THE ANALYSIS

In efforts to support provincial regulations in Papua and West Papua, as well as complement the Women and Child Health program in Papua (WCHPP) launched by UNICEF in 2006, UNFPA aims to develop a family planning services in these two provinces. To ensure that these programs are designed specifically to meet the needs of people in the region, UNFPA with the support of UNICEF, conducted a situation analysis of family planning services in Papua and West Papua in August-September 2008.

Results of the analysis will be used by UNFPA as a basis for developing a cooperative with the local government of the two provinces, UNICEF and other stakeholders in developing a family planning program appropriate to the needs of the local situation.

The analysis was designed in three phases, namely:
1. A desk review of family planning secondary data in the two provinces.
2. A comprehensive study based on gathering qualitative and quantitative data on family planning in four selected districts/puskesmas and villages in the two provinces.
3. A presentation, discussion and dissemination of findings and recommendations to stakeholders from the government, donors and other related institutions in Papua and West Papua.

This study was conducted by a national Consultant, Yenni Siswantini, with technical support from an international Consultant from UNFPA Bangkok, Dr. Josephine Sauvarin. The field study also involved various parties including UNFPA Indonesia staff; head of the family planning program of the National Family Planning Board (BKKBN) and the Health Department; representatives from local health offices (Dinas Kesehatan) and the National Family Planning Board in the two provinces (Papua and West Papua) and four districts; along with local individuals that were specially recruited for this study.

1.1. Objectives of the analysis

The main objectives of the analysis were:
1. To document and analyze the present situation of family planning programs.
2. To identify opportunities and challenges in promoting and adopting family planning methods in supporting reproductive health.
3. To identify family planning services based on the needs of the local situation.

1.2. Methodology

1. DESK STUDY

Secondary data was collected from related reports at the provincial and district level, from the local health offices and BKKBN; meanwhile data on the population and its distribution was taken from the Central Bureau of Statistics (BPS). An analysis of other data related to family planning from the SDKI 2007 Preliminary Report was also analyzed.

2. FIELD STUDY

This study was conducted during a 3 month period, from July to September 2008, and gathering of field data was conducted in August-September 2008. The field study was conducted in 2 provinces, Papua and West Papua,

and in 4 selected districts, Jayapura, Jayawijaya, Manokwari and Sorong. The study utilized a qualitative and quantitative approach through interviews with key stakeholders from relevant bodies at the central, provincial and district levels. The study was completed with focus group discussions with a number of community groups. At the puskesmas level, apart from conducting interviews with the Head of the Puskesmas, observations of counseling and family planning services were also done, along with an audit of family planning services and facilities, and an observation of the availability of contraceptive supplies.

Study Location

Determining the study location was done in stages (multistage purposive sampling), where the first stage involved selecting districts where UNICEF operates, namely Jayapura and Jayawijaya in Papua, and Sorong and Manokwari in West Papua. The second stage involved district[1] selection through stratified purposive sampling where the stratum was divided into areas where UNICEF operates, and areas where UNICEF does not operate. Based on this criterion, 4 districts were selected including 2 districts where UNICEF operates, and 2 districts where UNICEF does not operate. For districts where UNICEF does not operate, those that were geographically relatively further away from the capital were selected in order to obtain an idea of the situation in areas with less access to services and information, as compared to areas with better access, where UNICEF does operate. The number of puskesmas was limited to those at the district level. Results of the selection of study location are depicted in Table 1.

Table 1 :
Study location in Papua and West Papua

PROVINCE	DISTRICT	SUB-DISTRICT	PUSKESMAS	NOTE
PAPUA	Jayapura	Depapre	Depapre	UNICEF operates
		Kemtuk Gresi	Sawoy	
		Kurulu	Kurulu	
		Bolakme	Bolakme	
	Jayawijaya	Asologaima	Asologaima	UNICEF operates
		Walelegama	Walelegama	
		South Manokwari	Sanggeng	
		West Manokwari	Side	
WEST PAPUA	Manokwari	Ransiki	Ransiki	UNICEF operates
		West Manokwari	Side	
		Ransiki	Ransiki	
		Maripi	Maripi	
	Sorong	Aimas	Aimas	UNICEF operates
		Klamono	Klamono	
		Salawati	-	
		Makbon	Makbon	

Process for gathering data and selecting respondents

Gathering secondary data in Papua and West Papua was complemented by in-depth interviews with the head of the provincial National Family Planning Board (BKKBN) and/or the head of the agencies responsible for the family planning program at the district level; along with the head of the Health Department (Dinas Kesehatan) or those representing them at the provincial and district level. Interviews with individuals responsible for storage of contraceptives and other equipment were conducted at the province and district level.

Instruments used for the interviews and focus group discussions include interview guidelines and results of the

[1] Sub District level

interviews were recorded electronically.

Selection of respondents for the in-depth interviews was done through purposive sampling taking into consideration their knowledge on various related programs, policies and regulations, the socio-cultural situation, and the local economy related to family planning programs at the provincial and district level, as well as the villages. Based on these criteria, the following respondents were selected:

- **Provincial level :** Head of the National Family Planning Board (BKKBN), Head of the Health Department (Dinas Kesehatan), Head of the storage unit at BKKBN.
- **District level :** Head of the National Family Planning Board (BKKBN), Head of the Health Department (Dinas Kesehatan), Head of the storage unit at BKKBN.
- **Sub-district level :** Head of the District/lead officials within the district, head of the community health centers (Puskesmas), health officials/midwives in charge of providing family planning services.
- **Villages :** Head of the village, traditional and religious figures around the districts.

Focus Group Discussions (FGD) were conducted with community groups that were disaggregated based on age, marital status, and gender. Based on these criteria, groups selected included married females, married males, single females, single males, those between the ages of 20 and 30 years; adolescent females and adolescent males, those between the ages of 14 to 19 years. Each focus group consisted of between 4 to 8 participants.

To support the information obtained from the interviews, an observation of family planning services was conducted at the Puskesmas[2]. Locations and associated focus groups are depicted in Table 2.

Table 2 :
Distribution of focus groups and names of community health centers (Puskesmas) based on district sample.

Province/ District/ Sub-district	Puskesmas	FGD groups	Note
PAPUA			
Jayapura			
- Depapre	Depapre	- Female adolescents - Married males	UNICEF operates
- Kemtuk Gresi	Sawoy	- Married females - Unmarried males	
- Unurumguay	Unurumguay	- Married females - Female adolescents	
- Demta	Demta	- Male adolescents - Female adolescents	
Jayawijaya			
- Kurulu	Kurulu	- Married males - Female adolescents	UNICEF operates
- Bolakme	Bolakme	- Unmarried females - Male adolescents	
- Walelagama	Walelagama	- Married females - Unmarried males	
- Asologaima	Asologaima	- Married females - Unmarried males	
Manokwari			
- Manokwari Barat	Sanggeng	- Married females - Married males	
- Manokwari Selatan	Maripi	- Married males - Female adolescents	
- Rasinki	Ransiki	- Male adolescents - Unmarried males	
- Sidey	Sidey	- Male adolescents - Unmarried females	

[2] Referring to the book of instruments "Independent Study on quality of services" Module I published by the Department of Health

Provinsi / Kabupaten/ Distrik	Puskesmas	Kelompok FGD	Keterangan
Sorong			
- Aimas	Aimas	- Married females - Unmarried males	UNICEF operates
- Klamono	Klamono	- Unmarried females - Married males	
- Makbon	Makbon	- Unmarried females - Married makes	
- Salawati	Klafdalim	- Unmarried males	

Scope of the analysis

Family planning, according to the Law No.10/1992, includes attitudes and role ofthe community in increasing the age for marriage, planning births, maintaining family planning and increasing the welfare of the family. To achieve effective planning of births withing a family, sufficient family planning services are required. The analysis conducted in 4 districts mentiones above focuses on family plannign services. The scope of family planning services includes management, implementation, distribution of family planning information as well as a number of other factors directly and/or indirectly related to family planning services.

Instruments used

During the interviews, a number of instruments were prepared for the respondent groups. Instruments comprised of key questions that could be developed into other relevant questions based on data collection needs. To ease data collection, each instrument was given a code. The complete list of instruments used is listed in Table 3 below.

Table 3 :
Instruments used

KODE INSTRUMEN	RESPONDEN
Q-FP 001	Used to gather secondary data at the provincial, district, and subdistrict levels, and the puskesmas
Q-FP 002	Used to gather secondary data from storage unite at the BKKBN/Family Planning health departments in provinces and districts
Q-FP 003	Used for structured interviews with Heads or staff at the BKKBN and Dinas Kesehatan at the provincial and district level
Q-FP 004	Used for structured interviews with the district heads, village heads/community figures, and religious figures
Q-FP 005	Guidelines for FGD
Q-FP 006	Used for structured interviews with the head of the Puskesmas
Q-FP 007-008	Guidelines for facility auditing and observation of family planninf counselling services at the Puskesmas
Q-FP 009	Used for interviews with PLKB and/or PPKBD

More in-depth information on the respondents involved in this study is covered in a separate section of this report.

Results from data collection were analyzed through both a quantitative and qualitative approach. Quantitative data that originated from secondary data was presented in tables and/or graphs completed with relevant descriptive analyses.

Results of interviews were analyzed using a qualitative approach, starting with grouping data based on study questions, followed by notes and interpretations presented in a narrative form. In presenting the report, quotes on various opinions that support a specific narrative statement were included from a number of sources. In order to ensure confidentiality of respondents' identities, names of respondents whose opinions and statements were used as quotes were not revealed.

1.2.1 Limitations of the analysis

Family planning programs cover a variety of methods and issues, and therefore in order to obtain a complete indication of the family planning situation in Papua, this analysis that only focuses on the services in those study locations mentioned should be followed up with a more comprehensive analysis of family planning programs.

An accurate indication of family planning services in the 16 districts was not obtained as only 14 puskesmas and 1 polindes in the 16 locations were visited. Respondents for the discussion groups were not adequately represented, including unmarried females in Jayapura and adolescent males and females in Sorong.

Observation of family planning services could not be done throughout the different community health centers visited because of the limited number of patients and family planning clients attended to at the time.

Photo: UN agencies mission - 2008

Photo: Ms. Ansye Sopacua - 2008

Chapter II

OVERVIEW OF PAPUA AND WEST PAPUA

2.1 Demographics

Following the enactment of Law 21/2001[3] and Bylaw 1/2008[4], the province of Papua was divided into Papua and West Papua, obtaining special autonomy[5] as two separate provinces, different from other provinces. The MRP (Papua People's Council) was formed to implement this special autonomy. The Council is a cultural representation of the people of Papua that has the authority to protect the rights of the indigenous people of Papua based on respect for their tradition and culture, women's empowerment and ensuring a life filled with harmony.

The province of Papua covers an area of 309,934.40 square km[6] divided into 19 districts and one municipality, namely the districts of Jayapura, Keerom, Sarmi, Jayawijaya, Tolikara, Yakuhimo, Peg. Bintang, Merauke, Mappi, Asmat, Boven Digoel, Biak, Supiori, Nabire, Paniai, Puncak Jaya, Mimika, Yapen Waropen and Waropen, and the municipality of Jayapura. In 2007, according to the BPS (Bureau of Statistics) the population of Papua was 2,015,616[7]. This data is not aggregated by sex.

According to the BPS, West Papua extends over an area of square 251,037 km[8], comprising of 8 districts and one municipality, namely the districts of Fak-fak, Kaimana, Teluk Wondama, Teluk Bintuni, Manokwari, Sorong Selatan, Sorong, Raja Ampat, and the municipality of Sorong. Based on recent data from the West Papua Bureau of Statistics, West Papua's population in 2006 was 688,250, with approximately 356.187 males and 332.063 females. Population data disaggregated by age based on BPS projections in districts selected for the study are depicted in Table 4.

Table 4 :

Population disaggregated by age and sex in 4 study locations[9].

Age group	Jayapura		Jayawijaya		Manokwari		Sorong	
	Males	Females	Males	Females	Males	Females	Males	Females
0-4	5,571	4,961	12,177	11,207	8,062	9,508	6,872	6,333
05-09	8,450	6,245	11,746	10,700	14,741	10,497	5,663	5,838
09-14	7,380	8,368	11,869	10,995	9,736	10,110	4,838	5,503
15-19	8,024	6,545	11,233	10,356	9,846	7,234	3,842	3,945
20-24	5,067	5,626	10,654	9,724	5,873	7,660	4,094	2,826
25-29	5,366	3,804	9,658	8,949	7,356	10,114	4,113	3,146
30-34	3,477	4,310	9,277	8,467	8,537	7,005	3,395	3,395
35-39	4,453	4,723	8,457	7,824	6,642	6,826	3,052	2,470
45-49	3,949	2 ,472	6,967	6,674	2,612	3,226	1,905	990

[3] Law No 21/2001 on Special autonomy for Papua province
[4] Bylaw No 1/2008 on amendment in Law No 21/2001 on Special autonomy for Papua province
[5] Wikipedia Indonesia
[6] Data obtained from Government of Papua website
[7] Data obtained from Papua Statistics Bureau website
[8] Electronic document from West Papua in 2007 and government of West Papua website
[9] Source: Jayapura, Sorong, Jayawijaya and Manokwari, in Statistics Bureau 2006-2007

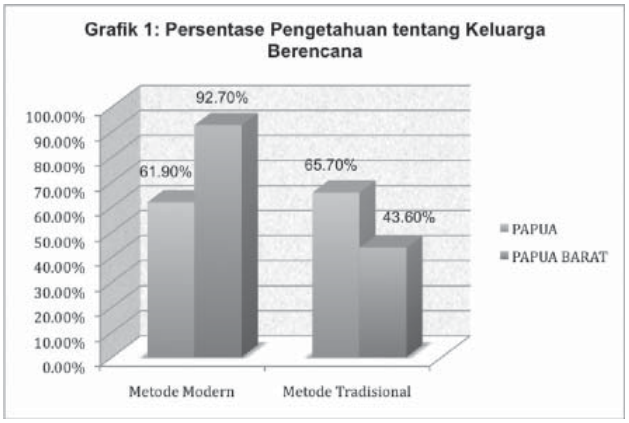
Age group	Jayapura		Jayawijaya		Manokwari		Sorong	
	Males	Females	Males	Females	Males	Females	Males	Females
50-54	1,306	1,569	5,870	5,685	2,823	1,925	1,194	760
60-64	472	238	3,493	3,533	1,653	276	420	336
65+	na	127	3,577	3,655	768	764	401	401
Total	58,976	53,393	117,561	109,913	85,850	80,472	43.204	37,905

The above table indicates that individuals in the 15-49 age group represent the largest group in the 4 selected study districts, 50-57% with a 100.9:123.9 male to female ratio. This shows that in the 4 study locations, the need and opportunity for the development of a reproductive health program including family planning one is relatively high. This means that the possibility of young marriages and giving birth at a relatively young age is a high.

2.2. Overview of family planning situation in Papua and West Papua

To obtain a glimpse of the family planning situation in Papua and West Papua at present, this section will provide an explanation of the analysis of secondary data from the Indonesian Demographic and Health Survey (SDKI) 2007 preliminary report and other relevant sources.

According to the SDKI 2007, asking respondents about their knowledge on childbirth and contraception is an important step in gaining an indication of access to services and use of contraceptives. Data from the SDKI 2007 indicates that in general knowledge on family planning among married females in Papua and West Papua is relatively good. Graph 1[10] shows the level of knowledge on contraception among married females aged 15-49 in Papua and West Papua. The level of knowledge on family planning among married females is grouped into 2 categories, knowledge on modern contraceptive methods, and knowledge on traditional contraceptive methods. Respondents in West Papua have an average knowledge level of 92.7%, similar to that of the national level of 98.3% and higher than that of respondents in Papua (61.9%). Graph 1 indicates a significant difference between Papua and West Papua. Knowledge in one group for modern contraceptive methods is 30.8% higher in West Papua; meanwhile knowledge on traditional contraceptive methods is 22.1% higher in Papua.

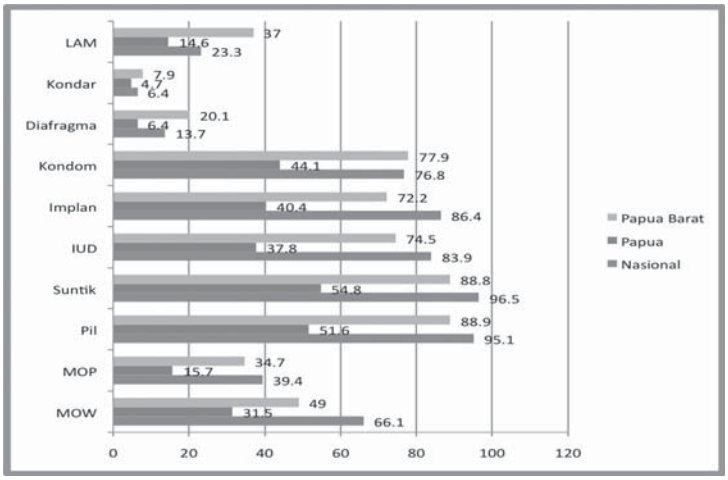


Knowledge on contraceptive methods in Papua and West Papua based on the SDKI 2007 is depicted on Table 7. The table shows that the percentage of married women who have knowledge on 10 modern contraceptive methods in Papua is lower than West Papua. In West Papua 92.7% of respondents have knowledge on at least one modern contraceptive method, as compared to 61.9% in Papua. The most well known contraceptive method in Papua is the contraceptive injection, known among 54.8% of respondents, whereas the most commonly known contraceptive method in West Papua is the pill, known among 88.9% of respondents. At the national level, the contraceptive injection is the most popular contraceptive method (known among 96.5% of people), followed by the pill (95.1%) and the implant (86.4%). A contraceptive method not popular among respondents in the two provinces is the emergency contraception, known only among 4.7% of respondents in Papua and 7.9% in West Papua. Similarly at the national level, knowledge on emergency contraception is only known among 6.4% of respondents.

[10] Collected from SDKI 2007 Preliminary Report

Graph 2;

Percentage of knowledge on modern contraceptives among married women aged 15-40 years in Papua and West Papua

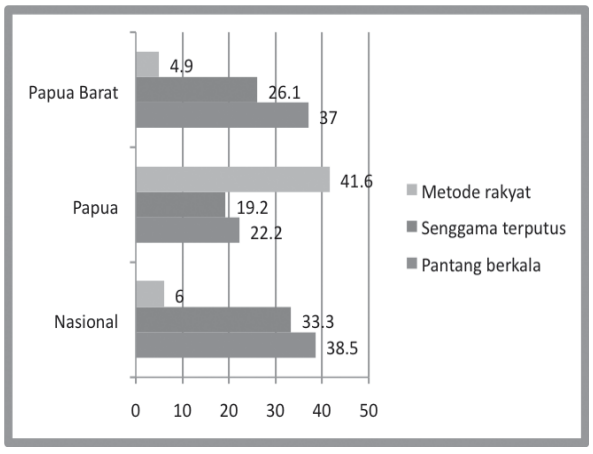


Source: SDKI 2007 Preliminary Report

SDKI data also indicates a difference in knowledge on traditional contraceptive methods in the two provinces. In Papua the folk method is well known among a higher number of respondents (41.6%), meanwhile in West Papua the more popular method among respondents is abstinence, known among 37.5% of respondents. This indicates that traditional contraceptive methods in Papua are relatively popular compared to West Papua.

Graph 3;

Percentage of knowledge on traditional contraceptives among married women aged 15-40 years in Papua and West Papua

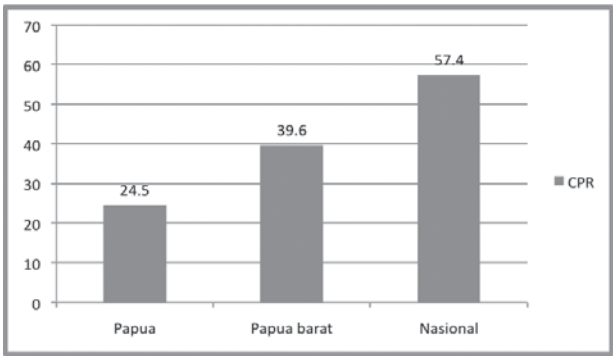


Source: SDKI 2007 Preliminary Report

The high level of knowledge among married females indicated in the data above does not translate to a high use of contraceptives in young couples in the two provinces. According to the SDKI 2007 report, the Contraceptive Prevalence Rate, or CPR, in Papua and West Papua is as indicated in Graph 4 below. From the graph it is evident that modern contraceptive methods are used by 24.5% of married females aged 15-49 years in Papua, and 37.5% of married females in West Papua. The CPR in these two provinces is very low, as compared to the national level rate of 57.4%, according to SDKI estimates.

Graph 4;

Coverage of modern family planning programs (%) in Papua and West Papua



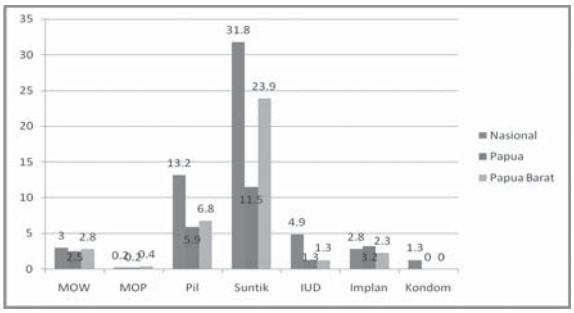
Source: SDKI 2007 Preliminary Report

SDKI 2007 figures also indicate a relatively high use of traditional contraceptive methods in Papua, among 13.8% of married female respondents aged 15-49. This is the highest percentage as compared to other provinces, and much higher than the national average of 4%; meanwhile only 2.1% of the same group of respondents in West Papua use traditional contraceptive methods. This data indirectly shows that there are a high number of married females in Papua who, for a number of possible reasons, do not yet have access to family planning services.

To get a better indication of the type of contraceptive method used by married females aged 15-49 in the two provinces, Graph 3 presents data from the SDKI 2007 Preliminary report.

Graph 5;

Coverage of modern family planning methods based on type of contraceptive



Source: SDKI 2007 Preliminary Report

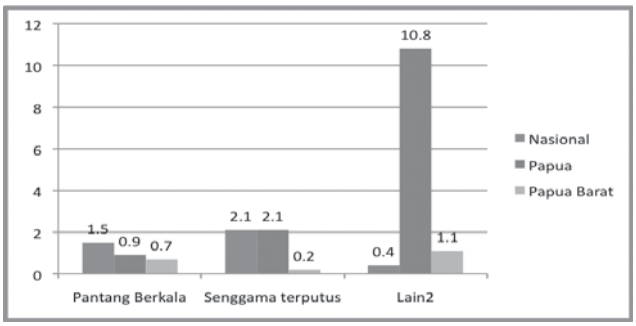
The above graph shows that the most popular contraceptive method among married females aged 15-49 in Papua and West Papua in the contraceptive injection, the pill, and the implant; 11.5% contraceptive injection, 5.9% pill, and 3.2% implant for Papua, and 23.9% contraceptive injection, 6.8% pill, and 2.3% implant for West Papua. The data also shows that contraceptive methods used by respondents are short term methods, and their long-term use is not guaranteed. The contraceptive injection usually takes between 1-3 months and its use greatly depends on the availability of health personnel, whereas the pill needs to be taken everyday, often leading to less frequent usage and high costs, resulting in a high possibility of discontinuation. Use of long-term contraceptive methods is still low, where female sterilization in Papua and West Papua is only 2.5% and 2.8% respectively among married females, lower than the national level of 3%. Use of the IUD is as low as 1.3% in the two provinces, much lower than the national average of 4.9%.

The graph also shows a low level of male participation in family planning and mother and child health, including prevention of maternal deaths. Indicators for low male participation is shown among others through data on male sterilization, practiced only by 0.2% of males in Papua and 0.4% in West Papua, and 0% condom use in the two provinces. Use of modern contraceptive methods in the two provinces is still very low as compared to the national average.

Meanwhile for traditional contraceptive methods that are divided into 3 categories in each province, SDKI 2007 data shows that use of the folk method in Papua is as high as 10.8%, much higher than the national level of 0.4%. This is the highest rate as compared to other provinces in Indonesia. The use of traditional contraceptive methods in the two provinces is shown Graph 4 below.

Graph 6;

Coverage of traditional family planning based on method



Source: SDKI 2007 Preliminary Report

Even traditionally, male participation in family planning is not very high. The method of interrupting intercourse is practiced by 2.1% of people in Papua, similar to the national average. However, it is as low as 0.2% in West Papua. Meanwhile abstinence is practiced by 0.9% of people in Papua and 0.7% in West Papua, supporting the statement that male participation in family planning is still low.

The SDKI 2007 Preliminary data also shows that the percentage of married females aged 15-49 who are not using contraceptives at present is still as high as 61.7% in Papua and 60.4% in West Papua, a relatively high level as compared to the national average of only 38.6%.

The SDKI 2007 Preliminary report also shows that more married females living in cities use contraceptive methods and are more likely to use long-term contraceptive methods. According to population census data (Supas) from 2005, the percentage of females living in cities in Papua[11] is 47.7%. According to the SDKI 2007 Preliminary report, the use of contraceptives increases according to level of education (40.1% among married females who have not been educated, and 61.4% among married females who have completed further education).

In the 4 study districts, family planning coverage based on type of modern contraceptives used is similar to that of the two provinces. Table 7 below shows the family planning coverage in each district. The contraceptive injection is the most method popular among young couples in 4 districts. The use of the contraceptive injection and the pill in Jayapura is much higher than in Papua, 24.0% and 7.1% respectively; meanwhile in Jayawijaya, use of all contraceptives is lower than the average rate in Papua.

The use of the pill, IUD, and implant in Sorong is above the average rate of West Papua. In Manokwari only the use of the implant (2.4%) is higher than that in West Papua, whereas the use of other contraceptives is lower.

[11] This data includes 2 provinces where in 2005 the 2 provinces were still one

Table 5[12] **:**

Contraceptive Prevalence Rate (CPR) (%) by contraceptive method in 4 provinces

Contraceptives	Jayapura	Jayawijaya	Sorong	Manokwari
PILL	7.1	0.89	14.5	6.7
IUD	0.9	0.01	2.0	0.2
INJECTION	29.0	1.41	14.3	21.6
CONDOM	0.4	0.06	0.0	2.3
IMPLANT	3.0	0.06	7.0	2.4
OTHERS[13]	0.6	0.01	2.6	0.4

Family planning coverage based on contraceptive method used in a few study locations at the sub district level is higher than that at the district level, with the most popular contraceptive method being the injection and the pill. Family planning coverage based on contraceptive method used at the sub district level is outlined in detail below.

Table 6[14] **:**

Active Family Planning coverage in subdistrict study areas

Sub-district	IUD	Pill	Injection	Condom	Implant	Others
DEPRAPRE	-	4.06	16.14	0.23	-	1.24
DEMTA	-	0.82	2.56	-	1.84	-
UNURUMGUAY	-	-	10.73	-	-	-
KEMTUK GRESI	-	2.72	5.77	0.33	0.54	-
ASOLOGAIMA	-	0.18	0.21	-	-	-
WALELAGAMA	-	1.09	4.35	1.63	-	-
AIMAS	2.20	17.11	15.44	0.00	7.56	2.59
SALAWATI	2.72	16.38	18.52	0.00	12.53	3.31
KLAMONO	3.26	18.91	19.78	0.00	4.57	3.70
MAKBON	1.59	9.52	6.35	0.00	1.06	3.70
RANSIKI	0.35	4.58	22.80	0.97	2.99	0.70
WEST MANOKWARI	0.41	4.94	18.01	0.34	2.18	0.32
SIDEY	0.40	12.35	24.16	0.54	10.34	0.67
SOUTH MANOKWARI	0.16	3.46	0.24	-	2.09	0.24

From the table above it is evident that use of the contraceptive injection in Sidey (24.16%) is the highest among the sub districts and higher than the district level. The use of the pill is the highest in Klamono (18.91%), which is higher than Sorong (14.5%). In Jayawijaya the use of the contraceptive injection is highest in Walelagama (4.35%), which is higher than at the district level (1.41%).

According to the SDKI 2007 Preliminary report, the level of unmet family planning needs nationally is similar to that of results of the SDKI 2003, which is 9.1%. At the provincial in Papua and West Papua, unmet needs, or family planning needs that have not been met, is indicated in graph 7 below.

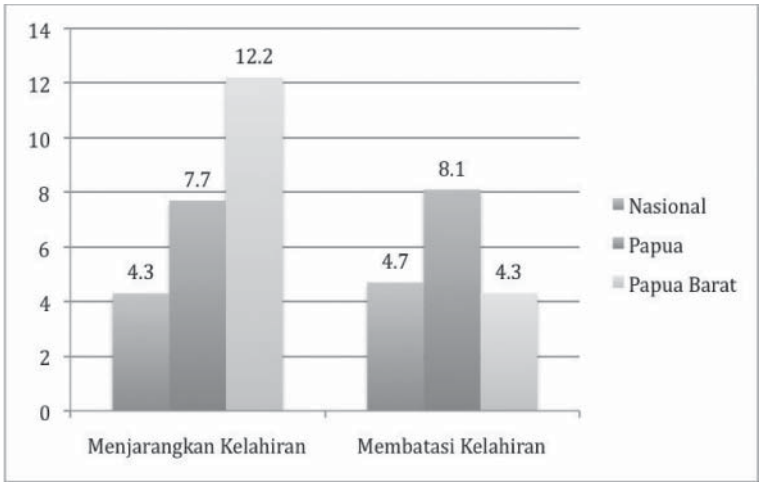
[12] Source: BPS Secondary data from 4 districts and family planning offices in 2007

[13] Includes among others male and female sterlisation

[14] Source: Statistics Bureau data from districts, official demographics, community health centres

Graph 7 :

Unmet family planning needs



Source: SDKI 2007 Preliminary Report

The graph shows that family planning needs to prevent frequency of births in Papua and West Papua is still high as compared to the national average, whereas needs for preventing future births is West Papua is lower than the national average. The SDKI 2007 Preliminary Report also states that the total family planning needs in Papua and West Papua is still high; 56.2 and 54.1 respectively. Based on that data in the 2 provinces, the opportunity for the development of family planning services is high. In the SDKI Preliminary report it states that 8 out of 10 married women delay further childbirth, or do not have more children, indicating a high need for family planning services among married women. In addition, the CPR in Papua and West Papua is 24.5% and 37.5% respectively, supporting the fact that there are still a high number of married women who require family planning services, but for a number of possible reasons, these needs are still unmet.

The Total Fertility Rate (TFR) or the average number of children born to a woman up to the end of her reproductive phase, assuming she follows the existing fertility pattern, was 2.6[15] nationally for the 3rd quarter of the previous year before the SDKI 2007. Meanwhile the Crude Birth Rate (CBR) according to the SDKI for the same period was 20.7 at the national level. Data from the SDKI 2007 Preliminary report also indicates that females who live in cities have a lower fertility level, and 0.5 children less than females who live in rural areas. The TFR in Papua and West Papua for the 3rd quarter previous to the survey was 2.9 for Papua and 3.4 for West Papua. This is higher than the national figure; whereas the average number of children born to women aged 45-49 is 4.3 in Papua and 3.8 in West Papua. This indicates that the average number of children born in Papua and West Papua is 3-4, a relatively high number.

Data obtained from Manokwari shows that 22.9% of married females delay childbirth, and 16.6% do not want any more children[16]. This indicates the need for family planning services in Manokwari. Such needs are likely in other districts, however keeping in mind that because recording of data on family planning services is not yet optimal, data on such needs have not been effectively recorded. Even so, by referring to unmet needs, we are able to conclude that communities' needs for family planning services have not been met.

In relation to the reproductive health situation, Papua and West Papua are also facing a serious problem in dealing with HIV and AIDS. According to data from the National AIDS Commission (KPA Nasional), the cumulative Case Rate of HIV and AIDS is highest in Papua, 15.1 times higher than the national level, whereas in West Papua it is 2.2 times higher than the national figure. Until March 2007, as reported by the Directorate of Disease Control and Environmental Health (PP & PL), the cumulative AIDS cases in Papua per 100,000 was 1.122 cases, 227 among them resulting in death. The Case Rate reached 60.93 higher than the national Case Rate of 3.96. Based on surveillance results from June 2008, according to the Dinas Kesehatan in Papua, HIV and AIDS cases in Papua have reached 4,114. Keeping in mind the high cases of HIV and AIDS in Papua, it will not be surprising if the local government makes HIV and AIDS prevention one of the key priorities in their health development strategy. Meanwhile in West Papua, cases of HIV and AIDS have reached 690, according to the West Papua Dinas Kesehatan.

[15] From the SDKI 2007 Preliminary Report, and based on the data, it does not include Papua and West Papua

[16] From the Department of Demographics and family planning in Manokwari, reported to the district Bureau of Statistics

The SDKI Preliminary report shows that 56.4% of married females and 66.0% of married males in Papua have heard of AIDS, whereas the figure for West Papua is 60.0% among married females and 89.3% among married males. This data shows that married males have a better knowledge of HIV and AIDS as compared to females. The level of knowledge on ways to reduce the risk of HIV transmission among males and females is shown below.

Table 7[17] **:**
Percentage of knowledge on ways to reduce risk of HIV transmission among married males and females

Methods of prevention	PAPUA		WEST PAPUA	
	Females	Males	Females	Males
Using condoms	32,7	41,0	31,6	71,1
Not having multiple partners	31,0	37,8	35,5	58,0
Using condoms andnot having multiple partners	23,3	26,3	23,9	49,9
Abstinence	31,8	39,5	32,4	51,1

[17] From the SDKI 2007 Preliminary Report

Photo: UN agencies mission - 2008

Chapter III

RESPONDENTS' PROFILE

As mentioned in Chapter 1, respondents for this study include a wide range of individuals, from the provincial level as well as village communities. Profiles of each respondent are heterogeneous according to gender, ethnic background, religion, and occupation.

Table 8:
Respondent data at the provincial study locations

Respondent Category	Males	Females	Total
Provincial BKKBN	5	1	6
District BKKBN	10	2	12
Provincial Dinas Kesehatan	1	0	1
District Dinas Kesehatan	2	3	5
District Heads	13	1	14
Puskesmas	5	10	15
PLKB	1	2	3
Community figures	13	0	13
Religious figures	16	1	17
PPKBD	0	2	2
Communities	89	95	184
Total	**158**	**118**	**272**

Data from the respondents are divided into 2 categories; individual interviews and group discussions. Characteristics of each respondent group in the 2 provinces and the 4 study locations are depicted below.

Table 9:
Characteristics of Government official respondents

Result	Papua	West Papua	Jayapura	Jayawijaya	Manokwari	Sorong	Total
1. BKKBN	3	2	3	1	2	3	14
- Males			1		1		2
- Females							
- Average year worked	5	> 5	5	2-5	> 5		
2. Dinas Kesehatan							
- Males	1				1	1	3
- Females			1	1	1		3
- Average year worked			> 5			5	
3. Kepala Distrik							
- Males			3	3	4	3	13
- Females			1				
- Average year worked			1-3	1-4	1-5	1-5	

Result	Papua	West Papua	Jayapura	Jayawijaya	Manokwari	Sorong	Total
4. Kepala Puskesmas							
- Males			1	3	1		5
- Females			3	1	3	3	10
- Average year worked			1-3	1-2	1-5	1-5	
5. PLKB/PPLKB							
- Males					1		1
- Females					2		2
- Average year worked					> 5		

Respondents from the National Family Planning Board (BKKBN) at the provincial level include: Head of the BKKBN in Papua and West Papua, and staff responsible at the storage unit. At the district level respondents include Head of the Demographics and family planning office, Kasubdin KB, Ka-sie and staff responsible at the storage unit. All officials involved in family planning institutions interviewed were from the BKKBN before the institutional change.

Respondents from the Health Department (Dinas Kesehatan) at the provincial level in Papua and West Papua were not available for an interview due to their tight schedules. At the district level, respondents included Head of the Health Department and Ka-subdin Kesga. Interviews at the district level were conducted with the Head of the district and district Secretary.

Interviews were also held with the Head of the community health centers (Puskesmas) and the Coordinators in charge in of family planning programs and/or midwives in charge of providing family planning services in the Puskesmas. Interviews with midwives also completed results of the observation of family planning services in these health centers.
The above table also shows that the average length of time that program officials had worked was relatively low. At the district level particularly, their background and experience with family planning programs significantly affected family planning coverage at that district. The length of time worked influenced individuals perceptions on family planning programs, thereby affecting the strategic plan and policies related to family planning services.

Table 10:
Characteritics of community figure respondents

Result	JAYAPURA	JAYAWIJAYA	MANOKWARI	SORONG	TOTAL
Community figures					
Males	5	2	3	3	**13**
Females					
Average years worked			> 5	3-5	
Religious figures					
Males	4	4	5	3	**16**
Females				1	**1**
Average years worked	> 5		1-5	> 5	
PPKBD					
Males	1			1	**2**
Females					
Average years worked	16			16	

Community figures interviewed include village heads and cultural figures. Out of 12 districts visited, interviews with village heads and cultural figures were conducted in only 9 districts. In Demta, 2 village heads were interviewed.

Religious figures who were Protestant included a priest and a member of the church, those who were Catholic included the head of the churches, and those that were Islam included the mosque imam.

Respondents from PLKB/PKB and PPKB represented additional respondents and were not the primary target, because the number of PPLKB/PKB and PPKBD was very limited.

Table 11:
Characteristics of FGD respondents

Result	Jayapura	Jayawijaya	Manokwari	Sorong	Total
FGD					
Married males	7	7	9	8	**31**
Married females	12	13	11	6	**42**
Unmarried males	6	8	6	17	**37**
Unmarried females	6	4	2	14	**26**
Adolescent males	8		13		**21**
Adolescent females	6	6	8	7	**27**
Age group					
14 – 19	14	10	16	12	**52**
20 – 24	12	13	7	16	**48**
25 – 30	6	14		5	**25**
31 – 35	2	1		1	**4**
36 – 40	2	3		3	**8**
41 – 45	7	1	1		**9**
46 – 50					
51 – 55	1				**1**
56 +					
Education					
Never schooled		6			**6**
Did not pass primary school		12		1	**13**
Passed primary school	3	2			**5**
High school	9	12	9	14	**44**
Further education	29	12	9	27	**77**
Religion					
Islam	1				**1**
Protestant	30	19	20	18	**87**
Catholic		25	3		**28**

Most respondents from the FGDs received information on reproductive health from areas where UNICEF operates.

Photo: Ms. Ansye Sopacua - 2008

Chapter IV

ORGANIZATION OF FAMILY PLANNING SERVICES IN PAPUA AND WEST PAPUA

4.1. Policies on Family Planning

At the national level, policies on family planning were organized by referring to laws and government regulations related to population and demographics as well as laws and regulations related to the relevant local government. The policies were then inserted into the National Strategic Plan for Family Planning Programs aimed at reaffirming the foundation of programs and family planning institutions that are strong and continuous with the availability of adequate staff support, sufficient funds, and good infrastructure from the district/city government. This is stated in the National Strategic Plan for Family Planning Program documents compiled for the period 2005-2009.

Meanwhile, in efforts to support the implementation of services for family planning programs at the district/city level, the Department of Health has compiled the National Strategic Plan for Family Planning Services Program. This National Strategic Plan was compiled as an effort to strengthen the management of the Family Planning Services Program in the health sector at the provincial and district/city level, particularly for family planning services through government and private health facilities. The objective of this National Strategic Plan for Family Planning Services Program is to increase the access and availability of good quality family planning services to support community efforts in ensuring an independent and healthy living to reduce the number of maternal deaths and Total Fertility Rate (TFR).

At the provincial level, the BKKBN National Strategic Plan is compiled based on targets that need to be achieved. As mentioned by an official in charge of the family planning program in one of the provinces visited, every BKKBN office possesses a work plan contract with the central BKKBN to achieve certain targets. Success is indicated by 4 variables: 1) Family Planning that covers new targets for women and men, private services, complications and failures; 2) Adolescent Reproductive Health (ARH) including an information centre for ARH; 3) Family empowerment; and 4) Institutionalization.

Referring to the above indicators, the province of Papua decided to focus the development of its family planning program on districts with a high number of couples of reproductive age and on poorer areas of the city, as well as on married females who want to have 2 children. Meanwhile the province of West Papua is focusing more on strengthening institutions because, as stated by the head of the local provincial BKKBN, one of the impacts of decentralization on family planning programs is the heterogeneity of family planning institutions at the district/city level, impacting on the heterogeneity of the development of family planning programs.

Decentralization and reformation that begin in 1999 has had quite a significant impact on family planning programs in a number of aspects: institutionalization and coordination; strategy and program compilation; staff and personnel structure; monitoring and reporting systems; and implications on budgeting. From observations and gathering data on the field, the changes can be summarized as follows:

Table 12:
Impact of decentralisation on Family Planning programs in Papua

Aspect	Pre-Decentralisation	Desentralisation
Institutionalization	BKKBN offices exist even at the district level accross Indonesia.	BKKBN offices exist only at the central level and provincial level. In districts/cities, they are in various forms.
Coordination	Institutions are vertical. Control and coordination of institutions can be direct from the central level to the districts/cities.	At present vertical control and coordination can only be done up to the provincial level. It is done in the forms of consultations at the district/city level.
Program Planning	Strategy compliation and Program planning is conducted in a centralised way based on information and field data that is regularly reported vertically.	Family planning programs at the district/city level is the responsibility of the local government; the central level provides guidance based on the priority of respective areas.
Program implementation staff	Field officer supervisors (PPLKB) and family planning field counsellors (PLKB) or family planning counsellors (PKB) are spread out to the subdistrict level and are crucial for the provision of family planning information.	Not all areas have an adequate budget to maintain PPLKB and PLKB or PKB; resulting in their very low numbers. These officers have high qualifications and therefore many of them switch to other more important positions. Newly recruited officers do not receive adequate training to become a counsellor.
Monitoring and Reporting system	Monitoring includes delivering reports on the development of programs and coverage of family planning programs implemented vertically.	Reports on program development and family planning coverage from the field is reported to the district level. Reporting from the district level is not systematic and routinely sent to the provincial level.
Budget implications	Budgets for family planning programs (including contraceptive supplies) is allocated vertically from the central BKKBN.	Need for contraceptive supplies for the community is still the responsible of the central BKKBN, but the budget for family planning programs at the district/city level becomes the responsibility of the local government.

Institutionalization

In 1999, with the Law No.22/1999 on District Autonomy coming into effect, the BKKBN institutional structure at the district/city level was determined by those making policy decisions in each district; some areas maintained their BKKBN offices, whereas others combined it with other departments/agencies that have related programs; some areas decided to only form a family planning program institution as one of the sub areas in relevant departments. The Central BKKBN analysis report 2008 shows that at present there are 125 independent BKKBN offices; 238 are combined with other departments and 15 are added to other existing offices/bodies.

The Government Regulation No. 41/2007[18] organizes more specifically family planning institutions at the district level. Article 22 verse 5 explains government affairs section (i) on women's empowerment and family planning. This means that existing institutions responsible for the development and implementation of family planning programs are to combine with the women's empowerment sector. Related to this regulation, there are only a few districts/cities in Papua and West Papua that have implemented it. The head of the provincial BKKBN in West Papua stated that the Government Regulation No. 41/2007 has only been implemented in the district of Bintuni, and other districts have not implemented it.

[18] Government Regulation 41/xxxx on: Local Organization

A number of family planning offices at the district/city level in Papua and West Papua still use the nomenclature family planning office; others are combined with the department of population and demographics, family planning bodies or with the agency for community empowerment. The highest officials in each department are matched according to the status of the institution, as a sub-department or head of the office. The complete list of agencies that handle family planning programs in Papua and West Papua is depicted below.

Table 13:
Agencies that handle family planning programs in Papua and West Papua

Province/ District	Agency	Highest position responsible for family planning programs
PAPUA		
Jayapura	Department of Population and Demography, Family planning bodies	Head of the family planning Sub-departments
Jayawijaya	Family planning office	Head of the family planning office
WEST PAPUA		
Manokwari	Department of Population and Demography, Family planning bodies	Head of the family planning Sub-departments
Sorong	Department for community empowerment and family planning	Head of the family planning
	Sub-departments	

Source: Secondary data from the central, provincial and district BKKBN 2008

Coordination

The heterogeneity of the organization of family planning bodies has direct implications on the control mechanism and coordination from the central, provincial and district/city BKKBN. When the institution was organized vertically, quality of the institution could be controlled directly from the central level to the district/city level. With the existing institutional situation, vertical control can only be done up to the provincial level, meanwhile the district/city level monitoring will be characterized by coordination and consultations. The fact is that coordination at the field level often experiences constraints, as shown below: the head of BKKBN in one of the provinces visited states that the suggestion he put forward to the district/city government on the importance of recruiting staff to run family planning programs, did not receive much of a respond, even though the need for good field officers is very much a reality. Another issue faced by BKKBN in one of the provinces visited is that there were districts that do not have a unit in charge of family planning programs, making it difficult to develop such programs in these districts. Meanwhile, districts that do have a unit in charge of family planning programs are not equipped with sufficient and good quality staff, resulting in family planning programs that are not developed to an optimal. The head of the BKKBN offices in these provinces also add that many staff in charge of family planning programs in the districts do not have a background in family planning, and inadequate knowledge on such programs, resulting in family planning programs being developed without a main focus.

Program Planning

Officials who manage family planning programs in the 2 provinces also add that the limited availability of data on family planning programs makes it difficult for compiling strategies and plans for family planning programs independently. One of the difficulties is in planning and organizing contraceptive supplies at the district/city level, both in terms of quantity and type of contraceptive. According to the national policy[19], the central BKKBN provides free contraceptives for the community in the provinces of Nangroe Aceh Darussalam, NTT and Papua (provinces of Papua and West Papua). Distribution of contraceptive supplies to the community is done through the pull system, where distribution from the provincial level to the district level and from the district level to the service providers (clinics) is done upon request based on an estimate of the need for it. As a matter of fact, as

[19] For other provinces, the central BKKBN only handles contraceptive supplies for groups unable to afford

stated by one of the provincial BKKBN officials, requests from the district/city are relatively low; as is requests from the service providers. This does not necessarily translate to a low need of the community but rather the inability of personnel to estimate these needs. This of course results in the contraceptive needs of the community not being met, even when the stock of contraceptives is available in storage.

On the other hand, the type and variety of contraceptives from the central level often does not match the needs of the community, as stated by one of the family planning officials in one of the districts, where the supply of the pill was inadequate despite a high need for it. Another constraint related to the distribution of contraceptives is funding. The central BKKBN only distributes contraceptive supplies up to the provincial level. There is no allocated budget from the central level, and limited funds at the district level often results on the distribution of contraceptives to the district level and service providers experiencing constraints, primarily for in Papua where the cost of transportation is very high.

Program staff

Another impact of altering the status of family planning institutions is the reduced number of PPLKB and PLKB or PKB at the district/city level.

Table 14 :
Distribution of PLKB/PPLKB and PPKBD in Papua and West Papua
in 2004-2008

District	PPLKB				PLKB/PKB			
	2004	2006	2007	2008	2004	2006	2007	2008
JAYAPURA	11		6	2	23		13	13
JAYAWIJAYA	10		6	1	21			8
MANOKWARI	12	14	31	4	27	68	49	20
SORONG	3			6	7			14

Family planning field officers placed at the district[20] level become the focal point in implementing and promoting information on family planning and its services down to the village level. Apart from that, they also have an important role in providing coverage data and services at the village level. This occurs in Papua and West Papua, in the study districts, where many field officers who have become district staff, or even district heads or the district secretary, many become staff of agencies that require them, and only a few remain in departments/ agencies that work in family planning. One official in charge of the family planning program in one of the districts visited stated that during the decentralization era the number of field officers reduced as they were relocated to other agencies that required them, and they were difficult to replace. Because family planning programs have not become a priority in these districts, the need for field staff has also not become a priority. Even when districts do recruit new field staff, they are often not equipped with the necessary skills to be responsible for information, education and communication related to family planning. In addition there is no sufficient mechanism for training field officers. Data from the field also supports this statement, where a new field officer at one of the districts visited was unable to list the types of contraceptives.

Monitoring and Reporting Systems

The limited number of staff available at the district/city level also impacts on the provincial access to district level data, including data on various programs, achievements, as well as data on the availability of funds. In relation to programs mentioned by an official responsible for a family planning program at the provincial level, to achieve targets set by the central level BKKBN, the provincial level can only appeal to family planning bodies/agencies at the district/city level. Field data, as stated by an official from the provincial BKKBN, and reports on development

[20] Sub district

of family planning programs and coverage is not routinely reported to the province. Data from various districts is often received after the set reporting period. There are a number of new family planning participants at the field level; however written reports are often not available.

Budget Implications

Related to the availability of funds, which is also a target for the Family Planning National Strategic Plan, nearly all provinces and districts visited have received funding support from APBD. According to officials in a number of districts visited, a proportion of the funding was allocated to the provision of contraceptive supplies. However, it seems that the budget allocation for family planning programs is not consistent. A number of local governments have not allocated funds for family planning programs in 2008.

Table 15[21] **:**
Amount and source of BKKBN budget in Papua and West Papua

YEAR	PAPUA		WEST PAPUA	
	APBD 1	APBN	DAK	APBN
2004		2.294.000.000	-	-
2005	1.000.000.000	9.847.394.000	-	-
2006		8.590.502.000	-	3.022.596.000
2007		12.963.929.000	-	7.641.201.000
2008		15.540.459.000	5.082.000.000	8.690.838.000

The detailed budget allocation in 4 study districts is outlined in Table 16 below. From the overall budget available, there are no funds allocated for the provision of contraceptives, because procurement of contraceptive supplies relies on the central level BKKBN.

Table 16:
Amount and source of family planning budget in 4 study districts (in millions)

Kabupaten	DAU					OTSUS				
	2004	2005	2006	2007	2008	2004	2005	2006	2007	2008
Jayapura	17	49	241,505	330,519	193	-	-	-	-	-
Jayawijaya	-	100	150	200	-	-	-	-	-	500
Manokwari	-	-	60	90	-	-	-	-	-	-
Sorong				251,905					242,200	

4.2. Function and role of the National Family Planning Board (BKKBN) and the Health Department (Dinas Kesehatan)

Analysis towards the role of BKKBN, Dinas Kesehatan, Community and private institutions in family planning programs was done by extracting information from the strategic plan complied by the BKKBN at the national level and the Ministry of Health. The 2 strategic plans are to act as references for the implementation of family planning programs at the district/city level. Although, as mentioned previously, the national strategic plan for family planning programs from the Ministry of Health has not been socialized across the all districts/cities, the role of the Dinas Kesehatan in family planning services at the district/city level is evident from the existing national strategic plan. The strategies of the two departments are summarized in Table 17 below.

[21] Source: BKKBN Papua and West Papua 2008

Table 17:
Summary of the BKKBN Family Planning Program National Strategic Plan and the Department of Health Family Planning Services

BKKBN[22]	DEPARTEMEN OF HEALTH[23]
1. Basic Strategies - Strengthen local programs - Guarantee sustainability of programs 2. Strategi Operasional - Increase capacity of family planning services at a naional level service - Increase quality and priority of programs - Stabilise comittments - Support policies and regulations - Monitor, evaluate and account increase accountability of services	1. Strengthen management of family planning services at all levels 2. Guarantee the availability of good quality resources for family planning services 3. Guarantee legal protection for personnel and clients of family planning services 4. Guarantee access to good quality family planning services 5. Community empowerment towards famly planning services 6. Emphasize cooperation between stakeholders

Source: SDKI 2007 Preliminary Report

It is evident from the 2 National Strategic plans above that the focus of BKKBN is on family planning institutions at the district/city level, whereas the health department focuses on services, strengthening and supporting BKKBN in implementation at the district/city level.

At the district level, based on results of interviews with family planning officials and those from the health departments in 4 districts visited, there is no written agreement that outlines the role of the BKKBN and Dinas kesehatan in supporting the implementation of family planning programs. In addition, 4 officials in family planning agencies and Dinas kesehatan in 4 districts visited agreed that BKKBN focuses more on promotion, advocacy, provision and distribution of contraceptives, where the Dinas kesehatan focuses on services. However, effective coordination of the two functions is still unclear. The Dinas Kesehatan in 4 districts visited does not have specific policy and strategy on family planning programs.

This was expressed at interviews with 4 heads of the Dinas Kesehatan and officials in the family health department in 4 visited districts. All respondents interviewed stated that at present the Dinas Kesehatan through the health services in hospitals as well as community health centers for family planning programs, is only limited to providing contraceptives to those who visit these services.

Family planning promotion for new mothers is also included in these services. The Dinas Kesehatan in the 4 study districts also did not have a specific budget for family planning; the management of health personnel providing family planning services such as community health centers is done through coordination with institutions that handle family planning issues. Although it was admitted by all officials at the Dinas Kesehatan that were interviewed that coordination with institutions that handle family planning issues is not smooth.

In relation to the promotion of family planning programs, officials in family planning bodies in 4 districts stated that promotions aim to target the community, and is conducted by existing field officers, meanwhile at the district level advocacy is done to gain support from policymakers and legislatives, particularly for matters related to the institution, manpower and budget.

In fulfilling their role as the body responsible for services at community health centers, in an era of decentralization, the Dinas Kesehatan does not possess a specific strategy for the development of family planning services. As mentioned previously, the National Strategic Plan for family planning services from the Department of Health has

[22] National Strategic Plan for Family Planning Programs 2005-2009, BKKBN, 2005
[23] National Strategic Plan for Family Planning Program 2007-2009, Ministry of Health, Indonesia, 2008

not been socialized throughout all districts/cities, therefore family planning services at the field level often refers to guidelines on family planning services that was compiled by BKKBN and made available to the community health centers.

4.3. Structure of health services

The structure of family planning health services at the district level includes hospitals, community health centers (Puskesmas), village health services (Polindes), private clinics and private midwives. Based on secondary data from the Dinas Kesehatan in Papua and West Papua, the number and locations for family planning services in the two provinces is shown below.

Table 18[24] **:**
Distribution of family planning clinics year 2007

FACILITY	PAPUA	WEST PAPUA
Government hospitals	10	6
Private hospitals	4	6
Puskesmas	168	81
Polindes	346	163
Private clinics/privte doctors	104	
Private midwives	37	
TOTAL	**931**	**256**

Table 19[25] **:**
New family planning clients based on health services year 2005

FACILITY	PAPUA	WEST PAPUA
Government family planning clinics	86,84	95,56
Private family planning clinics	1,28	0,88
Doctors	0,34	0.20
Private midwives	11,54	3,36

Table 20[26]**:**
Distribution of family planning clinics in 4 districts

FACILITY	JAYAPURA	JAYAWIJAYA	MANOKWARI	SORONG
Government hospitals	2	1	3	1
Government nursing homes		1		
Puskesmas	17	33	16	18
Polindes	28	15	55	
Private clinics/doctors	29	7	4	2
Private midwives	2			2
TOTAL	**62**	**57**	**78**	**23**

[24] Source: Secondary data from the Dinas Kesehatan and BKKBN in Papua and West Papua
[25] Indonesian Health Profile – Ministry of Health 2007
[26] Source: BPS, Dinas Kesehatan and family planning bodies in each district

From the table it is evident that the role of the private sector in the provision of family planning services in 3 districts is still low. In addition, data from the Dinas Kesehatan at the district level shows that family planning health service providers include gynaecologists in hospitals, general practitioners in hospitals and community health centers, and qualified midwives that include nurses and caretakers.

Based on results of the visit to the 2 provinces, data on availability of contraceptives in each province is shown in Table 21 below.

Table 21[27]:
Availability of contraceptives at the provincial level

Contraceptive	PAPUA		WEST PAPUA	
	Amount	Source	Amount	Source
Male condoms (gross)	3.168,75	Dipa 2007	16.320	Centrally allocated
Female condoms (dozen)	-		48	
Pill (cycle)	686.316	Dipa 2007	136.400	
Injection (vial)	293.434	Dipa 2007/08	71.500	
IUD (unit)	16.411	Dip a 2005/07	1.975	
Implant (unit)	6.640	Dipa 2007	1.970	
Others - Disposable 3 cc - Fallope Ring	744	Dipa 2006/07	77.891	

Table 22:
Availability of contraceptives at the district level

Contraceptive	JAYAPURA[28]	JAYAWIJAYA[29]	MANOKWARI[30]	SORONG[31]	Source
Male condoms (gross)	204	772	1.506	5.760	APBN, APBD, ABT, UNFPA, PKBS BBM In Jayawijaya, contraceptive supplies originate from the Netherlands
Female condoms (dozen)	0	0	0	0	
Pil (cycle) - Excluton - Livodiol - Planak	9.500	12.100	 373 800 100	 5.370	
Suntik (vial) - Depo progestin - Cyclo - Suntik KB I	5.580	8.520	 420 815 1.760	1. 500 6.000	
IUD (unit) - Coper T	1.010	450	 223	115	
Implant (unit)	103	50	0	0	
Others		3.500			

Apart from observing the availability of contraceptives, the condition of the storage units for contraceptives was also assessed during visits to each province. Storage conditions were similar, and were generally shut well and locked, and equipped with information. In Jayawijaya, Manokwari and Sorong, storage units were also used for other equipment such as rice, office stationery, tables, chairs, computers and printers.

Supplies were managed by officers trained in management of storage for contraceptive supplies. Only in Manokwari officers who managed the storage unit never received any training although they had worked for 18 years.

[27] Date as of 19 August 2008
[28] Data as of 15 August 2008
[29] Data as of 9 September 2008
[30] Data as of 20 August 2008
[31] Data as of 19 August 2008

Collection of data on services has not been optimal. BKKBN has provided data for reporting on the use of contraceptives distributed to community health centers. Meanwhile the reporting format provided by the Dinas Kesehatan is combined with that provided by the mother and child health (KIA) services. What they hope to achieve is that each community health centre provides reports on family planning services along with reports on KIA services every month. In addition, it is also hoped that the community health centers and/or midwives provide reports on use of contraceptives using a form provided by the family planning department (Dinas KB). Once reports on the use of contraceptives are received by the family planning department, it will be shared with Dinas Kesehatan, and vice versa. The district level family planning body then reports the data to the provincial level.

Based on results of the interview with officials at the Dinas Kesehatan and family planning bodies at the district level, the reporting mechanism for family planning services and use of contraceptives on the field has not been optimal.

Photo: Ms. Lily Widya Puspasari - 2008

Photo: Ms. Ansye Sopacua

Chapter V

COMMUNITY ATTITUDES TOWARDS FAMILY AND FAMILY PLANNING SERVICES

In an effort to gain an overview of the attitudes and views of the community towards family planning programs and services, data collection was conducted through focus group discussions with communities (respondents are listed in Chapter 3). To complete the results of the focus group discussions, in-depth interviews were conducted with government representatives at the district level, along with community figures represented by village heads, or cultural and religious figures.

There were 228 respondents at the community level. District level respondents included head of the districts and/or staff that represent them, community figures/village heads and religious figures.

5.1. Knowledge on family planning

According to the SDKI 2007 Preliminary Report, knowledge on types of modern contraceptive methods among married women in Papua and West Papua is relatively high. Apart from knowledge on modern contraceptive methods, respondents from the same group also have a high level of knowledge on traditional contraceptive methods.

Field data shows a similar situation. Knowledge on types of contraceptives is fairly high among most focus group discussion participants, including married males and females, and adolescent males and females. All 142 discussion participants could name at least once type of contraceptive.

Results of the discussions show that among married females particularly in Jayapura, and Manokwari, along with all 29 married females FGD participants, most respondents knew about at least 3 types of contraceptives, mainly the pill, contraceptive injection, and the implant. The situation was different in Jayawijaya, where 13 participants admitted not knowing about modern contraceptives.

Among adolescent males and females, almost all participants had knowledge about the condom, as they are often distributed in schools during HIV counseling sessions. However, they knew about the condom not as a contraceptive, but for disease prevention. Only a small number of adolescents knew of the condom as a contraceptive to prevent pregnancy. Knowledge on condoms as a contraceptive is generally good among sexually active adolescents who often use them with their partners.

In relation to knowledge on condoms, HIV and AIDS prevention programs through counselling in Papua and West Papua has been organized by the local government from the provincial level to the district level, with the high HIV prevalence in the two provinces. Counselling programs are conducted within different sectors of the community, mainly among adolescents through counselling programs in schools, leading to a high number of male and female FGD participants having a good knowledge of HIV and AIDS prevention through condom use. There have also been a number of counselling cadres trained for the community in a number of villages, such as a village in Jayawijaya. Discussion participants had also received training in HIV/AIDS from an international

organization. Similarly in Sorong, a number of adolescents as well as religious figures had previously participated in HIV/AIDS prevention training.

Furthermore, when asked questions on condom use, most married females generally said that they as well as their husbands, were not comfortable with it. Results from the FGD with a group of married women in Sawoy, Rasinki, Unurumguay dan Aimas supported this fact. The women believe that condoms are only used by men who 'buy' sex from other women, or men who tend to have multiple partners. In general, respondents also believed that condom use will result in a lack of trust between husband and wife. They believe that if you let your husband, or ask your husband to wear a condom, you are giving him the opportunity to have a number of other partners.

Most unmarried male participants also felt the same way. Most participants had knowledge about condoms, had access to them, and used condoms when visiting sites but did not use them when engaging in sexual relations with their partners.

In general, results from group discussions among male and female respondents in 3 districts, Jayapura, Manokwari and Sorong, show that the number of females who know of at least one type of contraceptive method is higher than males. This may be due to the higher number of family planning interventions targeted at women, as compared to men. In addition, methods available for females are higher than those for males. For example, in one of the areas where UNICEF operates, a group of female adolescents were receiving guidance counselling on reproductive health issues, and a number of them had a good knowledge of family planning.

Meanwhile in Jayawijaya, the level of knowledge among males in every discussion group was relatively better. The word relatively is used because although their knowledge on family planning is not always accurate, but as compared to female participants, male respondents had a better knowledge of family planning methods such as the condom, implant, injection, and pill.

Among adolescents in Papua, knowledge on contraceptives is generally limited to the contraceptive injection and the pill. Only a small number of respondents knew about the implant as a contraceptive method. Most adolescents gain information on contraceptives directly from conversations among parents, or because they are often asked to buy the pill or contraceptive injection.

The lack of information on family planning within the community has lead to a low level of understanding of family planning issues. The lack of information on family planning is evident among communities in Jayawijaya. Results of FGDs with married males, unmarried males and adolescents indicate that many participants believe that using the implant method as a contraceptive leads to a loss of weight among women, a disruption in their menstrual cycle, results in them becoming barren once the implant is removed, and ultimately leads to death. As stated by one of the FGD married males from Jayawijaya:

> *"I will tell you about my experience from a number of years ago with the implant. It is not suitable for us here, because the women here work very hard; therefore, we believe that it reduces your blood count, results in women losing weight and also death. Therefore, we think that the implant is not necessary".*

Among the 3 districts; Jayapura, Manokwari and Sorong; family planning is often regarded as a method to limit the number of children, to space childbirths, and to increase the quality of health of women and increase a family's economic level. This is the impression gathered from results of FGDs with married women aged 20-49 years. They also understand family planning as a government program that encourages only 2 children, referring to the family planning slogan they are familiar with that states "2 children are sufficient". Similar opinions were gathered from FGDs with groups of married males, and unmarried males and females. Meanwhile among the same group in Jayawijaya, the situation was slightly different as compared to the other districts. From 15 discussions in the districts of Walelagama and Asologaima, it seemed as though participants had never received information on family planning. Almost all participants stated that they did not have any knowledge on family planning and many

were hearing about family planning for the first time then.

Information and opinions on domestic violence also emerged from discussions with respondents on family planning. Information on the occurrence of domestic violence was also discussed among married female FGD participants. One participant stated that a neighbour from her village was once a victim of domestic violence when her husband discovered that she was following a family planning program without his knowledge. Domestic violence is also common if married women refuse sex with their husbands, despite them stating that the reason for not wanting to have sex is because they have to look after of their young children.

On the other hand, some people believe that with an increase in a family's economic level, family planning is not necessary. A family's economic status determines whether their children attend school. One married male participant from Jayawijaya stated that as long as a family is able to send their children to school, they do not need to adopt family planning practices, even though they have a high number of children. He adds that it is more important to send boys to school as they are the ones who will carry on the family name, whereas girls can assist with the household duties.

Results from discussions also indicated a significant difference between local residents from Papua and visitors. Visitors in communities that were survey areas generally regarded family planning as something one had to do adopt for economic reasons.

Data from FGDs and interviews with religious figures at the villages that were locations for transmigration indicated a high awareness of the benefits of family planning programs. A high use of contraceptives results in a reduced number of primary school students because many residents in Java do not have school aged children.

Generally, from discussions with the community, it is evident that in puskesmas facilities in areas where UNICEF conducts mother and child health interventions, most married and unmarried females, young adults and adolescents have a better knowledge of family planning compared to areas where UNICEF does not operate. Even though there are no specific interventions for family planning, routine management of mother and child health among these groups provides them with a better understanding of family planning issues. Meanwhile among males in areas where UNICEF operates and areas where it does not operate, the level of knowledge of family planning issues is similar. In areas where UNICEF operates, males are encouraged to be involved in socialization activities on general reproductive health.

Knowledge on traditional family planning methods

What is meant by traditional family planning methods are contraceptives that do not involve modern medication or concepts. Included in the term traditional contraceptives, apart from abstinence and interrupted intercourse, are those categorized as the folk method in the SDKI 2007 Preliminary report, also termed differently in a number of reports, and termed 'natural family planning' by a number of communities.

Individual interviews with community and religious figures as well as married and unmarried males and females yielded information on 'natural family planning', which usually involves husband and wife. Apart from certain practices (such as abstinence) and the use of traditional mixtures, they also use prayers. Meanwhile this natural family planning method was vaguely understood by adolescents. However, there were a few individuals who recognized prayer as a method that could be utilized.

Traditional mixtures included using a certain type of wood that is boiled and its liquid consumed. This was discovered in a discussion with communities in Sanggeng. In Biak a type of leaf mixture with betel nut leaves is sometimes consumed by husband and wife. A respondent in Sidey talked about a traditional contraceptive method for females who do not want to have any more children. A mixture is made from the skin of wood, which is combined with leaves of a certain flower and spinach leaves to form a mixture that is consumed or mixed with

pigs' intestines and then consumed.

Other traditional methods include burying the umbilical cord after giving birth. A respondent from Unurumguay also mentioned another traditional contraceptive method of tightly tying the belly button, which can be removed if more children are wanted. In Sawoy traditional contraception is practiced by praying with water while holding hands between husband and wife or a child and their mother, and then consuming that water. If more children are desired, the prayers can be repeated.

Traditional family planning methods are used by both females and males. In using traditional methods, the role of the husband is relatively important. There are also a number of methods that directly involve the males such as drinking mixtures prepared or praying. For abstinence and interruption of intercourse, the cooperation of males is very much required, without which these two methods would be impossible. In Jayawijaya, it was found that adopting traditional contraceptive methods while having children under the age of 3 often results in domestic violence. This also often leads to males having other partners or practicing polygamy.

Source of information on family planning

Results from FGDs with community and religious figures show that information on family planning often originates from formal and informal sources. Formal sources include health personnel (midwives, doctors, and/or caretakers), family planning outreach workers, family planning cadres, and through education in schools. Informal sources include religious figures (pastors, sisters, priests), cadres at health centers (Posyandu), books, the media (television, radio, newspapers), and external media such as billboards, along with information provided by parents and other family members.

Among married females, knowledge on family planning is often received from health personnel, family planning outreach workers, and cadres at health centers (Posyandu) and/or PPKBD; meanwhile among adolescents and young adults, information is often received from parents, the media, and schools.

In deciding the type of contraceptive method to use, clients often decide based on suggestions from health personnel or others such as family planning cadres, posyandu services, neighbors, and friends. This is common among married female respondents aged 20-45 years.

Results from FGDs among married females show that apart from relying on information from health personnel, information on family planning services was also obtained from family planning field officers (PPLKB/PLKB/PKB).

They expressed the need for the availability of family planning field officers. Along with the community, religious figures also realized the benefit of the PLKB/PKB, who not only provide counselling, but also increase the community's access to contraceptives.

5.2. Perceptions towards family planning services

Despite attitudes and opinions that do not support family planning, a result of the lack of knowledge on the need for it, an in-depth analysis of the FGDs indicate that in reality, the need for family planning remains high.

Access to accurate information can also affect one's decision to use contraception. A FGD with married females in Walelagama, Jayawijaya indicated that only a few participants could discuss family planning, that too as a result of receiving information on family planning from the facilitator of the discussion. One of the participants stated "The community here believes, particularly the men, that adopting family planning practices will make one barren, however, mothers often do want to adopt these family planning practices".

Females in Jayawijaya were often the main breadwinner of the family, many working as farmers who sold their crops at the market. One of the women stated that mothers who lived around her area once received an injection from a nurse termed as the "family planning injection". However, she was not aware of what the injection was and how they obtained it. This shows that access to information is not available, resulting in the community lacking accurate knowledge on family planning issues.

Meanwhile, a number of community and religious figures in Jayawijaya stated that modern family planning practices are not needed in Jayawijaya because culturally, the community has a certain way of practicing family planning, including refraining from sex at a young age.

Side effects of family planning practices

During FGDs, a number of respondents stated that they experienced side effects from using contraceptives, resulting in them stopping the use of contraceptives, or reverting to traditional contraceptive methods.

Side effects mentioned by half of respondents who used the contraceptive injection included headaches, disruption in menstrual cycle, itchiness, knee pains and allergies. After stopping the use of the injection and reverting to traditional contraceptive methods, their complaints often stopped. Others stated that they stopped the use of contraceptives because of its limited availability and high costs of services.

A number of participants provided their opinions in relation to this, including:

> *"I do not believe in family planning. I used the injection but it failed, and my child is 16 years old now. I have also used the spiral, but 6 years later I had pains in my stomach, and it felt like I was being stabbed. I also kept losing weight, and therefore I stopped" (a mother and FGD participant from Sanggeng)*

> *"I have also had the contraceptive injection, and my menstrual cycle was disrupted, I got my period after 3-6 months, and it was very painful, so I stopped practicing family planning" (a mother from the Hamor Ransik village)*

> *"I do not practice family planning because it disrupted my menstrual cycle and hurt my knees hurt, but once I stopped, my cycle returned to normal and my knees did not hurt anymore" (a mother from Unurumguay)*

> *"I have had the urge to practice family planning, and I have had the contraceptive injection, but I experienced itchiness, and so I stopped. Now I use the calendar. Family planning practices did not suit me, so I stopped" (a mother from Sawoy)*

Perceptions towards family planning costs

Married females who use contraceptives often obtain the pill or the injection from health personnel, both from community health centers, and from centers where midwives practice. If they are unavailable at health services or from health personnel, they will usually obtain them from the pharmacy or from field officers who often provide supplies. If they purchase the contraceptives themselves, particularly the injection, they will usually visit a midwife to get injected.

Results from interviews with officials from family planning bodies and health departments, and community centers indicate that contraceptives that are distributed in Papua are free. In reality, however, the costs for contraceptives differ in each district.

Normally they cost between Rp. 5.000 and Rp. 150.000, largely depending on the type and procurement source of the contraceptives. If the contraceptives are obtained from the BKKBN or the Dinas Kesehatan, family planning

services at community health centers are free. However if the contraceptives are obtained from the pharmacy or provided by midwives, they will charge a fee for it.

With the exception of askeskin (health insurance for those who are unable to afford) holders, and other communities who are unable to afford it, who are not charged a service fee, variation in costs for contraceptives are shown below:

Contraceptive method	Cost (Rp)
Injection	Approximately 5.000 – 20.000
Pill	Approximately 30.000 – 40.000
Implant	25.000 (with supplies from the BKKBN), 150.000 (personally obtained)

In general, communities in urban areas are not as affected by the costs of contraceptives obtained from health personnel or pharmacies. But for communities who are unable to afford supplies and for those who live in remote areas, almost all participants of the FGDs including all groups of married and unmarried males and females, and male and female adolescents suggest that family planning services for these group of people should be provided free of charge. Groups of people who often complain of the high costs of family planning services usually stop using these services and revert to traditional methods.

In one district, midwives and a cadre visit the villages once a month to provide contraceptives. Access to these villages is difficult, but there is a high need for contraceptive injections in these areas. Mother and child health services in these villages are provided through the posyandu, assisted by staff from the surrounding puskesmas facilities.

Posyandu services that are supported by the puskesmas facilities surrounding the area have a set monthly schedule. Family planning services provided at the posyandu generally include the pill and the contraceptive injection. In total, there are 71.160 posyandu in Papua and 714 posyandu in West Papua[32]. Posyandu facilities have an important role in providing health services for mothers and children, particularly in remote areas.

Family planning services for marginalized groups

Groups referred to as marginal in this study are those community groups that have limited access to information and family planning services. Communities who cannot afford such services, those in remote areas, unmarried individuals, and adolescents all fall within this category of marginal groups.

This group is discussed separately because there often exists specific policies for different groups of people. In the BKKBN National Strategic Plan for Family Planning, poorer communities and adolescents are often targets of strategic development family planning programs.

The reason for poorer communities being a target group for family planning programs is the high number of families with a low economic status in Indonesia. This often affects their ability to spend, including purchasing contraceptives. Poorer families in general have a high number of family members. Their condition often leads them to being passive in participating in family planning and increasing their and their family's quality of health. Meanwhile knowledge and awareness on Adolescent Reproductive Health (ARH) among adolescents is still relatively low. Reproductive issues are rarely discussed openly in Indonesian families. Adolescents are often comfortable discussing such issues openly with friends rather than parents. In addition, the availability of centers for counseling and advocacy on reproductive health rights for adolescents is still limited and insufficient to meet the needs of adolescents. ARH education in schools has also not been very successful.[33]

[32] Indonesian Health Profile 2005

[32] Obtained from the National Strategic Plan for Family Planning, 2005-2009, BKKBN, 2005

Families with a low economic status

Based on secondary data from the BKKBN and Dinas Kesehatan offices at the provincial and district level study locations, the number of families with a low economic status is shown below:

If the above data is compared with family planning coverage in each district, it is evident that there is a significant relationship between the number of families with a low economic status and family planning coverage. Jayawijaya, with the highest number of families with low economic status have the lowest family planning coverage, 2.44 for all types o contraceptives; whereas in Jayapura, with the lowest number of families with low economic status, has the highest family planning coverage among 3 other districts, as high 41.0.

PROVINCE	NUMBER OF FAMILIES
Papua	275.740
West Papua	273.562
DISTRICT	
Jayapura	6.317
Jayawijaya	153.509
Manokwari	15.170
Sorong	9.196

Papua and West Papua are vast, and most of its inhabitants live in remote rural areas that are not easily accessible. Health services in these areas are very limited, and even where puskesmas facilities do exist in these areas, health personnel are not always available to serve clients. A number of these areas are difficult to access using land transportation, and therefore can only be accessed through water and/or air transportation, implying high transportation costs. In relation to family planning, this situation will undoubtedly have an affect on the provision of services in these remote areas.

Based on results from interviews with officials from the BKKBN and Dinas Kesehatan at the district and provincial level, family planning needs of poorer communities are fulfilled by providing these services free of charge. Nationally in Papua and West Papua, there is a policy for free contraceptives provided by the central government. With this policy, communities that require contraceptives should be able to access them free of charge from the BKKBN and obtain family planning services from health centers.

At the puskesmas level, services for communities who cannot afford are provided free of charge, as stated by a number of puskesmas heads interviewed. However, these supplies are not always free as they are not always obtained from the BKKBN. For clients who cannot afford them, many midwives often admit to waiving service costs.

An example of provision of services can be seen in Manokwari. Services for poorer communities and those in remote areas are often provided through mass activities and those that utilize resources in the community, such as cadres and religious institutions. For example Minyambow, there are cadres that are trained by missionaries in providing the contraceptive injection and medication. Medically, this is usually not legitimate as there is no one available to supervise this. However, in emergency situations where there is a high demand for it, exceptions are often made. Services for the community are also provided during special events.

In districts where PPLKB or PLKB personnel are available, provision of information to remote communities is done by these field officers. An official from the Dinas Kesehatan and BKKBN at the district level stated that the availability of PPLKB/PLKB personnel is very helpful for field activities and data collection and recording. In addition, it also facilitates community access to family planning services.

In Sorong, as stated by the head of the local Dinas Kesehatan, community services in remote areas are provided through surrounding posyandu and puskesmas. The Dinas Kesehatan provides funds for transportation costs, and combines family planning services with other general services. The situation is similar in Jayapura.

The vastness of Papua and West Papua poses a barrier for communities living in remote areas who are unable to access family planning services, even if there is a demand for it. Geographical barriers result in high transportation

costs. Despite the availability of health services such as puskesmas, these barriers affect the distribution of contraceptive supplies from the districts.

FGD participants and community figures agree that this situation is one of the reasons for the low coverage of family planning in Papua, and they hope that the government, in this case the Dinas Kesehatan, will provide a means to increase the number of health personnel in these areas by providing them with a place to reside. The small number of places available for them to reside leads to personnel wanting to stay at the districts. This was evident in one district where health personnel at the puskesmas were rarely available, the reason being the unavailability of places for them to reside near the puskesmas.

Adolescents

As stated in Chapter 5, premarital sex in adolescents and young adults in Papua and West Papua is high and often leads to unwanted pregnancies. This leads to a high need of information and family planning services.

In relation to the high occurrence of premarital sex among adolescents in Papua, most respondents, particularly males, agree that unmarried sexually active individuals should receive family planning services. This was also expressed by religious and community figures interviewed. However, they only agree with the use of condoms, and not other contraceptive methods. They believe that if adolescents use other methods of contraceptives such as the pill or injection, it might impact on their ability to have children, or affect their future. The provision of condoms to adolescents hopes to reduce the number of pregnancies and drop outs among females in schools, as well as protect their family's name and the good name of religion. What is meant by protecting the good name of religion is that for example, if an adolescent girl who is part of a church falls pregnant, according to church officials, she will destroy the good name to the church.

Groups of female adolescents, young adults and married females do not agree with this. They believe that if adolescents are given access to family planning services, this will lead to them engaging in sexual behaviours without considering the risks associated.

As stated by a FGD participant among the married female group in Unurumguay:

> *"Adolescents should not use family planning services, because this will lead to them engaging more freely in sexual behaviours, knowing that there is no risk of pregnancy".*

Similar opinions were put forward by a number of respondents at the district level who believe that family planning is only meant for married couples, and will be abused if provided to adolescents.

It is interesting to note that a number of Christian and Catholic religious figures from 8 out of 16 districts visited offered religious support to pregnant adolescents through activities conducted at the church, even though they are against premarital sex. They also did not deny access to family planning services for adolescents. Similar to attitudes of the general community, these religious figures also believed that the most appropriate contraceptive method for adolescents is condom use. Apart from preventing HIV transmission, condoms also prevent unwanted pregnancies and school drop outs among adolescent females.

Unlike Christian and Catholic religious figures, Muslim religious figures were against the provision of family planning services for adolescents. They do not agree with premarital sex as it conflicts with religious teachings, and according to them providing adolescents with condoms will increase the chance of them sinning, and engaging in behaviours not allowed by religion.

Attitudes of Catholic, Christian and Muslim religious leaders on HIV issues seemed to be more positive, and most of them are actively involves in HIV prevention programs. In religious sessions, they often spare time to promote HIV prevention. A number of religious figures are also involves in HIV/AIDS training conducted by local NGOs.

In interviews with puskesmas health personnel, a number of them stated that they would not provide family planning services to adolescents and unmarried individuals. Based on field data, adolescents do not access family panning services in clinics available in Papua and West Papua, particularly in the puskesmas. However, according to a religious figure in Jayawijaya, a number of unmarried adolescents often use natural family planning methods.

In adolescents, condoms are promoted as a means of prevention HIV transmission, and condoms are also used by adolescent and adult males, often when engaging in sexual behavior with commercial sex workers or other multiple partners. Condoms are usually obtained free from NGOs or health personnel who provide counseling on HIV and AIDS prevention, or even from local pharmacies.

Discussions with married and unmarried males and adolescent males indicate that they do not usually have a problem with accessing condoms. From all respondents who had accessed condoms before, most received them from HIV and AIDS socialization sessions. However, there were no groups of adolescent males and unmarried males who stated that they had the courage to discuss this matter with their parents.

5.3. Community attitudes towards family planning

The first question directed at the participants of FGDs and in-depth interviews involved their opinion about family planning. The aim of this question was to generally gain an initial idea of the attitude of the community towards family planning, including the source of knowledge on these issues, the process of decision making.

What is your opinion on family planning?

From results of the FGDs and in-depth interviews with individuals from the districts and villages, and responses obtained, respondents from Papua and West Papua can be categorized in the following groups (a) those who support and participate in family planning programs, (b) those who support but do not participate in family planning programs, (c) those who do not support family planning programs because they believe that Papua is geographically large and needs a bigger population to manage its land, (d) those who do not support family planning programs because they conflict with religious beliefs adopted, (e) those who do not support family planning programs as they conflict with cultural and traditional norms that exist in Papua, (e) those who have conflicting opinions on family planning.

- Those who support and participate in family planning programs

This means that respondents support family planning programs in a positive way and also participate personally and support their partner in using contraceptives, facilitate counselling, or consistently promote family planning.

This type of attitude was only found among a few respondents in various areas, including a number of married females and religious and community figures. Four FGD participants among a group of married females stated that they support family planning programs as it helps mothers take care of their children, as too many children can be difficult to handle.
At the district level, results of interviews showed that 71.4% of respondents including the District Heads or their representatives understood and supported family planning programs.

Respondents at the district level also had a sufficient level of knowledge on the attitudes of its community towards family planning, as stated by a respondent from Makbon:

"I think family planning programs have been implemented for a while now, with positive results, and they have benefited the community. It is true that at the beginning the community was unaware of its importance, and thus was not participating, but once they saw results, they begin participating in such programs....At first they refused, because of their belief that individuals are meant to reproduce".

Similarly, one of the District Secretaries from Jayawijaya stated:

"Family planning for communities in Jayawijaya is not a new phenomenon. Before we knew of the existence of government family planning programs, we knew of natural family planning methods. Once family planning was introduced into the community, it was well received, and the community visited us on the field every time we provided posyandu services".

A number of religious figures in West Papua, such as in Klamono, Makbon and Aimas stated that if family planning programs are to be developed in Papua, it should involve three parties, religious figures, cultural figures and other recognized community figures. These three pillars within the community is known as the "Three Tungku", groups who have the ability to act as a bridge between the local government and the community in promoting and implementing various government programs, including family planning programs.

- Those who support but do not participate in family planning programs

This was common among adolescent males and females, unmarried males and females, and a number of married males and females. From individual interviews with religious figures, community figures and district representatives, similar attitudes were found. Many respondents stated that they agree with family planning methods as a way of spacing births, but not as a way of limiting the number of children. Furthermore, they agreed that spacing births increases the quality of the family, both economically and from an education perspective.

In Ransiki a mother, who was also the wife of the District Head, supported the family planning program in her district by becoming a cadre at the posyandu, even though she herself had never adopted family planning practices. Two religious figures from Demta and one from Aimas showed a similar attitude, supporting family planning and actively supporting their wives in using contraceptives. Similarly, a community figure in Unurumguay also supported his daughter who had been receivng contraceptive injections to space her births and limit the number of children she had.

- Those who do not support family planning programs due to geographical reasons

A lack of support towards family planning programs was evident among groups who believed that Papua does not yet need such programs because of its vastness and rich resources. Papua still needs a larger population to manage its resources and respondents expressed that they do not want to be a minority in their own territory.

Based on results of the FGDs, it was the unmarried and married males as well as adolescent males who stated that Papua did not require family planning programs because of geographical reasons. This was also stated by 2-3 other community figures and 2 religious figures, along with a district representative.

Below are a number of statements taken from the FGDs and individual interviews that support the above statements:

"Family planning is good, but for the people here, but if I want to have one child now, and then another child after 5 years, we should be able to. We need to have children to carry on our name" (a father from Jayawijaya)

"Family planning does not seem necessary. Papua is vast and the Papuan community is relatively small,

therefore a larger population is needed. It seems like because there are more visitors in Papua than local Papuans, the Papua community becomes a minority, not a majority" (a young unmarried male from Sorong)

- Those who do not support family planning programs due to conflict with religious beliefs

Another reason for not realising the need for family planning programs in Papua is the belief that it conflicts with religious ideals and practices. According to statistics, majority of Papuans and West Papuans are Protestants and Catholics. Based on data from BPS 2005, 57.4% of Papuans are Protestant, and 21.56%[34] are Catholic.

Based on results from the FGDs, 47.28% of 184 respondents who were Protestant believed that family planning is not allowed by religion because individuals are meant to reproduce, and therefore, adopting family planning practices by limiting the number of children goes against religious teachings.

A small number of respondents also stated that they do not feel the need for family planning programs in Papua as it will have a negative impact on the lives of women and their families. This is related to the culture and norms that have developed in certain communities in Papua.

Opinions regarding family planning going against religious teachings were found amongst a number of married female participants, unmarried female participants, and female adolescents, along with a number of religious figures and other community figures.

Opinions that support the above statement are indicated by the quotes below:

"People used to adopt family planning practices, but a misionary from the church once exclaimed that family planning practices are not allowed, because God wants people to reproduce and he wants the world to develop. But with such practices, its like we are going against this, it is just like murder" (a religious figure from Jayawijaya)

"Personally I think that family planning practices are important because it positively affects the health of mothers and children. On the other hand, from a religious perspective, God forbids us to hurt children. So whether family planning is important or not, we can pray to God for giving us less children, if we believe that God will fulfill our prayers" (a mother from Ransiki, Manokwari)

A number of religious figures, particularly those who were Protestant, stated that the community's understanding is not very accurate, because in the church itself there exists various interpretations, but generally the church understands family planning as "The family is responsible", meaning that every family should manage the number of children they have with full responsibility. If a Christian person has a number of children but is unable to take good care and take full responsibility of their children and their future, they will sin.

Churches that understand family planning as "The family is responsible" do not force their followers to limit their number of children, but they stress on building responsibility towards their children. Churches that understand family planning do promote limiting the number of children. Churches do not stop its followers from following family planning programs; the decision is up to the individual.

In principle, there is no difference between attitudes in Catholic and Protestant churches towards family planning programs. However, a number of Catholic churches recommend the use of traditional contraceptive methods such as abstinence and interrupted intercourse.

[34] Quoted from http/ijrsh.files.woerpress.com/2008/06/jumlah penduduk Indonesia menurut Agama.pdf. Source: BPS 2005

Meanwhile, Islamic religious figures interviewed stated their support towards the use of contraceptives among males and females. According to respondents, such practices do not go against the Al-Qur'an. Spacing births and limiting the number of children one has is one way of producing strong and healthy offspring.

Those who do not support family planning programs due to conflict with traditions and cultural norms

A number of unmarried males in Jayawijaya do not support family planning programs as they impact negatively on women and/or interfered with the cohesiveness of the household. A number of discussion participants believed that by adopting family planning practices, males and females are given the opportunity to have multiple partners. Therefore, according to them, family planning can have a negative impact on husband-wife relationships.

Family planning is also viewed as one reason for the occurrence of domestic violence in the home. In Jayawijaya, based on results of group discussions with married males and females and unmarried males, information on domestic violence was obtained. One participant from the married female group stated that she did not need to practice family planning because she once miscarried her child as a result of experiencing domestic violence while she was expecting, leading to her inability to have children.

One religious figure interviewed stated that there is a lack of support for family planning programs in the community as they believe that children are the responsibility of the family, and the government does not need to limit the number of children a family has. What they need to assist with is spacing the births of children to maintain maternal health within the community.

The lack of support for family planning programs is also influenced by the Papuan culture, where having 4 children is common and often highly desired. This impression was obtained from group discussion with married males and females and among a few unmarried males and females. However, although many adolescents and young adults (unmarried), agreed that Papua requires an increase in its population, most wanted to have 2 or 3 children when they get married.

Results of discussions with married males and females indicated that families in Papua often want 4 or 5 children. With more children, they will be able to maintain and develop their culture and traditions from generation to generation. Participants also felt that having more children will increase their security in the future. Sons will look after their parents at their old age, and daughters are able to work and increase a family's economic status. In a number of villages in Papua such as in Jayawijaya, females often work on the field to provide for the household and assist with other household duties.

Those with conflicting opinions

Besides being supportive or non-supportive of family planning programs, a number of respondents also had conflicting opinions about it, including a village head from Sorong in West Papua. He exclaimed that as an official at the village level he agreed with family planning programs for the community, but personally he does not agree with such programs as it goes against religious teachings that he follows.

Similarly, an Islamic religious figure in Sorong also felt the same way. As a religious leader he felt obliged to support government family planning programs, but personally he felt that participation in such programs would indicate a weakness in his faith or that he did not believe in the will of God.

What is your opinion on marriage?

Respondents were also asked about their opinions on marriage. Field data shows that the community in Papua and West Papua are permissive towards pre-marital sexual behaviours practiced by adolescents and young adults. They do not agree with these behaviours but they believe that it occurs due to the influence of a modern lifestyle,

and when parents are unable to control the behaviours of their children and adolescents outside the home.

Discussion results indicate that if a pregnancy happens, there are consequences for the males involved, for example they have to pay a fine or provide dowry amounting to twice as much as normal standards. He explained that if the dowry normally includes 5 pigs, and if a man impregnates a woman and then marries her, the dowry he will need to provide will include 10 pigs instead. In other districts, if a man impregnates a woman and she was still in school when they get married, the man must pay her parents the amount that they pay for her education, in addition to the dowry.

Results from FGDs and individual interviews show data on premarital sexual behaviours. Almost all respondents admit that premarital sex among adolescents is very common. Among unmarried male respondents aged 20-30 years, 50% of them admitted to engaging in sexual behaviours with their partners who, in general are still in high school. Three respondents admitted that their partners have been pregnant at least once, but they did not get married as the girl's parents did not agree to it. Pregnancy among adolescents is a major factor that influences the number of school drop outs among school-aged and high school adolescents in Papua and West Papua, because many schools require girls who become pregnant to be expelled.

Among unmarried females, a number of them also admitted to engaging in premarital sexual behaviours. In Jayawijaya an adolescent female who was a high school student admitted to having sexual relations with her partner. Although a number of participants know that their friends do engage in sexual behaviours, they believe that this risky behaviour could be damaging to girls, as they will be unable to continue their education if they fall pregnant.

In 2 districts, de facto relationsips, even with children involved, is generally accepted by the community. This may be due to the fact that marriage costs are very expensive, if performed properly according to set rituals. Individuals in de facto relationsips usually do get married at some point, often initiated by the church who perforam a mass marriage for them.

A number of males who have impregnated girls are not obliged to marry them once they have paid their fine. Even though relationships outside of marriage are common in Papua and West Papua, results from FGDs with male and female adolescents and young adults indicate that these individuals do want to have an official marriage in church when the time is right.

What is the ideal number of children to have?

Respondents were also asked about the ideal number of children a family should have. Referring to the TFR, the present national level in Papua is 2.6 children. Among those who have been married for a long time, they have an average of 4-6 children, particularly those living in the rural areas. Meanwhile those living in the urban areas have an average of 2-4 children.

Results of interviews with religious and community figures and results of FGDs with married and unmarried individuals in Jayawijaya indicate that on average a family has between 2 and 4 children. A number of groups in Jayawijaya believe that if a family has young children, there should not be any sexual relation between husband and wife until the children are older.

Meanwhile among unmarried adolescents and individuals, many individuals stated that they only want 2-3 children once they get married, depending on the economic situation at the time. Even though many respondents exclaim that they know about contraceptive methods, they are often uncertain that they will only have 2-3 children. This uncertainty is related to the cultural and religious belief that does not recommend limiting the number of children one has. Cultural ideals state that having many children is a sign of honor and pride.

Related to this belief, a number of participants stated the following:

"A wife must have children, if she has no children she must keep trying. If she gets a girl, she must keep trying for a boy. This is the way of the Arfak indigenous people".

"I think that children are important, they are a gift from God and because God has ordered us to procreate, we must not have only one or two children, the more we have, the more they can can help us in our old age" (a young girl from Makbon)

"In terms of tradition...well, we should have many children if possible, to make life easier for us. Children are a form of dowry, therefore they are needed. Their mothers were previously bought when their fathers paid a dowry for them. So without children you lose out", (2 men from the village of Hamor, Ransiki)

Children are considered valuable to communities in Papua and West Papua. A marriage without children is believed to affect the household in a negative way, because husbands are allowed to leave their wives or remarry if this is the case. Most respondents also exclaimed that having many children is an order from God, one that is stated in the Holy Scriptures. They also believe that because Papua is a vast place, it needs a larger generation of people to look after its land.

The view that children are an 'investment' when their parents are at an old age is categorized into 2 different types of opinions. A number of respondents believe that boys are more valuable than girls because they are able to take care of their parents at an old age. Therefore it is common for husbands to keep trying for a boy. If the wife does not give birth to a boy, the husband has the right to remarry in order to have a son. But there is another opinion where girls are seen as assets. Groups in Manokwari and Jayawijaya believe that girls symbolize wealth, and they are also an asset in helping their parents work on the field and assist with household duties.

5.4. Decision making process

Field data shows that there are groups of married females who need family planning services but do not have needs fulfilled (unmet needs). This is due to a number of factors including (a) the unavailability of services (b) the limited supply of contraceptives at the nearest health service, and (c) high costs. These factors often influence the shift from using modern contraceptive methods to using traditional methods.

The decision making process for adopting family planning practices is often an initiative taken by females due to their need for it. This is also supported by the fact that contraceptives are mostly targeted at females. Promotion of family planning services also often targets women, such as expectant mothers and married women or mothers who frequently visit the posyandu.

Male involvement in accessing information on family plannin is relatively low. Apart from not being the primary target of family planning services, availability of contraceptives for males is limited. As evident in data on coverage based on type of contraceptives in chapter 2, types of modern contraceptives for males are limited to the condom and male sterilisation, and types of tradition contraceptives include interruption of intercourse and abstinence.

For the male and female sterilisation process, agreement must be obtained from the client's husband or wife before the procedure. Before the procedure, both husband and wife are asked to sign an informed consent form, abiding to the rules related to standard family planning services introduced by the Department of Health.

Discussions with a number of married males and females indicated that this consent is very important to avoid negative consequences that wives could potentially face if they do not have agreement from their husbands. One of the reasons for this is that often culturally, it is believed that women in Papua are considered "bought" by men when they get married. In this culture, a man must provide dowry to the woman he wants to marry, according

to what is requested by the woman's family. Usually the woman's family determines the amount of the dowry based on her status. For example, if she is highly educated, the dowry requested will be higher, as her parents have spent on her education. After marriage the woman becomes a part of her husband's family and his family often wants the couple to have many children. In different cultures, if the woman is unable to have children, her husband is allowed to leave his wife and remarry.

Domestic violence in cases where a couple cannot have children is a common phenomenon. In Jayawijaya, there is a high rate of domestic violence where women are often the victim of violence by their husbands. This is often triggered by the inability of wives to have children. One unmarried male FGD participant stated that there was once a mother who adopted family planning practices without her husband's knowledge. When her husband found out, he physically assaulted her and threatened the midwive who provided the services with a weapon.

Such instances were also common in a number of villages in Jayapura. FGDs with unmarried males in Jayawijaya indicated that if women participated in family planning programs without their husband's knowledge, husbands often assume that their wives have the ability to engage in sexual relations with others, impacting negatively on their household.

Such situations are also considered by health personnel when providing family planning services to clients. In Puskesmas facilities, counselling is now given to couples, with the hope that husbands understand why their wives decide to adopt family planning practices.

On the other hand, it is important for husbands to be aware of their wives' involvement in such services as they can take action if their wives experience any side effects. FGDs with married males also indicated that a husand's consent is important so that they are aware of why their wives are not getting pregnant, or the reason for a significant gap between births.

Discussions with a number of married females indicated that in forced situations, many married women who use contraceptives do so without their husband's knowledge, and only if they are questioned by the husband will they explain their reasons for using contraceptives until their husbands agree with them using it.

Other examples obtained from results of FGDs on the role of men in decision making:

"You have to tell your husband, if you don't, he will get upset as he is not getting any children" (a mother from Hamor)

"If one wants to participate in a family planning program at the puskesmas, they need their husband's consent. Without this, they will not be served. We once experienced a problem where we provided services to a women, and her husband came into the centre and threatened our staff" (head of the Puskesmas in Sidey)

"Yes I agree that a husband and wife should come on together to request family planning services. Usually if women come alone, without their husbands, they want to have sexual relations with other partners. Therefore, a husband's consent is needed. If a woman comes in by herself, and her husband finds out from an outside source, she could be the victim of physical abuse from her husband. There have also been men who have wanted to be physically violent with health staff for providing family planning services to their wives" (a midwife from Walelagama)

"If women do not come on with their husbands for a legitimate reason, then it is ok, as long as there is an agreement between husband and wife" (a father from the village of Hamor, Ransiki)

The opinions above indicate that males have a very important role in dcision making and influencing the level of coverage of family planning services in Papua and West Papua.

Others stated that choosing the type of contraceptives should be discussed between husband and wife, or should be discussed with health personnel in a counselling session. Results indicate that in Jayawijaya, a high number of men have multiple partners. Therefore, many women participate in family planning programs without their husband's knowledge, and they are often served by health personnel who want to help ease the burden of these women.

Photo: UN agencies mission - 2008

Chapter VI

FAMILY PLANNING SERVICES

Family planning services that are accessed by new family planning participants, as showsn in the Indonesian Health Profile 2005, is cumulatively dominated by government provided services. Out of 4,690 new participants in Papua, 86.84% accessed government provided family planning services, followed by private midwife services (11.54%), while 1.28% received services from private family planning clinics and 0.88% accessed these services through private medical practitioners.

In West Papua, on the other hand, of the 2,944 new family planning participants, 95.55% accessed government-provided services, 3,36% private midwife services, 0,34% accessed private clinic services, while the remaining 0.20% accessed services through private medical practitioners.

6.1. Resources: Facilities; Equipment and Contraceptives; Human resources

Results from observations indicate that in every puskesmas, family planning services are often integrated with Maternal and Child Health (MCH) services. Facilities available are used simultaneously as schedules for family planning services and MCH services differ. However, midwives exclaim that family planning services can be provided at anytime, and not only during set times. Consultation rooms are often open and not private. Clean running water is only available in 4 puskesmas.

In 14 Puskesmas and 1 Polindes visited, there was generally adequate equipment and supplies for the provision of family planning services; 1 puskesmas was temporarily not providing services because the midwife in charge of these services was away on study leave.

Not all family planning services visited had trained staff on providing such services. Their skills and abilities in providing services was mostly obtained during their study, or through observing trained colleagues at work, or from BKKBN personnel who had previously provided mass services at the puskesmas.

Table 23
Number of health personnel proving family planning services at the puskesmas based on education and training received

PUSKESMAS	D-3	D-1	MIDWIVE C[35]	NOTE
Depapre		2	5	No one trained on IUD and implants
Demta		2	2	No one had participated in training related to family planning services
Unurumguay		1		No one had participated in training related to family planning services
Sawoy	1	3	3	Doctors trained in female surgery
Kurulu		1		Trained in counselling and implants
Bolakme				1 midwive without an indication of an educational background and untrained
Asologaima				3 without an indication of an educational background
Walelagama		2		1 trained on implants
Ransiki	1	7	4	5 midwives trained on implants; 2 trained on IUD
Sidey			4	2 trained on implants

[35] Education for midwives provided by the government of Papua: recruited from high school graduates with a 3 year education in midwifery

PUSKESMAS	D-3	D-1	MIDWIFE C	NOTE
Sanggeng	1	6	1	5 trained on IUD and implants
Maripi	2	1	8	9 trained on implants
Aimas			3	3 trained on IUD
Makbon			1	No one had participated in training related to family planning services
Klafdalim			1	No one had participated in training related to family planning services
Klamono		5		No one had participated in training related to family planning services

Source: Secondary data from the provincial and district BKKBN and Dinas Kesehatan

From the above table it is evident that out of 71 midwives involved in family planning services, only 23.9% or 17 midwives were trained in implementing such services. From that, 33.8% were trained on the implant, 14% on IUD, 1.4% were trained on reporting, and 1.4% on counselling and communication, information and education. All midwives trained were spread around 5 puskesmas: Sanggeng, Ransiki, Sidey, Maripi, Aimas, Kurulu and Walelagama.

Based on information from the staff at the Dinas Kesehatan in 3 districts visited, the frequency of training was previously limited. Before the shift in the structure of the BKKBN at the district level, they offered training for human resources. However, once it changed structure, the frequency of training has reduced. The Dinas Kesehatan both at the provincial level as well as the district level do not usually plan training sessions for family planning programs and services. The lack of human resources results in family planning services for the community not being optimal. For example, as stated by a midwife Coordinator; “There was a client who wanted to use the implant, but because the midwives at the puskesmas were not trained in inserting the implant, she went to the district hospital instead. But because the costs at the district level were too high, and it would also cost a lot to bring in personnel from the district level to the puskesmas, the client did not end up using the implant, even though it was suggested that she use contraceptives”.

The above case also shows that choosing contraceptive methods is affected by the availability of contraceptive supplies or where it requires assistance by health personnel to (health provider driven).

The head of the puskesmas and midwives interviewed admitted to the need for additional training particularly in inserting the implant and IUD. Unfortunately, only a small number of staff express the need for training in family planning counseling, despite observations on the field that show that counseling to decide what contraceptives to use, side effects, and information on ways to use contraceptives, is almost never provided by personnel.

The limited material on Information Education and Communication (IEC) available at the puskesmas also leads to counseling not being implemented at a maximal level. This was mentioned by a number of the heads of the puskesmas, for example during sessions where they were demonstrating condom use and there was no dildo available, or when they wanted to explain the mechanism of IUD insertion and there were no visual pictures and diagrams that could be used to aid the information relayed to clients. There is a low ability of counseling, because most staff have not been trained in counselling. Information to promote family planning if often given verbally at the puskesmas rather than through IEC materials that could positively support family planning information given.

The availability of contraceptive supplies at family planning health services is one thing that needs to be paid close attention to, without which family planning services cannot be provided optimally. From results of observations at the puskesmas, it was evident that there was a shortage of contraceptive supplies, both in terms of types and numbers. In general, the types of contraceptives available included condoms, the pill, and the contraceptive injection. Two puskesmas did not have any type of contraceptives available. In these puskesmas clients have to buy their own supplies (injections) at the pharmacy and refer to health personnel at the puskesmas to get

Table 24
Availability of contraceptives at the puskesmas based on date visited

PUSKESMAS	Male condom	Pill	Injection	IUD	Implant
Deprapre	12	333	78		
Demta	1	40	6		4
Unurumguay	3	100	95		
Sawoy		342	164		5
Asologaima		195	38		
Siepkosi	15	31*	1		9
Aimas		300	9		
Klafdalim		30	15		
Ransiki	40	100	60		10
Sanggeng	16	123	86	20	5
Maripi	12	107			
Sidey	1	200	40		9

Source: Observation results at the puskesmas

injected, similarly with the pill and other contraceptives. Condoms that are available are usually used for HIV prevention programs.

All puskesmas visited stated that contraceptive supplies were received from family planning bodies at the districts, but if supply was delayed or diminished, midwives often bought them from the pharmacy or provide a prescription for clients to obtain them.

Even though nationally it is recognized that family planning is a part of basic health services, generally it is seen that family planning program managers feel that it not adequately represented within health services, as it is often linked to the BKKBN. This directly impacts the attitudes of health staff at the puskesmas towards family planning.

Almost all puskesmas do not have a specific strategy for family planning services. Health personnel usually serve clients without promoting family planning. Only the puskesmas in Walelagama has a schedule and a plan for counseling on family planning issues even for remote areas. Attitudes of the community are also considered by the puskesmas when promoting family planning. Most puskesmas encourage that married women should be the ones obtaining contraceptives, and this should be done with their husband's consent. Family planning services for remote areas are usually provided through mobile services or through the posyandu. A number of puskesmas heads interviewed also agree that the implementation of family planning programs does not receive enough attention from the Dinas Kesehatan, leading to such services not being prioritized.

Nationally, BKKBN offices as well as the Department of Health have provided a number of guide books for family planning services as well as guidelines on assessing the quality of family planning services. However, these materials are often not found on the field. Protocols and guidelines for implementing family planning services are only available at 1 puskesmas. Services at other puskesmas are provided through knowledge and skills of respective staff, and usually do not refer to guidelines or set standards. In almost all puskesmas visited, there was no set procedure available for family planning services, and no monitoring system in place to ensure an optimal level of services provided and a system to ensure high quality of such services. Only 5 puskesmas were able to provide information on clients that were recorded adequately. A number of clients had 'client cards' which stated the client's schedule and type of services seeked, as well as when their next visit is due. However, the main method of reminding clients of their next visit is done verbally or put down in the calendar by midwives.

Table 25
Cost of family planning services in the puskesmas

Puskesmas	Injection (Rp)	Pill (Rp)	Implant (Rp)
Sawoy	Free	Free	25.000
Depapre	Free	Free	
Unurumguay	10.000		
Demta	20.000		
Walelagama	10.000		
Klafdalim	10.000	5.000	150.000 purchased personally
Aimas	15.000	5.000	
Makbon	20.000	-	
Klamono	5000 – 25.000	Free	
Sidey	10.000-20.000	3.000	
Ransiki	20.000 – 30.000	Purchased personally	100.000 purchased personally
Sanggeng	Free	Free	
Maripi	15.000	30.000	

Based on field data, the puskesmas does not have set costs for family planning services, which are usually between Rp. 5.000 – Rp. 150.000, depending on the type of contraceptive chosen and the source of the contraceptives. Contraceptives obtained from the BKKBN at a number of puskesmas are free of charge. However there are a number of puskesmas that charge for services, usually for the implant. If the contraceptives needed are not available at the puskesmas, clients are often asked to wait and return when these supplies are available. This often leads to clients not using contraceptives.

6.2. Client satisfaction of family planning services

FGDs with married males and females indicate that they often complain about the limited availability of contraceptives and relatively high costs of family planning services. However, there were no clients that were dissatisfied with the attitudes of health personnel.

Results from observation on the field indicate that the lack of health personnel available for family planning services and types of services available forces clients to stop the use of modern contraceptives and revert to traditional contraceptives when they experience dissatisfaction, for example side effects that result from the use of contraceptives.

6.3. Supervision and Management

At the national level, guidelines for supervision and management of family planning services are provided by the BKKBN as well as the Department of Health, including guidelines on supervising family planning service facilities. The Department of Health along with the BKKBN and USAID has also provided guidelines on the use study instruments to measure achievements at the facility. These are part of the guidelines on supervision and management of family planning services.

Field data, based on observations at puskesmas visited in 4 districts indicate that the mechanism for supervision is often not structured even at the district level. Supervision is usually ad hoc and is usually done through notes and reporting. Even when supervision is conducted through meetings and discussions, family planning issues are often not a priority of these discussions. Supervision from the districts Dinas Kesehatan is often conducted by staff from the Sub-din Kesga.

Most puskesmas indicated that supervision was never conducted, and development of programs is to a large extent indicated by reports as mentioned above.

Other issues related to supervision are geographic barriers and the availability of funds. Geographical factors result in high costs for supervision at the puskesmas according to 3 family planning staff at the district level. This results in supervision on the field not routinely conducted, and even when supervision is conducted, it only covers a few areas, usually areas that are easily accessible.

Photo: Ms. Melania Hidayat - 2008

Photo: Ms. Ansye Sopacua

Chapter VII

CONCLUSION AND RECOMMENDATIONS

7.1. Conclusion

- **Family planning situation in Papua and West Papua at present**

Secondary data from the SDKI 2007 Preliminary Report and documents from the provincial and district level indicates that family planning in Papua and West Papua requires serious attention. SDKI 2007 data shows that although the level of knowledge in family planning among married women aged 15-49 years is high, it does not automatically translate to a high coverage of family planning in the 2 provinces. Active family planning services or the Contraceptive Prevalence Rate (CPR) in Papua and West Papua is still very low, as low as 24.5% in Papua and 37.5% in West Papua, much lower than the national CPR (61.4%). CPR based on type of modern contraceptive indicates that the injection and the pill are the most popular contraceptive method, both short term methods with a high chance of discontinuation. On one hand the use of traditional contraceptives in Papua is as high as 10.8%, or 2.7 times higher than the national average. This shows that the need for family planning in Papua is high.

In 4 study districts Jayapura, Jayawijaya in Papua, and Manokwari and Sorong in West Papua, the situations are similar. Secondary data from each district shows that the CPR in Jayawijaya is 2.4%, the lowest as compared to the other 3 districts, and lower than the CPR in Papua. The TFR in Papua and West Papua is high, as compared to the national average. Unmet needs or family planning needs that have not been met in the 2 provinces is relatively high; 15.8% for Papua and 16.6% for West Papua. Meanwhile the need for family planning services is as high as 54.1% for Papua and 56.2% for West Papua. If these unmet needs are reduced, this will lead to a reduction in the TFR.

- **Organization of Family planning services in Papua and West Papua**

The issue of family planning institutions is an important one that should be addressed, with the implementation of PP-41/2007 that integrated family planning with women's empowerment. On one hand it is hoped that this will increase a woman's bargaining power. However, on the other hand, if such services are not implemented sufficiently with clear guidelines, family planning programs will not improve.

Coordination between the provincial BKKBN family planning bodies at the district level with the Dinas Kesehatan that provides services needs to be improved, because without effective coordination program implementation on the field will have a negative impact on family planning services. The lack of advocacy towards policymakers at the district level results in low support for the development of family planning programs at the district/city level.

There is no mechanism that exists for the provision of contraceptives in Papua and West Papua. This often results in a high possibility of uneven distribution on the field, where contraceptives are not provided based on needs of the community. If implementers do not abide to policies on costs for contraceptives, such policies will not be able to be utilized effectively by the community.

Because family planning programs are not in the agenda for development of health programs particularly at the district level, they do not receive much attention. This is evident from the limited budget allocated for family planning programs from the provincial level to the district level. This limited budget further results in an uneven distribution of family planning services for the community who require them, particularly for community groups in remote areas. The availability of competent field officers needs to be increased, to assist with the needs of the communities who require these services.

- **Community attitudes towards family planning and family planning services**

Observations from the field indicate that if family planning promotion is conducted in a proper manner and takes into consideration socio-cultural issues within the community in Papua, it will receive a positive response. Apart from cultural beliefs that believe that the higher umber of children the better and that Papua needs a larger population, the demand for family planning services is high. The high use of traditional contraceptive methods indicates a need for family planning in the community. The high number of individuals who revert to traditional contraceptive methods because of side effects of modern contraceptives indicates the lack of support and counseling available from health personnel for clients.

A low level of understanding of the community on the objectives of family planning programs is the result of the lack of media information easily accessible by the community, and therefore most information on family is received informally by communities. The limited types and number of IEC materials available, and those that are not appropriate to the local needs, is another reason for the low level of knowledge within the community on family planning.

Using religious or cultural institutions as a way of disseminating information to communities is an alternative to promote family planning. These institutions could be very helpful and effective in promoting government and community programs that focus on family planning. At the services level, the limited type of contraceptives available leads to a limited number of contraceptives that can be promoted to the community. On the other hand, the community needs alternative contraceptives to those available, in cases where side effects occur, individuals have alternative types of contraceptive methods to choose from, lowering the use of traditional contraceptives.

The high level of pre-marital sex among adolescents results in a high number of unwanted pregnancies. Even though according to norms this is unacceptable in the community, there has been no real effort by different sectors. Religious teachings have not reduced pre-marital sex among adolescents. The high number of unwanted pregnancies among unmarried females should be considered when shifting the target of family planning programs in Papua and West Papua.

The number of children wanted by families in Papua is one reason for the lack of appreciation for family planning programs. Therefore, there needs to be a new strategy to increase the involvement of the community towards family planning in Papua, in accordance with regulations on family planning, which is to increase community participation.

- **Family planning services**

Observations from the field show that the quality of family planning services is still low, which is indicated by inadequate family planning services at the puskesmas level. The limited number of midwives trained in providing long-term family planning contraceptives such as the implant and IUD leads to a low level of promotion of these two types of contraceptives.

The quality of counseling ability of midwives is also low as most midwives have not been trained in counseling. This affects the long-term use of contraceptives, where counseling is necessary to prevent a high

discontinuation rate in clients. Commitment from health personnel to continue promoting family planning to the community needs to be paid attention, because this can push for an increase in community trust towards modern contraceptive methods.

Guidelines on implementing family planning programs for medical personnel and family planning clinics at the national level are not usually available at puskesmas facilities and other services. Because of this, procedures adapted at such services are often as a result of practice, rather than of sufficient knowledge or based on guidelines that exist.

The unavailability of a set reporting mechanism leads to family planning services that are not always reliable and data on services that are not accurate. Therefore, plans for program development are often not appropriate to community needs.

Services for communities who cannot afford them and those in remote areas are affected by limited funds as well as health personnel available for such services. One indicator is that there are many communities in remote areas that do not have adequate access to information and family planning services. The availability of health services in a number of remote areas is not supported by the availability of adequate health personnel and sufficient contraceptives. This is the main reason for communities not referring to health centers for modern contraceptive methods.

7.2. Recommendations

- **Organization of Family planning services in Papua and West Papua**

To increase the quality of coordination among family planning agencies/bodies and the Dinas Kesehatan, there should be a working group or a management team at the district/city level. A routine coordination mechanism at the provincial and district level should be jointly developed and implemented consistently by all parties involved.

In terms of family planning institutions, there should be commitment between the provincial and government in family planning institution management, referring to government regulation 41. Implementation of this regulation should be complemented by competent human resources from the district level down to the district level. An increase in the number of personnel on the field should be a priority, as their need and availability can be used to push for an increase in quality of family planning services for the community.

Advocacy on the importance of family planning in increasing the quality and welfare of community health in Papua and West Papua should be increased. What this hopes to achieve is the integration of family planning programs into the local strategy development plan, leading to budget allocation for family planning and services at the district level.

The issue of distribution of contraceptives can be addressed by building the cooperation between family planning bodies/agencies and the Dinas Kesehatan, particularly at the district level for the storage of contraceptive supplies. Contraceptive supplies can be stored at storage units owned by the Dinas Kesehatan. This mechanism can assist the administration and distribution of supplies to service level, in this case puskesmas facilities. This mechanism should be complemented with the development of a reporting system provided both by the BKKBN and the Department of Health.

- **Community attitudes towards family planning and family planning services**

To increase the coverage of family planning in Papua and West Papua, there should be a mechanism that involves all bodies, starting from the policymakers at the provincial level down to the sub district level. Utilizing

the strength and influence of religious and community figures can be useful in shifting the existing paradigm on family planning that is developing within communities. Promotion of health planning services should be adapted to ways that can be accepted by the community in Papua and West Papua, keeping in mind the culture and norms that exist.

There should be IEC materials available that focuses on the culture and needs of the community in Papua. IEC materials that increase community awareness on the benefits of family planning should also be developed.

- **Family planning services**

Increasing the quality of health services can be done by improving the function of such services including the puskesmas, pustu, and polindes. An adequate supply of contraceptives should be supported with a systematic distribution mechanism. Written protocols for service provision should be developed, socialized and implemented. The availability of supplies at the puskesmas needs to be focused on by providing contraceptives that are not available. Program managers at the puskesmas should be equipped with logistic management skills so that they are able to forecast needs accurately and guarantee efficiency in reporting and avoid the possibility of stock outs. In addition, government commitment in supporting the distribution of contraceptive supplies should be encouraged and emphasized through advocacy activities.

The need for trained health personnel at family planning services can be estimated by mapping the numbers and identities of personnel that have been trained, the types of training provided, and the need for refresher training for those that have been trained. An effective in-service training mechanism should then be developed together with the Dinas Kesehatan and other family planning bodies to gradually increase the knowledge and skills of health personnel in responding to the family planning needs of the community. This should be followed by increasing the frequency of good quality training on IUDs, implants, and counseling.

To increase the quality of family planning services in health facilities or puskesmas, apart from increasing the frequency of trainings, there should also be a mechanism that ensures that guidelines on family planning services that have been published by the Department of Health and the BKKBN are accepted and provided by these services.

Keeping in mind the high HIV rate in Papua and West Papua, and the high incidence of premarital sex among adolescents, developing integrated family planning services with STI and HIV services, and ARH services, should be considered. Implementation of family planning as part of basic health services at the puskesmas should be structured and systematic so that family planning services receive the same attention as do other basic health services at the facilities.

To ensure the availability of contraceptive supplies according to the needs of the community, there should be increased cooperation between different sectors, including involving the private sector. The availability of contraceptives should not rely solely upon supplies at the BKKBN or other family planning agencies/bodies.

Keeping in mind the vastness of Papua and West Papua and the existence of a number of remote areas that are difficult to access, as well as the cultures and norms that exist within the provinces, a strategy and policy to guarantee the provision of family planning services for all communities in Papua and West Papua should be developed.

Family Planning Situation Analysis in Papua and West Papua

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