Revitalization of Family Planning in Indonesia

A Strategy for Empirically Based Implementation

National Family Planning Coordinating Board

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Principal contributors:

Gary L Lewis

and

Haripurnomo

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Foreword

The consultancy of Gary L. Lewis and Harry Purnomo provide objective inputs on the revitalization of the family planning program in Indonesia. It is part of a series of consultations intended to guide the process of change needed to re-strengthen the program. The series comprises three consultations. The first provided an assessment and analysis of strategic issues of the program by Terence H. Hull and Henry Mosley. The second framed the issues into an operational framework for the program was prepared by Muhadjir Darwin and Sukamdi. The third consultancy was to develop implementation strategies based on the first two consultancies to be used to stimulate the planning process for a revitalized program

This book contains the ideas of the consultants on strategies to address the empirically identified issues found by the first two consultancies These consultants analyzed, provided illustrative operational strategies required to implement the program family planning program of the future. The Government of Indonesia, in this case the BKKBN, appreciates the analysis and inputs of all the consultants.

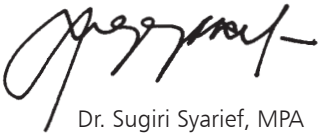
The three critical message to come out of this exercise are 1) despite past successes there are still serious population problems and issues with the reproductive health and family planning program; 2) there is a very large role to be played by the Government in addressing these critical issues , and 3) Changes in the vision, mission and organizations will be required to meet the challenges faced by the program and by Indonesian couples seeking healthier families.

BKKBN will seriously use these worthwhile recommendations to guide planning and implementation of a revitalized family planning program. The analysis and

recommendations, as far as suitable, will be integrated within the existing policy, program, and operation strategies. They will also be used to develop new initiatives that address the evolving nature of reproductive health and family planning in Indonesia.

As the chairperson of BKKBN I would like to express my gratitude to all parties participated in this consultation activity. I would also like to thank and give my appreciation to the consultants for their hard working and ideas. I am confident that this consultation will enrich the family planning program in the future. Thank you.

Jakarta, 2009



Dr. Sugiri Syarief, MPA
Chairperson of BKKBN

Abbreviation

Bappenas: *Badan Perencanaan Pembangunan Nasional, National Development Planning Agency.*

BAPPEDA Provinsi: *Badan Perencana Pembangunan Daerah Provinsi, Regional Development Planning Agency at Provincial Level.*

BAPPEDA Kabupaten/Kota: *Badan Perencana Pembangunan Daerah Kabupaten/Kota, Regional Development Planning Agency at District/Municipality Level.*

BKKBN: *Badan Koordinasi Keluarga Berencana Nasional, National Family Planning Coordinating Board.*

DEPKES: *Departemen Kesehatan, Ministry of Health.*

DPRD Provinsi: *Dewan Perwakilan Rakyat Daerah Provinsi, Provincial Regional House of Representatives.*

DPRD Kabupaten/Kota: *Dewan Perwakilan Rakyat Daerah Kabupaten/Kota, District/Municipality Regional House of Representatives.*

FS: *Female Sterilization.*

IBI: *Ikatan Bidan Indonesia, Indonesian Midwives Association.*

IEC: *Information Education and Communication.*

IDHS: *Indonesian Demographic and Health Survey.*

MS: *Male Sterilization.*

Menkokesra: *Menteri Koordinator Kesejahteraan Rakyat, Coordinating Ministry for People's Welfare.*

POGI: *Perhimpunan Obstetri dan Ginekologi Indonesia, Indonesian Association of Obstetrician-Gynecologists.*

RH/FP: *Reproductive Health/Family Planning.*

WHO: *World Health Organization.*

YKB: *Yayasan Kusuma Buana. Kusuma Buana Foundation*.

Contents

Introduction and Justification

This Report was commissioned by the Indonesian National Family Planning Coordinating Board (BKKBN) as the follow-on to exercises by Prof. Hull and Mosley[1], and another by Prof. Muhadjir Darwin and Sukamdi, MSc[2] to review the latest data and to identify future directions for the reproductive health and family planning program (RH/FP). The purpose of this report was to take the identified issues and suggest operational strategies for how the Government could contribute to addressing these continuing demographic, reproductive health, and family planning issues.

The empirically identified needs that justify continued support for RH/FP programs as described in Hull and Mosley's Revitalization of Family Planning in Indonesia are summarized below:

- Total Births - Every year there are 4.3 million births in Indonesia. While declines in fertility and increases in contraceptive use are real, the population crisis is also still real;
- The Expanding Base – the number of women needing RH/FP services will increase from the current 64 million to 68 million by the year 2015;

[1] *Terrance Hull and Henry Mosley, Revitalization of Family Planning in Indonesia. GOI and UNFPA, Jakarta, February 2009, http://www.itp-bkkbn.org/pulin/004_population_data_information.html*

[2] *Muhadjir, "Revitalization of Family Planning Program in Indonesia," Center for Population and Policy Studies, Gadjah Mada University, 2009.*

- Age appropriate family planning methods – an aging population of women should predict an increase in use of long term clinical methods, when their use is actually declining;
- Unmarried women - There are 24 million unmarried women of reproductive age. Eleven million of these are between the ages of 20 and 35 and most are likely to be at risk of an unwanted pregnancy. Their RH/FP needs are being ignored at considerable personal and social cost;
- The Private Sector and Quality - The shift to private sector providers and sources requires actions to address the supply and the demand for quality of care;
- A Changing Method Mix - The contraceptive method mix is loosing the diversity of methods that was the hallmark of the RH/FP program and an indication of freedom of choice;
- Contraceptive Use - Contraceptive prevalence rates appear to have plateaued and among uneducated women declined. The proportion of women with an unmet need for family planning has risen;
- Long-term Methods - There is a huge "unmet need" for long-term methods if age and parity are considered in method choice;
- Abortion - There is a huge social cost from unintended pregnancies and the associated abortions.
- Adolescents - Current monitoring systems do not adequately measure the RH/FP needs of adolescent women. So while estimates are difficult to make there is certainly a large and growing unmet need.

Darwin and Sukamdi also framed directions for the program and structure of future support for RH/FP programs.

- The failure to meet the targets for the Total Fertility Rate as laid out in the Mid-Term Development Plan 2004-2009

should be a policy and program concern to the national Government;

- A future priority for the national program should be RH/FP services to the poor; [3]
- The principles of reproductive rights, as articulated in the ICPD the Millennium Development Goals (MDGs), should be an important part of the framework for the activities of the Government and the structure of the organization implementing government policy; [4]
- The Population Law (Law 10/1992) is out of date, unclear or ambiguous, and in conflict with others laws (ex. decentralization) and should be revised;
- Decentralization has changed the functions of government organizations involved in RH/FP, without rationalizing the structures to address the new functions. Since decentralization is continuing this restructuring is essential, and should clearly articulate the structure, roles, and responsibilities at the national, provincial, and district/municipality levels;
- The Government needs to "create synergistic relationships among institutions" to achieve its RH/FP mission;
- A demand creation program should be used to address opposition to family planning especially focusing on addressing the "anti-natalist discourse"

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[3] *The authors base this priority on cost – "government's lack of ability to provide cheap family planning services." While the priority is appropriate, their interpretation of why it is needed is not supported by the data. A small percentage of the poor say cost or access causes their non-use. Multi variant analysis found desire for larger families explained difference in contraceptive use. For a more detailed discussion of this issue see the Equity Strategy.*

[4] *Darwin and Sukamdi discuss articulately the issues of human rights, individual rights and the responsibilities of the Government to protect these rights. This discussions, however, seems out of date in a program where: the vast majority of users get and pay for family planning in the private sector, method knowledge is virtually universal, freedom of choice in methods has resulted in a skewed method mix, and access and cost are reported as an insignificant constraint to use. Perhaps the Government's role should focus on consumer rights and protections. It is also worth noting that the Indonesian RH/FP program is almost unique in having to reconsider the was it protects reproductive rights because of the way the service delivery structure has matured.*

- To avoid territorial disputes BKKBN should "avert the family welfare program"
- The Government should operate as a "trail blazer" role to precipitate change;
- The Government should revive its "core competencies"

Using the two data reviews, the Indonesian Demographic and Health Surveys, field visits, and interviews with various experts and stakeholders, the team of Gary Lewis and Silvester Haripurnomo have prepared this report to provide strategies and activities that will help the Government address continuing issues. The Revitalization Strategy: focuses resources on specific addressable problems, redefines the role of the Government in the context of decentralization, and recognizes that Indonesia's family planning program is a private sector program that the Government should play a supporting and facilitating role.

In using this report certain principles guided the final product.

- This report focuses on existing and future RH/FP issues, while recognizing the advantage and opportunities created by the past success of government leadership and support;
- This report uses the term RH/FP Program to broadly describe the structure that allows couples to improve their reproductive health through the use of family planning, regardless of the source, the method, the cost or the location of service. The Program is not a specific institution, agency, or sector, but is the intersection of all of them;

- For the Government to play a strategic role in addressing Indonesia's Family Planning issues, it will require: strategic interventions, policy changes, and considerable change in the structures, approaches and vision of the Government, and to an unknown degree - additional human and financial resources.

One question that should be answered early is there any reason for the Government to support an RH/FP program or a unique organization in the Government that's primary focus is RH/FP. Consider a few of the arguments and counter-arguments.

Indonesia's RH/FP program is private sector driven. The shift to a private sector family planning program has resulted in better prices, easier access, more product and provider choices for consumers, and freed up government resources to address other health issues. The problem is that family planning in Indonesia is now subject to the risk of the open market: changes in the competitive environment can effect prices, availability and quality; the virtually unregulated market can not ensure quality of care; there is little stimulus to innovate; changes in government business regulations can inadvertently cause private sector players to withdraw from the provision of RH/FP services or products; and coverage may vary if there is no incentive to serve small or poor market areas. The private sector would benefit from continued support for expansion, oversight systems to ensure quality, and monitoring and support to ensure market stability.

RH/FP is widely accepted and much used, so government support is no longer needed.

- While widely supported, RH/FP is still an issue with political and religious sensitivities. Social or political instability could result in a loss of political support that could

create conflict and opportunities for misinformation and mistrust;

- Decentralization has shown that national priorities are often not local political priorities, so continued support is necessary to ensure that local governments continue to protect the reproductive health of all couples. Slight increases in fertility, suggest the mixed messages of decentralization and lack of national government leadership have already started to erode the social and economic benefits of past successes;
- There are new cohorts of women coming into their reproductive ages that have a positive attitude towards RH/FP services, but are less well informed than their mothers.

By most international standards, Indonesian has a mature RH/FP program that needs less government involvement or a large bureaucracy.

- Policy support for family planning is still high, but changes over the last ten years in government structures and budgeting, and the instability created by decentralization has resulted in the marginalization of government structures that provided operational support for RH/FP. The needs for focused interventions, and the Government's role in protecting public welfare through its regulatory functions requires a focused organizational response;
- The RH/FP program may be mature, but as the Hull & Mosley and Darwin & Sukamdi papers clearly illustrate there are several large programmatic and demographic holes in the RH/FP program that clearly suggest that the label of mature is still premature in selected areas. And it is these areas that need the strength and commitment of Government resources and focus;

- RH/FP programs are still the most cost effective and easiest to implement socioeconomic interventions.

Given the magnitude of health problems in Indonesia RH/FP is no longer the best investment for improving the quality of life for all Indonesians. Past success and the impressive trends in contraceptive use and fertility decline have lead to some complacency in Indonesia and in the international community. And yet, Indonesia is probably closer to a population related crisis than it was in the 1970s. With the world's fourth largest population, huge urban growth, and some of the most densely populated areas in the world, Indonesia: is already a frontline nation in new infectious diseases, has an environmental crisis with regional impacts, suffers a huge human tragedy with every natural disaster, and risks collapse of civil society from sectarian conflicts. All or any of these problems could destroy the hard won social and economic successes of Indonesia, and all of them are related to population.

There are, of course, other arguments, but in the end the Government has: an obligation to the people to play a role in a critical health issue; the skills and structures to have a substantial impact; and a pressing need for continued and focused involvement. If further confirmation of the Team's position on this argument is needed, a review of the following strategies and activities should persuade anyone of the need and the potential for the Government to contribute to the RH/FP program of Indonesia.

Strategies and Activities for the Revitalization: the Government Role in RH/FP Program

The mandate of this exercise and the resulting paper is to identify strategies that would help the Government address the RH/FP needs of all Indonesian couples, and provide illustrative activities that could be implemented in support of these strategies. This chapter lays out the eight strategies and associated activities that were distilled from the data review. In considering these strategies the reader should consider:

- The strategies presented are based on the empirically identified issues, supported by other documents, interviews with reproductive stakeholders, and field visits;
- The strategies are overlapping and mutually reinforcing;
- The key strategies that have the most overlap are Private Sector, Decentralization and Communication. These three, if implemented, will have the greatest impact on the reproductive health of all Indonesian couples and the social and economic development of Indonesia;
- The illustrative activities are based on an established empirical need, technical feasibility, and clear impacts on reproductive health, contraceptive use, reproductive rights, and the health and wellbeing of Indonesian families;

- The strategies are specific to the Government's core role in RH/FP. While the agencies involved have had broader roles (ex. poverty alleviation, data collection, etc.), these roles are not considered in this strategy;
- The activities proposed are as comprehensive as the Team could make them, but there is still considerable room for innovation and experimentation;
- All strategies and activities do not have to start at once, nor do all activities have to be included in the final strategies. The final strategy and the timing of implementation can be influenced by financial resources, human resources, policy considerations, and the interests of the Government;
- The primary sources for empirical data for this paper were the Indonesian Demographic and Health Survey – 2007 [5] and preceding surveys. Rather than repeated footnotes the authors identify its source in the text as often as possible. All other data sources are footnoted at the point of use;
- The opinions and interpretations of in this paper are the responsibility of the authors and do not necessarily reflect the policies or opinions of the BKKBN, the Asia Development Bank, or the Government of Indonesia. Any errors in fact, interpretation, or sources are clearly the fault of the authors and not due to the able support of the organizations involved.

[5] *Statistics Indonesia (BPS) and Macro International. 2008. Indonesia Demographic and Health Survey -2007. Calverton Maryland USA.*

Strategy to support the role of the private sector in RH/FP

Mission Statement

Revitalization will collaborate with the private sector (commercial and NGO) to maximize the access to high quality, low cost, RH/FP services, while protecting the client's right of choice.

Issue

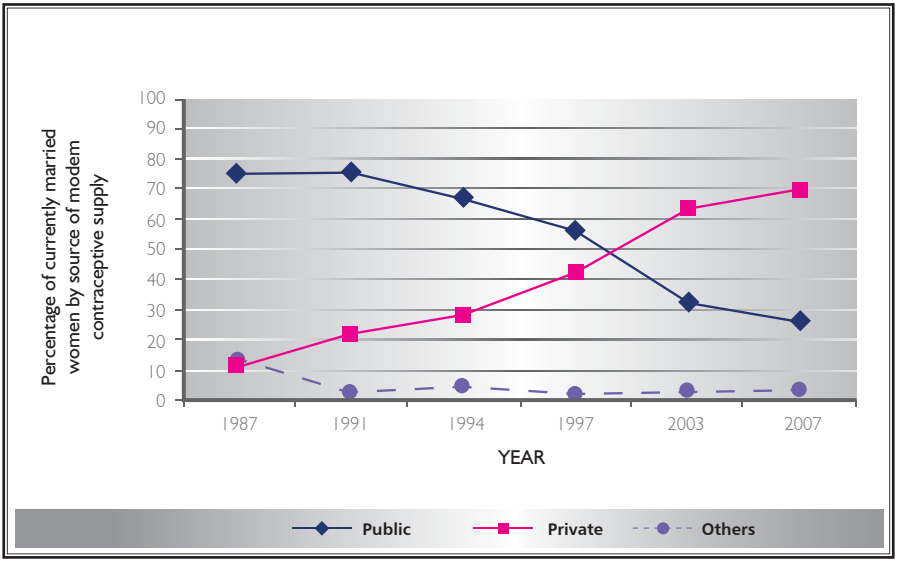
Currently, 72% of current users get services or supplies from the private sector. The expanded role of private providers NGOs and local producers has occurred with almost no recognition from the Government. This will have to change if the Government is to play a continuing role in RH/FP.

Background

Family planning became a national issue and priority in the 1970s. With strong political support, an ever increasing budget, and support from the international donor community, the government program succeeded in making family planning a social norm and a common practice. These achievements used a "top-down" approach with local implementation by government workers and volunteers. In the 1980s the Government added a private sector approach by introducing the Blue Circle - a branding and promotion of private sector fee-based RH/FP providers. This was followed by KB Mandiri – a self reliance program to encourage family planning users to use unsubsidized services and supplies. In the late 1980s, the Government through BKKBN began shifting contraceptive procurement to local producers. Local production continued to grow as both international and

domestic producers entered the huge Indonesian market. This has resulted in very low prices, widespread distribution and the continued growth of Indonesia's private sector RH/FP program.

Trends in Percentage of User Procuring Their Methods by source



Note: Posyandu and Pos KB desa are shown as "public" in this graph, though they are categorized as "other private" in DHS survey coding.

A benchmark event occurred in 1998 when the majority of users were receiving services or supplies from private sector providers. The subsidized public sector program that defined

[6] *Source: Contraceptive Prevalence Survey, 1987 and Demographic and Health Surveys, 1991, 1994, 1997, 2002-3, 2007.*

RH/FP in Indonesia became a secondary player in the larger Indonesian RH/FP program. This trend continues today. Currently, 72% of current users get services or supplies from the private sector. The two most important contractive methods in Indonesia are Pills and Injectables (73% of current users). About 63% of pill users and 80% of Injectable users are served in the private sector. Cost for contraceptives provides a metric for why the private sector has and will continue to grow – Pills and Injectables cost almost the same thing regardless of where you get the method. Average pill cost is Rp. 6,000/US$.60 in the public sector and Rp. 7,000 in the private sector. Average injectable cost is Rp. 13,000/US$1.30 in the public sector and Rp. 14,000 in the private sector. For clinical methods, the private sector is three times as expensive as the public sector, and yet about 32% of female sterilization users report their source of service to be the private sector. If cost is no longer a major consideration in choosing a source of services, greater convenience and better quality of care will favor private sector services, and the public sector role in delivering RH/FP will continue to decline.

The public sector's often stated role is the provision of family planning services to the poor. And yet the IDHS-07 reports, 92% of contraceptive users pay for services or supplies. Even the methods subsidized by the Government through BKKBN are paid for: 95.4% of Pill users paid, 97% of Injectable users paid, and 90% of condom users paid. Clearly Government subsidies are not reaching the poor or anyone else.

Since the Indonesian family planning program is now unsubsidized and private sector driven, and since family

planning is a national priority, the logical question is **what is the role of the Government in supporting private sector family planning program?** After its early support, the Government currently plays no regulatory, monitoring, or supportive role to the family planning services used by the vast majority Indonesian couples. The lack of support for the private sector appears to be a management decision, and is not based on the need for support, the lack of precedent for support, or the critical impacts that support would provide to Indonesian couples seeking an improved quality of life by planning their families.

The question – **what is the relationship between local governments and private sector?** – is just as important. With RH/FP services shifting to the private sector and decentralization shifting responsibility for service delivery and supplies to district governments, how can decentralization and private sector converge to ensure safe, effective, convenient, affordable, high quality RH/FP service delivery? The districts' responses can range from: ignore the private sector and focus on public sector delivery and community outreach, to active engagement and partnership. Obviously the latter is the most desirable. The Government should be stimulating dialog and helping the districts identify opportunities for collaboration by all RH/FP stakeholders in the district.

Strategy

The current effort to revitalize the Government's role in the national family planning program should recognize the Government's traditional and continuing need to partner with the private sector. This strategy is intended to support: the continued expansion of the private sector, while maintaining the traditional oversight responsibilities to protect the public

wellbeing. In order to ensure efficacy, efficiency, and consumer confidence the Government should have as a major priority the expansion, improved quality of care, and sustainability of the private sector RH/FP program.

Expanding the Role of the Pharmaceutical Industry in Providing Contraceptive Commodities

Indonesia has benefited from a growing capacity for local production of pharmaceuticals. Currently, oral pills, condoms, injectables, implants and IUDs are produced in Indonesia. As a result of the large capacity and competition, commodities are widely available and reasonably priced for the huge local market. Continued growth in this sector is good for the Indonesian health sector and should be supported. Activities that would support a positive and ongoing collaboration with the pharmaceutical industry could include:

- Quality monitoring and testing – currently pharmaceutical are tested when they are registered. Over time raw material sourcing changes; manufacturing processes and equipment change; and packaging can change. The Government should do random checks of Pills, Injectables and implants and compare them to the standards registered and approved and/or to the international manufacturing standards specified by WHO. Monitoring counterfeiting of contraceptives should also be a regular activity. Counterfeit pharmaceuticals are not a problem for RH/FP because the low retail cost of contraceptives (Pills and Injectables) makes it unprofitable. There is, however, counterfeiting of brand labels. Lower cost pill packs have the brand label covered with a fake brand label of a higher priced pill pack. Since the lower cost

pills are effective contraceptives method failures are unlikely, but there is a risk of loss of consumer confidence in the contraceptives, and increased discontinuation due to clients experiencing different side effects. Quality monitoring should be part of the ongoing quality control efforts of the Government. Specific activities would include: setting policy, establishing legal sanctions, setting up operational guidelines, and building the organizational structure for effective monitoring and enforcement;

- *Jamu* (traditional herbal medicines) registration and consumer protection – Currently DepKes/BPOM registers *Jamu* made for commercial sale (but not the homemade products sold door-to-door by the iconic *Jamu* ladies). Registration legitimizes these products despite their questionable quality of production and their untested claims of medical effectiveness. *Jamu* for contraception delays the use of modern methods. *Jamu* for pregnancy termination can delay seeking medical help and, and may have side-effects on the woman and or the pregnancy. The Government should reexamine its policies of registration, require better labeling, monitor manufacturing, and increase laboratory capacity to test products for quality and the claimed medical effectiveness. It should also do a public education campaign on the uses of *Jamu*, the modern alternatives, reading the labels, and possible side effects;

- Communication for informed choice, motivation, and effective use – A common theme in all RH/FP programs around the world is that the pharmaceutical firms are poor at communicating detailed information to the consumers of their products. The distribution chain is too long for information to flow effectively. Governments address

this through regulation (package inserts, side effects warnings in advertizing, etc.), and through government sponsored communication campaigns using mass media, health workers, community events, mobile media vans, and any other channel that can reach consumers with more detailed information. The IDHS has measured a number of indicators on the quality of information transfer to users, and found disturbing results. It is clear that the Government needs to play a much larger role in communication, regardless of the method used, the source of the method, or the characteristics of the client. Communication issues are more fully described in the Communication Strategy;

- Support for innovation – Competition and the market tend to drive innovation in the private sector. The Government should have a role in promoting innovation, facilitating entry into the market, and speeding up its adoptions. Likewise, the Government can also help reduce the waste of time and resources caused by "innovations" that are not value added to the family planning program. Innovations might include: new drug formulations, new delivery systems (ex. auto-lock syringes), new products (ex. Emergency Contraception, more efficient sterilizers), new packaging, and better product job aids for providers. The role of the Government should: facilitate registration of new drugs or devices, promote innovations in communication activities to create public awareness, socialize innovations to health providers through ongoing training activities and/or special campaigns, and possibly subsidize rapid adoption of innovations that have unique benefits to consumers. To facilitate innovation, the Government must build a positive collaboration and open communication with the pharmaceutical companies. Because innovation can bring a market advantage in a

competitive environment, the Government must: be seen as fair and supportive of all firms, avoid politics, and provide valued resources to ensure the participation of the private sector. Playing this role will ensure that Indonesian consumers have the best and most cost effective RH/FP products available;

- Cooperation in marketing branded family planning products – If the Government is to have a role in family planning it must build a cooperative relationship with the private sector. One way is to help market private sector products without favoring one producer or brand. The Government has a history of doing this with its "Blue Lady" and "Blue Circle" campaigns. Promotional activities could include: facilitating the distribution of brand specific client- educational materials through health facilities and by field workers; including the names of partnering firms and brands in government-produced IEC materials; and special media events involving private sector partners;
- Facilitate local government procurement of health commodities – Under decentralization, drug procurement is the responsibility of district governments, guided by the Essential Drugs Guidelines. To date DepKes has and BKKBN has not supported this transfer of responsibility. As mentioned earlier, the Government through BKKBN procures and distributes contraceptive products down to the districts. Central commodity procurement is scheduled to end next year and should end; the commodities procured are so cheap that they do not need to be subsidized and they are not subsidized by the time the reach the client; there are major infrastructure costs for warehousing, transport and staff that duplicate the Essential Drugs Program; and clinical methods that would benefit from a subsidy are not adequately subsidized. Districts may choose to subsidize these products with their health budget to support the poor,

serve marginalized population, or to encourage new users. Facilitating direct communication between districts and the pharmaceutical producers with an annual "catalog," - timed to government budget cycles, with product listings, prices based on volume, ordering lead times, and contact information - has several benefits.

- ✓ Pricing can be annually negotiated at a national level and published for use by local governments and NGOs;
- ✓ Competition between pharmaceutical firms and suppliers would ensure low prices;
- ✓ Publication would reduce corruption;
- ✓ Districts could procure based on local brand preferences;
- ✓ Delivery schedules could be negotiated to reduce storage and transport costs;
- ✓ The districts would be complying with the Essential Drug Guidelines and reduce commodity management costs;
- ✓ Districts could develop contraceptive security strategies that best address their specific situation and resources;[8]
- ✓ Quality of products and service (timely delivery, provision of provider and client IEC materials, etc.) could be ensured by exclusion of companies that fail to provide quality products and service;
- ✓ Pharmaceutical firms would be able to develop marketing/detailing structures for dealing with districts;

[8] *BKKBN already has the technical capacity and tools to help districts do contraceptive security assessments and strategies. See Thompson, Daniel. September 2002. Training Module A Guide to Managing Contraceptive Supplies. STARH, Johns Hopkins University, Jakarta & JSI. (English and Bahasa) and Thompson, Daniel. Instrumen Perencanaan Kabupaten/Kota untuk Jaminan Ketersediaan Kontrasepsi (Contraceptive Security District Planning Tool Kit). STARH Program, Johns Hopkins University, Jakarta. (Bahasa)*

- ✓ Pharmaceutical firms would expand their marketing and support (detailing) to private health providers in districts where there is local procurement;
- ✓ Pharmaceutical firms would see the Government as a partner in developing a fair and competitive market place.

- Expand geographic coverage – pharmaceutical producers have representatives or detailers in many areas, but other areas are served by informal distributers or are uncovered. The Government should work with the firms on a mapping exercise, identify underserved areas, and support representation by at least one of the firms. Ideally, the Government might also do the mapping and overlap populations and numbers of representatives to identify areas that would benefit from additional representatives;
- Provide consumers with price choices – The Government should monitor market availability and price to ensure consumers at every economic level have access in the private sector to contraceptive supplies. This monitoring could be done in partnership with the Indonesian Pharmacist Association and local governments. If a gap is found, negotiations could be held to produce a product that fills the price gap. Currently there is a full range of prices on pills and condoms produced in Indonesia. IDHS-07 reports that 2.5% of women and 1% of men reported cost as a reason for non-use of contraception. What may be more problematic is guaranteeing a full price range is in all areas of the country. The strength of the private sector family planning program and the past successes of the government program have resulted in wide availability and reasonably priced commodities, so pricing issues is not a major priority, but the issues should be part of the Government's ongoing efforts at consumer protection.

Expand the Role of Private Sector Employers that Provide RH/FP Services

There are a large number of industrial employers that provide health services or insurance to their employees. In many cases these employees are women and can get RH/FP services from onsite clinics or contracted health providers. The Government has had pilot projects and donor-driven activities in the past, but currently there is little support for these programs. These employers are supporting the national interest by providing RH/FP services, and the Government can and should support them.

- Inventory of firms – The Government should prepare an inventory of firms with a large numbers of employees and the health services they offer. This inventory provides a roadmap for the provision of support;
- Quality assurance – The Government could provide periodic assessment and recommendations on the quality of care provided, and compliance with National Service Delivery Guidelines;
- Access to Resources – The Government should provide access to the same materials, job aids, guidelines, IEC materials and training that are available to public sector facilities and NGOs;
- Referrals – The Government can help the employers set up a referral network to help with problem cases or provide specialized services;
- Establishing RH/FP services – The Government should provide the technical support for set up, initial demand creation, and education activities for employees to expand job based RH/FP services;
- Recognition – The Government should recognize the contribution of these firms to the nation's reproductive health.

Expand the Role of NGOs in Providing RH/FP Services

In a number of countries the national RH/FP program is implemented by NGOs with funding from the government (ex. PROFAMILIA in Colombia). There are a number of Indonesian NGOs – large, small, religious, national, local, women's – that provide RH/FP services or related support. These groups often serve marginalized populations and work in underserved areas. Some of these groups also add to the resources available for RH/FP programs by generating international support. These groups provide an essential health service, but get little or no support from the Government.[9] The Government should recognize the NGOs as partners, and develop the trust necessary for a supportive and collaborative relationship. There are a number of ways the Government can implement a positive and collaborative relationship with health NGOs.

- Provide flexible development grants to the NGOs (ex. to strengthen management, to buy technical support, to expand services, to promote facilities);
- Provide access to Government sponsored training and other capacity building activities;
- Facilitate expansion of coverage with grants, joint planning, and coordination with local governments;
- Include promotion of NGO activities and services in the Government communication activities;
- Monitor and provide assistance to improve the quality of care in NGO clinics;
- Provide the same materials, job aids, guidelines, and IEC materials that are available to public sector facilities;

[9] *One of the best examples of an NGO that is providing unique and valuable services is the Indonesian Midwives Association (IBI). IBI runs a RH/FP quality certification program for private-practice midwives. Bidan Delima currently operates in 15 provinces and has 8,000 certified midwives. Neither DepKes nor BKKBN provide support to Bidan Delima, despite their shared agenda of improved reproductive health for Indonesian couples*

- Provide special incentives to NGOs that serve underserved populations;
- Support program evaluation so NGO lessons learned are available to guide all RH/FP activities.

Expand the Role and Improve the Quality of Private Practitioners Providing RH/FP Services (doctors and midwives)

Private practice providers are already a significant part of the Indonesian RH/FP program – especially midwives who are the source of services for 48% of current users of modern methods (IDHS-07). It is very likely the absolute numbers of private providers will grow and that they will take a larger share of the RH/FP services. There are several reasons for this growth: the number of midwifery schools has tripled in the last three years; purchasing health care has high social value for Indonesians; the expanding cash economy allows more families to buy health care; health insurance coverage is increasing; and finally, public sector health care is more and more associated with and targeted to the poor. The operational question is how can the national Government fulfill its responsibilities in: setting policy and standards, ensuring compliance and quality of care, coordination, research, supporting social equity, supporting innovation, and in building capacity with a large and critical group of RH/FP providers? The answer is for the Government to: make the private sector and specifically private practioners and more specifically midwives a priority, set up an operational unit dedicated to implementing support, build partnerships that provide access and credibility to private practioners, and to develop a long term strategy for the partnership between Government and private practice RH/FP providers.

Outlined below are some activities that could play a role in the strategy.

- The Government should develop an ongoing program with the health professional associations to channel information on: innovations, problems, quality-of-care issues, training opportunities, new regulations and guidelines and changing priorities to their membership. For example, financial and technical support can be provided to help organizations set up and maintain membership databases and internet sites that would allow more rapid communication with members;
- The Government should set up operating agreements that would facilitate use of the professional organizations as a technical resource for the Government. The professional organizations could set up a consulting pool (like JNPK – the Clinical Training Network) that could do training, field assessments, quality reviews, project design, evaluations, and planning exercises. The consultants would augment Government staff and could provide technical support to local government, and NGOs;
- It is in the interest of the Government to improve the skills of the private practice RH/FP providers, especially midwives. The Government should support a continuing education program for midwives. Currently training is offered on an ad hoc basis and rarely at the scale required to address the capacity-building needs of the 60,000 village midwives and thousands of other private practice midwives who have been in their villages for ten or more years. The courses could be implemented and managed by a consortium between IBI, universities, clinical training groups and the Government. Course content could include: counseling, contraceptive technology updates, infection prevention (possibly linked to current concerns around the spread of infectious diseases like avian influenza), marketing and small-business management skills, applied skills like IUD

insertion or removal of implants, safe delivery practices, and neonatal care. This activity is not a small undertaking and should be permanently institutionalized because the numbers are large enough and RH/FP technology and systems are changing enough so that the need will continue indefinitely. Government midwives also need the update training, so the system when operating might benefit all midwives. Also experience suggests that midwives want new and updated skills and many are willing to contribute to the cost of training;

- The Government should provide the same materials, job aids, guidelines, IEC materials that are available to public sector facilities;
- The National Communication Strategy should also be used to support private providers. The Strategy can do this by encouraging KB Mandiri (user self reliance), educating clients to expect quality services from private providers, promoting informed choice, and reducing fear of side effects;
- As part of its mandate, the Government should begin setting up district-level mechanisms for monitoring the role of private providers in ensuring quality and access. The district office would: do quality spot checks, run periodic surveys, take consumer complaints, participate in licensing decisions, and investigate the cause of method failures and maternal mortalities. Some of the data would be reported to Jakarta to identify common problems, trends in quality, and issues needing an active response (ex. retraining, job aids, commodities, policy changes, changes in district priorities and budgeting, etc.) Local affiliates of the professional organizations might also be partners in the quality assurance exercises.

Expanded Involvement with Pharmacies and the Pharmacist Association (level-4). Pharmacies are widespread and often visited by RH/FP clients using resupply methods. They are also the major source of condoms (71% of users from IDHS-07). Possible collaborations for the Government could include:

- Use of pharmacies to distribute client education materials
- District Governments using their licensing authority to ensure that pharmacies carry contraceptives, and that new pharmacies are located in underserved sub-districts.

Strategy for Technical Support for Decentralization

Mission Statement

Revitalization will require the structure and resources at the national and provincial levels to provide technical support to districts to: establish programs, set priorities, introduce innovations, allocate resources, identify problems, and generate the political will for continued support for quality RH/FP services.

Issue

Decentralization has given District Governments responsibility, authority, and funding for RH/FP. Districts vary in the ability to address this "Essential Service." It is especially problematic for new district, poorer districts and districts that did not have strong programs in 2003. A major role of the Government should be to support local governments to provide essential services, implement national policy, and ensure equal access to all essential services.

Passing a decentralization law giving authority to local Governments is easy. It is much harder and may take years for local governments to be able to administer and govern their new responsibilities. This difficult process has been made more difficult in Indonesia by the formation of new districts and provinces, the lack of a intermediate authority (provinces), the lack of limits or oversight authority in the law, and the large number of districts (490+). The large number of districts is problematic because it makes oversight difficult, divides scarce management resources, makes priority-setting a local political issue, and allows a wide variety of tested and untested strategies for achieving objectives.

These problems are recognized[10] and some are being addressed through regulatory change and some are being addressed through ad hoc technical support. If national RH/FP policies, funding, and mandated services are to be addressed by districts a more organized response is required. There needs to be a formalized and funded technical support team to ensure the continuing implementation and impacts of national RH/FP policy on maternal mortality, women's status, woman and child health and reproductive rights.

Some issues and problems need ongoing monitoring and support. Current Government support is ad hoc, has no regularized activities and has no organizational structure specifically to manage support to the districts. The Government should be proactive in monitoring, identifying problems, informing districts of common problems and possible solutions. Another problem is that in most districts need help in recognizing and cooperating with the private sector RH/FP program. The Government needs to help districts develop a strategic collaboration with the private sector – something that it has not done itself. These kinds of problems are why revitalization and the associated changes in function and mindset are critical if the Government is to have a continuing role in RH/FP.

Strategy

Technical support for the decentralization of RH/FP (and other social services) is the most direct way for the Government to address the needs of the people of Indonesia. It is a huge job requiring expertise, political support, resources, good communication, and a structure with approaches the districts can understand and access. Perhaps the best metaphor is a

[10] *World Bank, Investing in Indonesia's Health: Challenges and Opportunities for Future Public Spending*

fire station – always open, always ready to help, and reactive and proactive in protecting the public. In a revitalized RH/FP program the Government would have a large staff, and funding to address the technical support needs of all local governments. Suggestions on the structure and functions of a national technical support capacity in RH/FP follow.

- Develop an organizational structure (Echelon 1 or 2) staffed and funded to provide support, monitor problems, develop tools to aid local management, and to report to national level officials on the status of national RH/FP policies as being implemented at local level;
- Do a large-scale assessment of technical issues being faced by districts to help set technical priorities (ex. issues could include budgeting, private sector, quality of care, advocacy, community involvement, staffing, logistical problems, difficult communities, etc.);
- Develop a core staff of technical specialists and consultants to address general and specific issues - strategic planning, coordination, budgeting/financing, advocacy, communication, quality of care, monitoring, evaluation, partnering, etc;
- Develop management systems for technical assistance (travel, field logistics, communication, reporting, supervision, consultant contracting, etc.);
- Identify consultants from NGOs, universities and other districts to augment government staff;
- Develop a communication network to facilitate: requests for support, transmission of data and reports, inter-district communication, distribution of problem alerts, notices of opportunities for training, etc;
- Develop partnerships with national organizations (IBI, POGI, Muslimat, YKB, etc.) that have local networks to facilitate communication and to provide technical support to their local implementing agencies;

- Develop capacity of provincial RH/FP offices to provide assistance, identify problems and needs for technical assistance, and to coordinate assistance for efficiency (ex. several districts with same issues addressed collectively);
- Set priorities for allocating technical support (ex. new districts, low prevalence provinces and districts, districts with little political support for RH/FP districts with a serious problem, etc.);
- Promote technical assistance to provinces and districts;
- Document problems and solutions, and disseminate as lessons learned;
- Provide regular reports on RH/FP problems and issues to: districts, provinces, NGOs, and national agencies (DPR, the President, DepKes, Menkokesra, Bappenas, etc.).

The National Communication Strategy

Mission Statement

Revitalization of the Government's traditional role in communication will: 1) support the other strategies; 2) communicate the Government's continuing commitment to RH/FP to the general public and to the decision makers in local government; 3) protect reproductive rights as defined by an individual's ability to make an informed choice about family size, contraceptive use, and the source of services.; and to fulfill its role in public education, protecting the public welfare, and improving the quality of life of all Indonesians.

Issue

The Indonesian RH/FP program was built on strong behavior-change communication campaigns that resulted in destigmatizing family planning, promoting contraceptive use, changing family size desires, and making RH/FP a personal responsibility that lead to the shift to private sector providers. Over the last ten years, this critical and unique function of government has been neglected. By using existing government technical capacity, existing data to define messages and desired impacts, and contracting private sector sources for sophisticated market analysis, design, production, and media placement the Government to could initiate communication activities quickly.

Background

The current RH/FP Program is not the same program it was ten or even five years ago, and the role of communication has to change. The messages have to be more focused than the broad messages of the past. The channels of communication are more varied and expensive. There are new audiences

(ex. local officials[11], parliamentarians, private sector clients). There are new behaviors that need to be addressed (ex. method choice, high-risk pregnancies). Joint planning with all stakeholders is needed to ensure consistent messages, maximum reach, and clear behavioral outcomes. Only the Government has the strategic vision, the credibility, the mandate, the commitment to public wellbeing, the national focus, and the ability to bring several stakeholders together to develop the unified approach that is essential to a revitalized National Communication Strategy.

Like all strategies proposed in this document, the role of the Communication Strategy in public information and education is strongly justified by the most recent IDHS-07.

- About 85% of currently married women are exposed to the mass media every week, and 80% of women are exposed to television. Even among the poorest (59%), least educated (51%), and rural (80%) women media exposure was high. Clearly, any government agency must be active in using the mass media if it is responsible for increasing public awareness;
- Knowledge of a contraceptive method is virtually universal among currently married women (99%) and men (95%), and approval of contraception among women is 95%. Knowledge is high and attitudes positive towards RH/FP. Consequently, messages will have to be more focused in content (ex. specific methods, countering misinformation, effective use, method options) and targeted to specific audiences to have an impact on knowledge, attitudes and practices;

[11] *Another audience for the Communication Strategy is decision makers in local governments. They consume and are influenced by mass media. They also know their communities are influenced by mass media. So a good communication program can inform the public, inform local officials, create the political support for activities, and increase support for RH/FP services. Direct advocacy to local governments is also part of a larger Communication Strategy, but is included in the Decentralization Strategy.*

- Nine out of ten women who were not using contraception and had contact with a health provider in the previous year did not discuss RH/FP issues. Clearly this is a missed opportunity for the transfer of information essential for informed RH/FP choices. The Government needs to improve the communication skills of all health providers and use mass media to empower clients to seek complete information from providers;
- IDHS-07 found "…knowledge of the reproductive cycle is generally limited even among couples claiming to use the Rhythm method. There is still a significant need for educating women and men about the mechanisms of reproduction";
- Among women using the pill, 14% were not taking it properly (in order or everyday). For women using the one-month Injectable, 19% had not had an injection in the last 30 days. For users of the three-month Injectable, only 4% were not on schedule;
- Side effects and health concerns were given as the reason for discontinuing contraceptive use by 29% of discontinuers (For segments of use in the last five years). Better information on side-effects and motivation could reduce this rate.

The above data clearly indicate there is a need for greater public awareness of methods, side-effects, misinformation, and proper use. There also needs to be greater awareness of risk factors from additional pregnancies (see High Risk Strategy) and appropriate method choice (See Method Mix Strategy) for RH/FP clients to make informed choices.

Strategy

The National Communication Strategy is critical component of a national RH/FP program, regardless of future revitalization efforts. A discussion of the roles of a communication

strategy only makes sense in the context of messages, audiences, behaviors, and channels. So for this paper the illustrative activities of National Communication Strategy will be presented in the context of each of the Revitalization Strategies.

Quality Strategy

Some objectives of this strategy will be achieved by increasing the supply and demand for quality RH/FP care. The supply activities are addressed in Capacity Building, Method Mix, and Decentralization Strategies, so the emphasis here will be on **demand-generation** for quality RH/FP care. The audience for quality messages will be women seeking health services, public and private health providers, and local government health officials. The messages would cover basic quality behaviors that clients can observe and expect (hand washing, follow-up, explanation of possible side effects, information on other appropriate methods available). They would also be intended to empower clients to ask for services and information, and act if they felt they were not getting good service. The channels of communication would be: mass media, field workers and volunteers, public and private providers, facility handouts and posters, and events.

High Risk Strategy

The objectives of this strategy will be achieved through effective communication activities linked to a proactive service delivery program (specificcly increased access to long

term methods). Audiences include: women, their partners and family, public and private health providers (including providers of other health services who can screen and refer), policy makers, and NGOs providing health services. Messages could include: individual risk factors, cumulative effects of multiple risk factors, where to go for additional information and services, roles for partners and family, demand creation for information and services, and use of prenatal care and attended delivery for high risk pregnancies. Channels of communication include: mass media, family planning field workers and volunteers, public and private providers, client handouts, clinic and pharmacy posters, and medical curriculums (see Capacity Building Strategy).

Method Mix Strategy

The objectives of this strategy will be achieved through an effective service delivery program linked to strong communication activities. Audiences include: women, public and private health providers, policy makers, pharmaceutical companies, and NGOs. Messages could include: right to choose a method, how to make informed choices, profiles of healthy method choices, where to go for additional information and services, cost issues, relative effectiveness issues, and demand creation for more effective methods. Channels of communication include: print media to provide more complex information, other mass media, public and private providers, client handouts, clinic and pharmacy posters, field workers and volunteers, medical curriculums (see Capacity Building Strategy).

Private Sector Strategy

The Government's Communication Strategy should be designed to build a collaborative partnership with the private sector. The Strategy should have as its objectives: joint planning of communication campaigns at the national level; strengthened partnerships between local governments and the private sector providers; improved quality of RH/FP services; and increasing use of private and unsubsidized RH/FP services and supplies. Audiences include: consumers, public and private providers, local governments, and pharmacies. Messages could promote: increase demand for RH/FP services and supplies; increased competition between local producers to benefit consumers; improved quality of products; support for innovation and new products; consumers education for fair pricing and product comparability; informed choice and continued and effective use for private sector clients; increasing availability (ex. advertizing pharmacies in the district that carry a full line of contraceptives), and promotion of certified or quality providers or retail sites (ex. Blue Circle). Channels for messages include mass media (national and local), local governments, professional association, corporate communication structures (newsletters, web sites, staff meetings, etc.), facility materials like posters and client handouts, and field workers and volunteers.

Capacity Building Strategy and Decentralization Strategies

The agendas of the Communication Strategy and these two strategies meet in the needs of local governments to: identify communication needs and target audiences, localize

national communication activities, plan campaigns, produce communication products, pretest products, develop (local) media plans, build partnerships, implement activities, and assess impacts to get lessons learned. There are two mutually reinforcing approaches that will benefit all three strategies – training and management. Training should build local capacity, while national level implementers should manage their activities in such away that it benefits and supports the skills and campaigns of the districts, by:

- Developing tools and systems that allow districts to identify and report on issues that would benefit from a communication intervention. (The lack of feedback is an indication of the need for technical support. Feedback helps the Government set priorities in a number of areas, including Communication);
- Giving a higher priority to national communication activities that allow local governments to tie in local campaigns with events and materials;
- Document the process of a campaign so that local governments have a model of the thought process and the results;
- Regularly distribute lessons learned, good model campaigns, and local materials to all districts;
- Develop communication material in digital formats that allow local production and branding by the district government;
- Develop job aids to help local governments and NGOs apply a strategic process (ex. P - Process) to planning a local communication strategy.

The Equity Strategy

The resources developed for all the other Strategies will support the Equity Strategy. The Communication Strategy will do this

by helping to reach those districts, provinces, and marginalized population that are historically underserved by RH/FP services with effective behavior change communication. Audiences would be determined at the national and district levels, and could include: traditionally conservative communities, the very poor, the isolated, young adults, or communities at risk of HIV/AIDS. Messages would vary depending on the situation, but should lead to smaller family size desires, increase use of RH/FP services, and informed and effective users. Channels for communication could include national and local media, NGOs, family planning field workers and volunteers, local governments, community events, religious leaders, and health providers.

Capacity Building Strategy to Address Decentralization and Priorities in Reproductive Health/Family Planning

Mission Statement

Revitalization will develop skilled management, technical and clinical human resources to ensure efficient and effective support for the national family planning program.

Issues

Decentralization and the changing roles and priorities of the RH/FP program have resulted in an operating structure with very little capacity to manage any Government support for national RH/FP policies or objectives. This lack of capacity has resulted in confusion, lost opportunities, and increasingly ineffectual activities. If the Government is to play any role in RH/FP there will have to be a concerted effort to establish ongoing systems to address the dire need for human resources to implement national and local RH/FP policies and program.

Strategy

There is a critical need for training and other capacity building activities, but current training structures are not prepared for the task .[13] The first step in building a new training structure

[13] *The team did not examine the MoH training capacity, but was familiar with the BKKBN activities. Training is spread across the organization, is budge driven, and lacks a strategy or objectives. Hull and Mosley tried to get data on all BKKBN training activities, but training is so dispersed and ad hoc that no such data base exists. BKKBN has good trainers, some good materials, good facilities, and good communication with provincial training centers that can be used for Capacity Building.*

is a **national management training strategy.** To produce the strategy the Government will have to:

- Identify the skills needed at the national, provincial, district, and sub-district levels to implement new strategies (ex. Private Sector, Decentralization, Quality, etc.);
- Carry out a large scale needs assessment by polling provinces districts and NGOs to get their perceptions of needs and priorities;
- Identify the skills needed by the partner organizations (NGOs, private sector, professional associations, universities);
- Review current training content and materials to: 1) get rid of training that is no longer relevant (ex. logistics and warehousing), 2) identify existing training that will be needed by a revitalized RH/FP program (ex. Basic training in Population and Family Planning, Advocacy), and 3) update existing training and/or materials;
- Prepare a 5-year National Strategy and Implementation Plan (based on the four activities above) that are relevant to the needs of the revitalized national RH/FP program.

Addressing the Need for Management and Operational Capacity at the District Level

Decentralization transferred authority for planning and implementation of almost all government functions to local governments that were usually unprepared for the responsibility. Six years later many districts still lack the RH/FP skills to identify priorities, build partnerships, generate political support, plan activities, implement plans, and assess results (and a number of districts have done an incredible and imaginative job of addressing the RH/FP needs of their constituencies). The lack of skilled staff is especially hard on new districts, but all districts suffer from loss or transfers of

experienced staff, high turnover, and no options for acquiring skills.

It is recommended that a permanent staff-development program be setup in Jakarta and in regional training centers to give district-level staff basic and management skills in RH/FP. The activity should be permanent because with the large number of districts, the regular creation of new districts, staff turnover, changing RH/FP priorities, and new lessons learned, it is unlikely that the need for even basic staff development will be met for several years. It is recommended that the training be at the national or provincial level because: it establishes the training as a critical priority, the resources and facilities for training already exist, and it offers the opportunity to build a national peer network to share problems and experiences. This activity should be funded at the national level to: help communicate the national commitment to advancing RH/FP in Indonesia, foster the role of Jakarta as a technical resource for district governments, and to facilitate two-way communication between Jakarta and the districts on problems, innovations, and lessons learned.

It is suggested that formal training programs be set up for three different district officials – Family planning staff, BAPEDA, and members of DPR-D. Training for Family planning staff[14] should cover: population policy, reproductive rights, strategic planning, advocacy, basics of contraceptive services, partnership building with NGOs and the commercial sector, budgeting, monitoring and problem identification, coordination, communication and public education, community mobilization, and accessing available technical

[14] *Assuming one week (6 days) training sessions, 42 training sessions a year, with 15 participants, x 450 districts x 3 district FP staff = 1350 participants and 2+ years for the initial round of training.*

resources. BAPEDA is playing and increasingly important role in planning and financing district activities. One or two BAPEDA staff[15] should have an introduction to RH/FP issues in a two or three day session. The training and familiarization could cover: population policy, reproductive rights, strategic planning, budgeting, coordination, administration, and available technical resources. DPR-D members are also a critical part of local priority setting and operations. They also have an oversight function. At least one member of each DPR-D[16] should be familiar with population issues, national policy, social and economic benefits of family planning, "essential health services" requirements, NGO partnerships, etc. It may also be useful to facilitate other social welfare agencies (ex. health, women's empowerment, education) to make presentations.

For illustrative purposes, some assumptions have been made in the footnotes to show the magnitude of the effort involved. Using the assumptions the Government would need 423 training sessions. Complete coverage of district family planning staff would take more than two years. Continuing staff turnover, elections, and new districts would generate a continuing need for district staff development.

Recommendation: Training is one approach to building district capacity. However it is also recommended that the Government support districts with job aids, manuals guidelines, lessons-learned/best practices, and other supportive tools for management, planning, and implementation. Many tools already exist (ex. district-level planning, contraceptive security assessment). The Government should have an ongoing organizational structure to develop, update, and distribute

[15] *Assuming two day training sessions, 450 districts x 1 BAPEDA staff = 450 participants and 30 sessions of training.*

[16] *Assuming two day training sessions + one day for other agencies, 450 districts x 1 DPRD member = 450 participants and 30 sessions of training.*

tools for improved district level management. It should also have the ongoing capacity to communicate with districts and provinces on their changing skill needs, and the utility of training received.

Addressing the Need for Management and Technical Support Capacity at the Provincial Level

Provincial governments still hold considerable influence with district governments. They are also ideally situation to monitor district progress, identify problems or issues that go across districts, and to be a collective and more available technical resource for the districts. Unfortunately, all provincial offices have had problems adapting to new roles. Also with new regulations (P.P.41), provincial-level RH/FP responsibilities have been moved into the governor's office. As a consequence of new roles and turnover in staff, the provincial RH/FP offices are unprepared to play the monitoring and technical support roles that are their logical functions under decentralization.

In order for provincial RH/FP offices to play a role in government support for the family planning program, the following actions are recommended:

- The Government (Jakarta) should coordinate with the provincial governors in implementing P.P. 41 and moving the RH/FP support functions: to ensure full utilization of experienced staff, to set up management and technical support systems, while ensuring that the offices have sufficient funding for staff, travel and operations to effectively support and coordinate activities in the districts;
- The Government should also provide: training to provincial staff on required technical skills, similar to the training

provided district staff, but focus on coordination, technical support functions, and organizing cross-district activities (ex. procurement, training); mentoring province staff with experienced national or provincial staff; providing technical updates; and using the provincial offices as a channel for communicating with the districts.

The Government should also develop monitoring tools for use by the provincial offices to ensure districts are complying with the "Essential Services" requirements set by the national government.

Strategy to Improve the Quality of Reproductive Health/ Family Planning Care

Mission Statement

Revitalization will facilitate the continued improvement of quality with greater client safety, more efficient services, and increased client satisfaction, with the goal of meeting international quality standards for RH/FP services.

Issue

Quality of RH/FP care has improved with the production and distribution of several clinical standards and guidelines, and the introduction of quality certification for private practice midwives *(Bidan Delima)*.[17] However, there are still serious problems with the quality of RH/FP care that impact on client safety, effectiveness of use, and levels of use.

Background

Impacts on quality-of-care (using clinical guidelines, job aids, and some training), were measured in STARH project areas (16 districts) in 2002 and 2004.[18] Counseling improved significantly (use of counseling job aids) rose from 8% to 48%. Method screening (asked all appropriate questions) rose from 13% to 20%. Providers following all the infection prevention clinical procedures rose from 7% to 39%. Providers following all method-specific clinical procedures for the method rose

[17] *STARH Program. September 2006. Bidan Delima Evaluation Report*
[18] *STARH Program. November 2006. Assessing the Impact of Interventions to Improve the Quality Of Family Planning using the Quick Investigation of Quality: The Experience of the STARH Program in Indonesia (2002-2004).*

from 25% to 51%. So quality can be improved and the change measured, but levels of 20%, 39% or 51% highlight the gap between actual quality and the desired 100% compliance with quality standards.

IDHS-07 found that (after seeking pregnancy) the major reason for discontinuation was side effects/health concerns – 29%. Among women not using, the major reason for non-use (after seeking pregnancy) was also side effects/health concerns – 34%. And yet among women using contraception only 35% were informed of possible side effects, and 37% were told what to do for side effects. Quality of care is far below international standards, and is a major constraint to effective and continuous contraceptive use. Despite the obvious benefits of improved quality of care, there are currently no major efforts by the Government to improve quality. There is no effort to monitor or address the quality of the majority of private practioners or facilities. In fact, the IDHS-07 indicators of quality suggest that the private sector provides slightly higher quality than Government health providers. Supervision is virtually nonexistent. Local governments responsible for public health clinics are unable to assess quality or correct problems. Even though they provide the bulk of RH/FP services, private providers often do not have access to materials or job aids. Providers continue to ignore standards (ex. general anesthesia for sterilization)

One of the main roles for the Government is the protection of public wellbeing. Improving the quality of RH/FP care has a direct effect on the quality of life for women, children, families and communities. The Government with its regulatory powers, with its technical capacities, with its national leadership position, and with its social obligations

should be playing a major role in the quality of RH/FP services and providers, at all level of the health-delivery system and for all types of providers. The proposed role of the Government in a revitalized program can only be held by the Government, and if it opts to not address quality, quality will not be addressed.

Quality of care can be defined to include:

- Effectiveness (protects the couple from risk (unwanted pregnancy, sexually transmitted infections);
- Safety (the product or procedure puts the user or the provider at no unnecessary, short/long term health risks);
- Comfort (no physical and psychological consequences to practicing);
- Efficiency (reasonable access, cost, and ease of use minimizes the client's loss of time and other resources).

Strategy

Quality is a complex issue: it happens in several places; many people, including the client, are responsible for it; it is dynamic and can change positively or negatively; it is subjective; it is variable within a system, a facility and between providers; and it can be addressed in several different ways. Because of this complexity quality can be found in the Private Sector, the Capacity Building, the Communication, the Decentralization, the Equity, and the High Risk Strategies. Also because of its complexity, strong partnerships will be required for improvements to be made, scaled up, and sustained. Below are some illustrative activities that help define the Government's role in improving the quality of RH/FP care in Indonesia.

- Setting Standards – In the last few years Indonesia has set many empirically based standards by issuing a number of guidelines:

Family Planning, Infection Prevention[19], Safe Delivery, Sterilization, and Counseling. These standards need to be reviewed periodically and modified to update practices based on new data, address issues in the service delivery structure, and to address new products, processes, and services. The Government with partners should be doing these periodic reviews, disseminating updates or publishing new volumes with updated information. The Standards may also need to be reprinted to provide or replace copies;

- Job AIDS – BKKBN, DepKes and NGOs have produced and distributed a number of job aids for clinicians and family planning field workers to ensure that clients are fully informed on the risks and benefits and how to use their contraceptive method. The Government should be looking at these tools, updating them and distributing new stocks as part of its commitment to quality care, informed choice and reproductive rights;
- Monitoring Quality – The development of standards also greatly facilitated the measurement of quality in health facilities. Facility surveys were used to measure changes in quality. A number of self assessment and supervision tools were also developed to allow greater attention to problems with quality. These tools need to be used as the basis for an updated effort to monitor quality and direct responses;
- Private Sector Quality – Most work on quality has been directed to Government facilities (exception – the Bidan

[19] *A specific example of an infection prevention activity, which is much needed and within the current capacities of the Government is bio-hazardous waste management. Infection prevention guidelines have been produced and distributed but each facility's handling of bio-hazardous waste is ad hoc. RH/FP services are a major producer – think of the 64 million syringes used every year for injectables. The revitalized RH/FP program could use its: logistics management, procurement skills, pending private sector partnerships, and its links to professional associations to put the necessary equipment in every health facility (point-of-use disposal containers, needle breakers, equipment sterilizers, incinerators, etc.). Costs could be shared with private facilities/ providers, or they could be given out as part of the private sector partnering activities.*

Delima Program at IBI that addressed quality for private practice midwives). A new series of tool, job aids and monitoring systems will need to be developed to support improved quality in the private sector. Midwives should be the first priority for the new tools;

- Partnerships – A new Quality Strategy is a major expansion in the role of the Government, and will require a much larger group of stakeholders. There should be a "Partners in Quality" plan to set up the partnerships, lay out responsibilities, set priorities and set the operational procedures (meetings, committees, reporting, etc.). Professional organizations should be major player in both technical and communication components of implementation;
- Communication – The Communication Strategy should include a component to educate clients on quality to create an expectation and demand for quality;
- The Role of Local Governments – District governments are closest to the RH/FP service delivery points where quality happens. They are also responsible for quality in government facilities. All efforts should be made to help local governments assess quality and improve the environment, staffing, and supplies. They should also be encouraged to work with the private sector providers – pharmacies, private clinics and hospitals, NGO facilities, and private practice midwives and doctors. Other strategies (ex. Capacity Building, Decentralization, technical support) will also support local governments in improving quality;
- International Cooperation – the international agencies and donors are a valuable resource for quality improvement efforts. They collect the empirical evidence that is the basis for model standards. They develop tools, training, and job aids that can be adapted for use in other

programs. They also fund research and pilot interventions. The Government should facilitate communication with these agencies so that the Indonesian experience can be communicated, and the lessons learned from the rest of the world can inform Indonesia's RH/FP program;

- Research in Support of Quality Services – The Government should maintain the capacity to do data collection and analysis to: provide empirical testing of new interventions, help setting priorities, support going to scale, publish and disseminate findings, and doing cost effectiveness analysis to determine the efficiency of various approaches. The information can also be used internationally. Illustrative research topics - Couple satisfaction with sterilization; informed consent and how much information is enough, predicting method failure from client characteristics, attitudes to the IUD and constraints to increasing demand, post-abortion complications profiles from hospital admissions.

Support Strategy for Ensuring Equity in Access and Use of Reproductive Health/Family Planning Services

Mission Statement

Revitalization will bring resources to bear on ensuring the health and social benefits of RH/FP are equitably distributed geographically, socially, and economically.

Issue

As the RH/FP program in Indonesia matures, greater attention should be paid to dealing with the inequities in RH/FP use, access, and quality. These inequities can be between provinces, between districts within a province, and between the general population and marginalized groups (ex. Young adults, the unmarried, Internally Displaced Persons (IDPs), Slum dwellers). The Equity Strategy overlaps with several other strategies – Capacity Building, Decentralization, Private Sector, Quality, High Risk, and Communication. So these strategies if carried out will reinforce each other and share tools and technical capacity.

Background

One of the reasons reaching the hard-to-reach is costly is that each group is hard to reach for a different reason: geography, religion, culture, leadership, political instability, widely dispersed, tradition bound, illiterate, access to health services, a legal status that marginalizes, extreme poverty, highly mobile. To be effective RH/FP interventions must be tailored to the specific constraints of each group. The first step the Government must take in addressing Equity is to

set priorities for groups to be targeted for special attention. Some illustrative priority groups are described in the following section.

- Under-performing Provinces – are an obvious and appropriate approach for the Equity Strategy to take. Every province has a RH/FP bureaucracy in some form. The unit costs are lower because of the large number of couples. The Government could select a group of provinces with the lowest modern method contraceptive prevalence rate (CPR) (Papua – 25%, Muluku – 29%, NTT – 30%), or low CPR but high population (North Sumatra 42%, South Sulawesi – 43%). In contrast, the high CPR provinces are: Bengkulu – 70%, North Sulawesi – 67%, Lampung – 66%, Bali – 65%. Other indicators could be used, but usually the same provinces would be the priority;
- Under-performing Districts – would also be and easy approach. Provinces could identify their poorest performing district(s). The districts get special funding and technical support from Jakarta, the province and/or other successful districts in the province. This approach may not address the most disadvantaged, but it is easier to implement technically and politically;
- Young Adults and The Unmarried - Hull and Mosley point out a well know demographic phenomena – as age of marriage, or education, or social exposure increase the likelihood of premarital sex increases. Indonesia's success at increasing all three suggests that the risks of premarital conceptions to young adults and the unmarried is and will continue to increase. To confirm that Indonesia follows the international pattern the IDHS-07 found that the median age of marriage for women 25-29 (20.8 years) was almost two years higher than media age at first intercourse (19 years). Clearly the problems of a premarital pregnancy (early school leaving, unstable marriages, risks of unsafe

abortion, and the unfair bearing of consequences by the woman) have social and economic costs to Indonesia. Current laws and policies limit access to RH/FP information and services for the young and unmarried. Youth serving NGOs, some schools and some employers are helping a small number of Indonesian women who wish to delay marriage, but are in a relationship. The widespread availability of condoms in the market place is probably reducing premarital pregnancies, but there are no data estimating impact. No government wants to get involved in such a personal and politically sensitive issue. Unfortunately, the social costs are too high to ignore and the problem is only going to get bigger. Further research could help the Government to reframe current policies, design interventions that are appropriate, and support groups working on the issue;

- Internally Displaced Persons (IDPs)- Civil strife and natural disasters have generated a continuing need for health and RH/FP services for IDPs who have lost jobs, homes, and access to regular health care. The Government currently makes every effort to meet the needs of IDPs, but response is ad hoc and often RH/FP is not considered until the later stages of support. The Government could address the needs of this group, by having a buffer stock of contraceptives, IEC materials, and a plan and structure for dealing with these types of events;[20]
- The urban poor – This group is marginalized by their poverty, their illegal migrant status, and the unstable life style of work in the informal job sector. Even if the have access to free health services they may not be using

[20] *The Ache Tsunami provided a good case study for addressing RH/FP needs in a crisis. Critical needs were: contraceptive stocks, health workers, IEC materials to help clients being seen by foreign health workers, Emergency Contraception, transport to distribute commodities, linkages between camps and health providers with stocks (injection is the most important method and the schedules of the visiting medical teams and women in the camps were different).*

contraception because they hold traditional values for larger family sizes and lowest rates of media exposure that might help educate them on healthy fertility;[21,22]

Strategy

It is a traditional function of Government to address social inequities, and so it is appropriate for the Government to focus human and financial resources on decreasing disparities in RH/FP status. By improving the equity of RH/FP access and use, the Government also reduces disparities in a range of social and economic issues (ex. women's status, girls' education, maternal mortality, infant and child health, household income, etc.). The private sector, which drives the national RH/FP program, is unlikely to address Equity for the same reasons the Government has not – it is difficult and costly to reach and change the society's most marginalized groups. The Government should recognize the problem and bring a highly focused strategy and the necessary resources to equalizing reproductive health, or suffer increasing disparities in health, economic and social status.

Because the issues, approaches, and required resources would be different for every group, we are not suggesting activities, as with the other Strategies. Instead we have described a process for the Government to set priorities and identify interventions.

- Prepare a general implementation plan with selection criteria for identifying priority areas or groups;
- Make multiple selections and then final selections based on: interest from the local government, potential for

[21] *Menayang V, Widiastuti. T. August 2004. Understanding the Constraints and Supports to the Family Planning Practices of the Poor. A STARH Qualitative Research Study. STARH Program, Johns Hopkins University, Jakarta. (English)*

[22] *Schoemaker, J. June 2004. Contraceptive Use among the Poor in Indonesia. STARH Program, Johns Hopkins University, Jakarta. Also published in International Family Planning Perspectives*

lessons learned and scaling up, impact, available partners, reasonable timelines, and available budgets;

- Do a needs-assessment for each selected area or group.[23] Since the constraints to change RH/FP behavior are likely to constrain other behaviors, also use needs-assessments by other development and/or academic researchers;
- Prepare a partnership strategy with local governments, NGOs, and other government agencies;
- Do an assessment of RH/FP services to ensure demand can be met, and a plan to increase services if inadequate;
- Prepare (with partners) an implementation plan with technical support, budgets, time lines, activities, a capacity building plan, clear achievement benchmarks, job aids and other tools;
- Prepare a monitoring/evaluation plan to assess progress and a withdrawal plan should the project not be implementing effectively for any reason. Since many of these interventions will be difficult, implementation can be phased. Also since these are special campaigns, the projects should have a specific deadline (ex. one or two years), so intermediate impacts are acceptable;
- Implement;
- Use the project outputs, and the monitoring evaluation results to document lessons learned and best practices for other areas or groups;
- The Government will be responsible for those components of the project for which there is no local capacity. The Government will also be responsible for sharing lessons learned, best practices, and partners with other areas and groups, and the donor community.

[21] *In picking an area like a province, you may have several groups, each with its own set of constraints for using RH/FP services. Each group involved in the Equity strategy should get a separate needs assessment.*

Strategy for Preventing High Risk Pregnancies

Mission Statement

Revitalization will focus special attention on getting women with increased risks from pregnancy to use contraception and to use more effective methods, and getting high risk women wanting the pregnancy to get prenatal care and assisted delivery.

Issue

Maternal mortality continues to be a major health issue. The IDHS-07 estimates the current maternal mortality ratio to be 228 per 100,000 live births, down from 390 for the five year period before the IDHS2002-3. It is one of Indonesia's most problematic Millennium Development Goals (MDGs). Reducing high risk and unwanted pregnancies is one of the simplest and most direct ways to reduce maternal mortality. The national family planning program has contributed significantly to reducing the number of Indonesian families that have suffered a maternal death. This was done by making contraception widely available and changing the norms around family size. The program addressed its efforts to all couple, and leveraged by economic development, improved status and education for women, and increasing access to low cost contraceptives, prevented hundreds of thousands of high risk pregnancies. As the program matures and as Government roles changes, efforts should focus on those women for whom a pregnancy (wanted or unwanted) increases the risk of maternity related mortality or morbidity. Because these couples are the hard to identify and reach and

the approaches to reaching them are varied and complex, the Government should use its technical skills, access, credibility, and mandate to address the problem.

Background

The High Risk Strategy will focus on preventing, delaying, or increasing care for pregnancies to woman who are exposed to the following risk factors:

- Too young (19 years and under) – The young mother is at greater risk of adverse consequences during delivery and subject to higher rates of maternal mortality than more mature women. The children of young mothers also suffer higher levels of morbidity and mortality. And yet the IDHS-07 found that 17% or one out of six women 18 and 19 year old had begun childbearing (pregnant or already had child). For all adolescent girls 15-19 years of age 9% or one in every eleven has begun child bearing.[24]
- Early marriage may prevent the stigma of being an unmarried mother, but does nothing to reduce the health risks to the child and the mother. The problem of teen pregnancy is greater in rural areas with 12.7% of women 15 to 19 years of age having begun childbearing, as apposed to their urban counterparts where only 3.9% are at higher risk of pregnancy related mortality and morbidity. Education also shows a common pattern of less educated teenagers having begun childbearing earlier. The rates drop dramatically for girls with some secondary schooling (5.5%) from those with some primary schooling (21.4%) The IDHS-07, using births in the last five years, found that 3% of births occurred to women less than 18 years of age. The children born to these young mothers were

[24] *While the rates of teen pregnancy are disturbingly high, they are under reported. These figures do not include young women who have had spontaneous or induced abortions, young women with early-term pregnancies not yet recognized, and young women who out of embarrassment misreport their pregnancy status.*

3.6 times as likely to have died by their 5th birthday as children born to women that had no other risk factors (age, parity, and birth interval). If the health consequences of teen pregnancy were a disease it would be considered an epidemic and a national response would be mounted to address the threat to the nation

- High parity – The health risks to the mother and the child increase with the number of children the woman has had. The success of the family planning program has reduced family size with the concomitant decrease in high risk pregnancies. The risk of high parity births is still a concern. IDHS-07 found that among currently married women 15 to 49 years of age 21.3% had had a high risk pregnancy (a fourth child ever born); 11.5% had had two high risk pregnancies (a fourth and fifth child ever born); and 6.4% had had three or more high risk pregnancies. Among currently married women with three children, 21% reported that they would like to have another child (and by definition a higher risk pregnancy). IDHS-07, using three or more children as the at-risk group, found that 8.1% of births in the last five years were third or higher order births, and that these children were 2.3 times as likely to have died before the fifth birthday as children born to women who had no risk factors;
- Older Ages – Like parity, there is an incremental increase in the risks of pregnancy as a woman's age increases. Late pregnancies have been decreasing due to the past successes of family planning in Indonesia, but they still exist. IDHS-07 found an age-specific fertility rate of 6.1% for women 35-39 years of age, 1.9% for women 40 to 44, and .6% for women 45-49. IDHS-07, using births to women over 34 years of age as the at-risk group, found that 4.7% of births in the last five years were to these women, and that these children were 2.3 times as likely to have died before the fifth birthday as children born to

women who had no risk factors. Given, desired family size and the number of women who want no more children it is likely that these pregnancies are a combination of desired, method failure (see the Method Mix Strategy for more discussion of age-appropriate method use), and the woman's mistaken belief that she is unable to get pregnant;

- Too short an interval between births - Like the previous risk factors, there is an incremental increased risk from a pregnancy when the interval between the last live birth and the current pregnancy is shorter. This risk factor is one Indonesia has had considerable success reducing. According to IDHS-07 the median birth interval is now 4.6 years. And yet, 29.5% of births (excluding only child births where there is no interval) had an interval of less than 36 months. Clearly this is too large a risk group to be ignored;
- History of Delivery Complications - Complications with a past delivery may be a warning sign of a chronic problem and the likelihood of future complications. A couple that experiences a delivery with complications should carefully consider the risks of another pregnancy, the need for antenatal care, the presence of a skilled birth attendant, and the possibility of having the birth in a facility with equipment and medication to respond to an emergency. These couples also need a health professional that can help them weigh the risks of another pregnancy and help them make informed choices on: having another pregnancy, when to have it if they want another child, and how to avoid pregnancy if they decide the risk is too high. The IDHS-07 found that 47% of women reported delivery complications, for last pregnancies in the last five years;
- Other Health Risk Factors – In making and informed decision about getting pregnant there are other health

factors that should be considered in the decision making process (ex. smoking, high blood pressure, diabetes);

- Recent pregnancy termination – When a pregnancy ends spontaneously or induced, another short interval pregnancy will put the woman at risk. When the pregnancy termination is induced she also faces the risk of another abortion if contraception is not used. Women experiencing a pregnancy termination need counseling, contraception, and awareness of the risk of a subsequent short-interval pregnancy.

Strategy

Public education and protecting the welfare of the public is one of the functions of Government. With regard to RH/FP and maternal mortality it is also national policy and an international commitment. This is another example of a critical role that only the Government can do.

Public education should use a range of channels:

- Mass media to sensitize couple, community leaders, health workers and policy makers;
- Health facilities and providers in the public and private sectors should have materials on risk (ex. posters, handouts, videos);
- Health providers should do counseling (with supporting job aids) to inform and remind clients of their risks.

Illustrative content for messages could include:

- The factors positive and negative that should inform

decision making on when or if to have another child;
- The risks if taken can effect the woman, all the children, and the community;
- What to do if the couple opts to not take the risk ("Protect yourself and your family," "Talk to your health provider about family planning," "Use a method");
- What to do if the couple opts to take the risk (regular antenatal care, nutrition, emergency plan and transport, know signs of complications, birth attended by a health professional, birth in a facility if possible);
- Promotion of more effective methods for women at risk.

Every contact between a health provider and a client, regardless of the reason for the contact is an opportunity to reduce that client's risk of a maternity related death.

The High Risk Strategy should help providers to:
- Do a simple screening and referral of a non RH/FP client for risk factors (ex. age over 35 years, four children in for a vaccination, a child under one year, etc.);
- Have a general counseling session with all appropriate clients on the risk factors that will allow the client to make an informed decision on future pregnancies;
- Identify and refer women with multiple risk factors for early client education and treatment;
- Avoid "missed opportunities" by taking advantage of all opportunities to counsel on risk – antenatal, postnatal, immunizations, infections, etc.);
- Counsel clients on the most appropriate methods based on level of risk, future pregnancy plans, access to services,

and client choice;

- Tools to improve provider performance could include clinical guidelines, job aids, and client educational materials.

Strategy for Balancing The Contraceptive Method Mix

Mission Statement

Revitalization will balance the contraceptive method mix by increasing access to more effective and long-term methods. Women will also be informed about health risks and appropriate "stage-of-life" methods.

Issue

Indonesia's contraceptive method mix is unusual, and is often commented on by international and national experts. The high reliance on hormonal methods (78% of Users) makes the national program susceptible to backlash. The increased use of injectables has helped shift the method mix away from more effective methods. Older and higher risk women continue to use less effective methods

Background

An increasing contraceptive prevalence rate, a national "cafeteria" policy that ensures a woman's choice of method, slightly greater use of more effective methods, wide availability of most methods, and reasonable cost-to-use are all good things, and Indonesia should be proud of its progress in RH/FP. Cost, culture, and access have, however, lead to changes in the method mix that should concern program managers and policy makers. The problem with the Indonesian method mix includes:

- There is a high reliance on hormonal methods – 78% of users are protected by Pills, Injectables, or Implants. Should there be a problem with a hormonal method

(rumors, new side effects, a bad batch) it could severely damage the program;

- Injectables have become the methods of choice for 32% of married women, up from 12% in 1991. Injectables growth has come at the expense of almost every other method, but IUDs have lost the greatest share. Increased injectable use at the expense of the IUD means some loss in user effectiveness. Again an over reliance on a single method should be a concern;
- The risk of pregnancy complications and related mortality goes up with age. For older women an "age appropriate" method should be one that is more effective. Yet among currently married women ages 40-44, 35% and among women 45-49, 19% are using injectables or the pill. Both have high rates of clinical effectiveness, but have lower rates of use effectiveness. To minimize risk of maternal mortality a good method mix would have older women moving to more effective methods – IUD, implants, sterilization;
- If pills and injectables are not appropriate for older women, traditional methods (periodic abstinence, withdrawal, folk methods) certainly are not appropriate for the 5% of currently married women ages 40-44, and the 4% of women ages 45-49 that are using them to prevent pregnancy;
- In considering methods that are inappropriate for certain ages one would have to include Implants. Implants are expensive (Rp.130,000 /US$ 13 in the private sector and Rp. 52,000 in the public sector) but very popular and always in short supply. The "Cafeteria Policy" says clients get their choice of method if available. If a19 year old woman with one child, wanting to delay her next pregnancy, wants an Implant, she will get it if available. In all likelihood, the woman will have the Implant removed, wasting two or three years of protection. That protection

might be better used by the large numbers of Indonesian women not wanting any more children, not ready to commit to the permanence of sterilization, and who would benefit from the greater effectiveness and ease of use of the Implant. If screening criteria, like those used for Sterilization (age and parity) were applied to Implant the method would be more cost effective and would be preventing more high risk pregnancies;

- High parity women are also at greater risk from an unwanted pregnancy, and yet 27% of married women with 5 or more children are using pills and injectables. Only 13% are using "parity appropriate" methods;
- Family planning users are overly reliant on resupply methods. About 46% of currently married women use resupply methods. Shifting long term users and high risk women would save: costs, time, problems with stock outs and provider availability, while reducing the woman's pregnancy risks;
- Couples who desire no more children have a greater risk from using less effective methods. The greater risk is because they are likely to: be older, have higher parity, and they are more likely to opt to terminate the pregnancy with abortion. To illustrate, 55% of Injection users and 62% of pill users want no more children and could lower their risk of an unwanted pregnancy by moving to IUD, sterilization, or Implant;
- Subsidies could and should be used to balance the method mix towards more effective and age appropriate methods. The Government currently subsidies less expensive and less effective RH/FP methods, while the more expensive and effective methods have limited subsidies;[25]

[25] *Sterilization has recently been subsidized by Government sponsored health insurance. This has probably increased sterilization use some, but cost and logistics problems have limited the impact of the subsidies.*

To rebalance method mix the Government should put greater emphasis on longer term clinical methods sterilization – sterilization, Implants and IUDs.

Strategy

A Crash Program for Female Sterilization (FS).

This method is effective, cost effective and provinces report existing demand. The drawback is that FS is a resource intensive method, requiring logistics, counseling, consent requirements, a medical team, a surgical facility, and follow-up. Because FS requires a higher level of quality than other methods, it is recommended that revitalizing FS activities be done in a carefully managed "crash program" approach. Implementation will require coordinated efforts:

- Design a one or two year "crash" program to address the backlog and to institutionalize sterilization at the district level;
- Get the funding to implement and subsidize the FS program;
- Partner with the professional groups (POGI and JNPK) to identify skilled surgeons interested in participating, training local doctors, and managing the visiting teams;
- Get provincial and district RH/FP to do a preliminary assessment of demand so that geographic priorities can be set and planning can identify facilities that minimize travel for clients;
- Use provincial and district RH/FP offices to do recruiting, preliminary screening, counseling, informed consent, manage travel logistics, and do follow-up with clients;
- Identify quality facilities that can provide large blocks of surgery time (first choice teaching hospitals with existing capacity);
- Form the traveling surgical teams;

- Identify local facilities and doctors that can be trained to provide continuing service;
- To cover costs, rationalize funding by coordinating insurance, national subsidies, local contribution, and possibly client cost share;
- Reduce sterilization costs by reducing facility inefficiencies - In the past, hospitals doing sterilizations have complained that their cost to do a FS exceeds their payment. This is often true but not because the subsidies are too small, but because the hospitals do FS very inefficiently. They continue to use general anesthesia despite the fact that it is against the government service delivery standards and requires an anesthesiologist in the surgery. The surgical teams are often unnecessarily large, while the post-surgery monitoring staff is often unacceptably small. And finally, the procedures are done in small batches losing economies-of-scale. Also, costs are often based on blocks of theater and team time and not the number of procedures done (So one or five FS could cost the same). Better planning and coordination would solve this problem;
- Implement a media campaign to promote the methods, the requirements, the benefits, and how to get services;
- Develop materials for satisfied acceptors to act as promoters (client follow- up is important).

The Crash Program in FS is intended to augment not replace ongoing FS activities. By increasing awareness, the numbers of satisfied clients, and the quality of facilities and providers, when the crash program ends the ongoing FS activities will be stronger.

Increasing Use of Postpartum Sterilization and IUD

Currently there are no active efforts to promote postpartum family planning. Both IUD and sterilization are appropriate postpartum methods. Women interested in postpartum methods are a smaller population – limited to women delivering in a medical facility and knowing they want to prevent or delay another pregnancy. Postpartum family planning has the advantages of: efficiency, cost, convenience, and it prevents high risk short interval births. Activities in support of postpartum long-term methods include:

- Media promotion of postpartum use;
- Materials and socialization of postpartum use with midwives and doctors that do prenatal care;
- Production and distribution of client education materials;
- Specialized training for midwives and doctors;
- Partnerships with private sector birthing facilities to promote and provide long-term methods;
- Partnership with professional associations to communicate with their members the benefits of post partum long-term methods, their positive role in client education and opportunities for training if needed.

Promoting the Use of Male Sterilization (MS)

The proportion of men using MS, while never large, has steadily dropped (.06 in 1991 to .02 in 2007 IDHS). This is a little surprising since no-scalpel vasectomy was introduced and the number of sites where it is available has increased over the years. Given its effectiveness, safety, and low cost it should still be an important part of the national RH/FP program. This is another example of the critical and unique role of the Government in ensuring access to safe and

effective contraception. If the Government does not support an expanding role for MS in the national RH/FP program, it will never make a significant contribution to the reproductive health of Indonesian couples. Possible activities include:

- Use media to promote MS including: testimonials, correcting misinformation, benefits, spousal communication, and ease of the procedure and safety;
- Monitor quality to ensure continued client safety and satisfaction;
- Produce materials and provide small budgets for facilities currently offering MS services to promote their services;
- Continue to expand the number of facilities that offer the service;
- Develop a program with large private sector employers to offer MS services as a job benefit;
- Use subsidies and insurance to cover the cost of the procedure and make it more attractive.

Promoting the Use of IUDs

Use of the IUD, once a major building block of the national family planning program, has declined precipitously (from 13.9% in 1991 to 4.9% in 2007 – IDHS-07). The decline is generally attributed to the rise of injectables. There are no data to explain the shift in popularity between the two methods, but there are a range of possible explanations and opinions.[26] And yet IUD is still a good and appropriate method for use in Indonesia. It also provides an effective

[26] *Possible but not studied reasons for the decline in IUD: more severe side effects than injectables; the cultural belief that injections are "real medicine"; IUD training in the 1980's and 90s was given to so many midwives that there were insufficient numbers of clients wanting IUD so trainees never got competent or confident in their capacity to insert IUD; Injections, which entered the program later, are perceived to be more modern; midwives prefer injectables because they are more in demand, less trouble, and the create an income stream. In any case, research is required before a major investment is made in revitalizing IUD use.*

long-term method for women with a high risk from and unwanted or unplanned pregnancy. It is interesting that IUD remains a popular method among the best educated and the wealthiest groups of women, suggesting that IUD may be promoted back into a role in balancing out the method mix. Activities could include:

- Use media to promote IUD and its benefits, focusing on women who would benefit from a very effective, low cost, low maintenance method;
- Provide materials, IUDs and a budget for health centers (puskesmas) to do special IUD campaigns to recruit new IUD users;
- Test locally produced IUDs to ensure they conform to registration standards;
- Partner with local governments to do an inventory of IUD providers to identify holes in IUD availability, and a need for training.

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ANNEX 1

Organizational and Structural Observation

The Revitalization Strategy exercise is intended to be an empirically based examination of the future direction for the role of the National Government in family planning and reproductive health. It is important to note that there is a critical role for the Government to play. The social and human benefit of an effective RH/FP program impacts the lives of every Indonesian and is one of the best development investments available to the Government. These investment benefits will only come if an organization implements effective programs that address real RH/FP problems. To maintain focus on the issues and not be drawn into the complexities of organizations, mandates, budgets, politics, and history the Team decided to focus on strategies for addressing the issues identified in the IDHS-07 and Hull and Mosley and Darwin and Sukamdi reports. The Team has added this annex commenting on organizational issues. Because an in-depth examination of current programs and BKKBN was not part of the exercise these are these observations are made to stimulate dialog and more introspection of the future of the organizations involved. That organizational change is needed is not a question. All three expert panels involved in the Revitalization Exercise have recommended major organizational changes. The questions are: can BKKBN change; will the Government support the changes and the new programs that they require; can the changes take place fast enough to have an impact?

Below are the comments and observations of the Team. For reference we have added highlights of the organizational

recommendations from the Hull and Mosley Report with links to the proposed strategies and our observations, and occasionally an elaboration. Note that organizational issues raised are to facilitate discussion and decision making. A more detailed examination by organizational and program experts will be necessary to develop a restructuring plan for a revitalized BKKBN.

Core Business

What is the "core business" of BKKBN? In the private sector "core business" refers to the basic and most important aspect of your business. If a business grows "organically" it means the business model uses the core skills, markets, systems, and partnerships to add a new activity or branch on to the core. And like a tree, if the trunk is healthy the branches are likely to be healthy. The core business of BKKBN is family planning, but for the last several years the primary focus has been on protecting the institution by broadening its mandate. This has increase territorial conflicts, distracted the organization from its core business, and added activities that have only limited relationship to the core business. RH/FP is too important to the social and economic wellbeing of Indonesia to be ignored.

The RH part of RH/FP

While the core business of BKKBN is family planning, it has always worked in other areas of reproductive health. A good example of this is the IDHS run by BKKBN. The Survey also collects data on: maternal and infant mortality, immunizations, smoking, access to health services, vital registration, pre and post natal care, safe delivery practices, child health status, breast feeding, HIV/AIDS, malaria, and health seeking behaviors. This model of cooperation and shared technical resources should be the norm for BKKBN and for a revitalized RH/FP program. Because family planning and

maternal and infant health overlap in their beneficiaries, health providers, behaviors and attitudes, audiences, constraints to compliance, and need for improvements in quality of care, BKKBN's technical and field resources should be used to the benefit of the broader health agenda. Research, capacity building, communication, private sector partnerships, are all areas where BKKBN would make an ideal partner for DepKes or other agencies whose issues and constituencies overlap. This function would be implemented by: formalizing the role in law and policy, changing organizational structures to manage the activities, preparing memos-of-understanding between agencies, allocating budgets across agencies to ensure cooperation, and making partnerships collaboration subject to periodic external management review.

Management Audit

BKKBN has a number of activities that are traditional functions. Many of these activities have little or no current relevance to the RH/FP, contraceptive use, or fertility decline in Indonesia. An external organizational and management audit should be done to determine the utility of every activity and organizational unit in BKKBN. Staff should be transferred from unproductive functions (ex. commodities, monitoring, and administration) to other units with clear functions and potential to expand (ex. training, technical support, and communication). This restructuring would free up resources for activities that have an impact on RH/FP.

Reactive vs. Proactive Management Styles

Management is often characterized as proactive (top down, directive, hierarchical) or reactive (collaborative, shared decision making, shared authority, flexibility in implementation). Historically, the Government's management style has been proactive, with instruction flowing from Jakarta to every

operating unit. This proactive style was especially strong in BKKBN because of political support, success, innovation, resources, feedback from the field, and the close connections between units. This management style was the foundation of the RH/FP "Indonesian Miracle." The political, social, and structural (decentralization) changes of the last ten years require a mix of the two management styles. In operating at the national level BKKBN needs to be proactive by making decisions and informing provinces and districts on policy, regulatory functions, innovation, communication, advocacy, partnerships, and research. At the district level BKKBN needs to share decision making with local governments on crisis management, quality control, and policy enforcement. BKKBN will be reactive to requests from the districts on monitoring, technical support, communication, capacity building, partnerships and management systems. This will require some practice and support for both levels to get used to sharing decision making.

Leadership

The historical top-down management of BKKBN created one of the most functional bureaucracies in Indonesia, with control and resources flowing from Jakarta down to every village. Decentralization shifted control and resources for all social services including RH/FP directly to the districts. Six years after decentralization, BKKBN is still trying to develop a positive and supportive relationship with the districts. One of the common themes the Team heard in the field was the desire for more leadership (not control) from BKKBN. The districts are weak in design and management of implementation. As a result they are slow to initiate, unwilling to innovate, and fearful of failing. Leadership with guidelines, activities the districts could adopt and adapt, and tools they could apply would greatly increase confidence and local support for RH/FP.

Field Workers

Pre-decentralization BKKBN had a huge field network with thousands of workers and volunteers. The field network allowed BKKBN to reach almost every village in the Indonesia. Control of the network fell to local governments with decentralization. The network has suffered under district management, but there are still many districts that maintain and use the network for a range of development activities including RH/FP. BKKBN should have the capacity to support the districts and the field workers/volunteers. BKKBN should support field workers/volunteers with materials, training, and model activities. Districts should be supported with technical assistance to help manage, supervise, recruit, train, and maximize impacts.

Partnerships

One of the most important skills the Government will have to learn, if they are to continue to be involved in RH/FP, is the building and maintenance of partnerships. One description of a partnership is two parties with complimentary needs and skills agree to share those needs and skills to maximize the benefit to both. With 70% of the market share of RH/FP services and supplies, the private health providers, NGOs, and the pharmaceutical industry does not need the Government to maintain their current position. But both share common goals of improved reproductive health through increased use of family planning (perhaps for different reasons). So the question is what could BKKBN share in a functioning partnership - funding, credibility, technical skills, a national focus, a common goal? BKKBN needs to develop a management team to create supportive and respectful partnerships with the pharmaceutical industry, the professional organization, the NGOs, universities and other schools, large employers, and any other organization

that shares its objective of an improved and health quality of life for all Indonesians.

Decentralization

There has been considerable resistance within BKKBN to decentralization and the loss of control implicit in the process. This is understandable given the past success and sophisticated central bureaucracy of BKKBN. There is little evidence that situations will change. The resistance is just a distraction from the organization's main functions. By using the resources and intellect that have gone into resistance to decentralization, BKKBN could take a different, but positive, role in Indonesia's reproductive health.

Knowledge Management

A critical function in a revitalized RH/FP program will be knowledge management. Most of the technical skills for this function exist within BKKBN, but they are underutilized, uncoordinated, and unfocused. A "Knowledge Management Coordination Division" could:

- Support the digital domains of the organization (web sites, archives, picture and video files, etc);
- Provide regular printed and electronic updates to the 490+ districts and the provinces on innovation, new best practices, policy changes, new job aids, job openings, training opportunities, etc;
- Coordinate with the professional associations and NGOs to provide regular updates to private-sector providers;
- Manage document storage and distribution (ex. Family Planning Service Delivery Guidelines, Infection Prevention Manuals, training materials);
- Monitor for international updates on guidelines and standards;
- Coordinate updating and republication of guidelines and standards at appropriate intervals (usually 3 to 4 years);

- Manage a system for district evaluations and supervision visits with technical support from technical divisions;
- Compile field information (surveys, project evaluations, field reports, university data, etc. for use by national and local management;
- Support publication of project and donor reports;
- Provide a reference point for media interactions;
- Organize and record the results of advisory and working group sessions;
- Manage the regular flow of information to partners to ensure their engagement in addressing RH/FP issues;
- Set up and maintain a system for districts to feedback needs, issues, problems, and possible problems. Then respond/acknowledge and refer the issue for appropriate action;
- Set up and maintain a system for partners (universities, NGO, commercial partners, other government agencies, professional groups) to feedback needs, issues, problems, and possible problems. Then respond/acknowledge and refer for appropriate action;
- Prepare advocacy documents (in collaboration with technical units) for The Government (the Istana, DPR, Ministries, and international agencies,);
- Support the development or improvement of electronic communication to facilitate cheaper, faster, regular communication between units.

Organizational Change

An external and empowered advisory group that could lead a reorganization of BKKBN would be useful. Generating organizational change internally is difficult, as reflected in the lack of any substantive change in the structure of BKKBN in the last 20 years. The advisory group could provide impartial inputs on new functions, irrelevant traditional functions to be dropped, shifting existing staff, recruitment of new staff,

timelines for change, and a new structure that reflects the program needs for the next 10 years.

District-level Advisory Panel

The Government would benefit from a structure that could represent and advice on the district perspectives on policies and activities. A panel of about ten selected district representatives should meet regularly to:

- Propose ways to structure and present national policy for ease of application by the districts;
- Advise on the impacts of new or changed policies and layout responses to facilitate the rapid compliance to national policies;
- Suggest new policies or policy changes that would help districts;
- Help set priorities in: technical support, capacity building, and communication;
- Review activity plans, tools, job aids, communication materials from the perspective of elected officials in the district who are expected to use these products;
- Lead district feedback on national planning documents.

Ministry of Health and RH/FP

The Strategies presented in this report are all directed towards a strengthened and more relevant role for the Government in RH/FP. The illustrative activities in each Strategy are not allocated to any agency. Based on the historical allocation of responsibilities, many activities would fall to the Ministry and many more would go to BKKBN. The Ministry's traditional mandate or perception of mandate focuses on clinical service provision through health centers and hospitals. The Ministry may want to do a similar exercise looking at changing roles and structures in RH/FP services. Illustrative roles that utilizes the Ministry's comparative advantages include:

- Providing districts with technical support to manage facilities, including: quality, staffing, equipment and supplies, community out reach, monitoring, budgeting, procurement, and compliance with national policy.
- Serving the poor and communities with limited access with subsidized RH/FP services in its national clinical network. Without changes this role may be limited because access and price are not significant constraints to use (less than 3% among all nonusers in IDHS-07) so the Ministry does not have a comparative advantage over the private sector. Also marginalized users are also more likely to be first time users and prefer resupply methods over clinical methods, giving another advantage to private providers.
- Providing subsidized Implants to women who are less likely to be able to use resupply methods effectively.
- Inclusion of contraceptives supplies in the Essential Drug System to improve access, reduce costs, and improve the "social safety net."
- Improve quality of care in health centers and posts (public sector facilities have lower levels of quality for selected IDHS indicators than the private sector).
- Screening all women clients for maternal mortality or morbidity risk factors.
- Supporting changes in the method mix towards long-term clinical methods by increasing availability in Ministry clinical facilities.
- Playing a supporting role in an expanding and improving private sector health system.
- Expanding and using Ministry facilities in an active referral system for problem cases (high risk pregnancies, abortion complications, method failures, clinical methods, etc.)

ANNEX 2

The Role of an Existing Capacity Research in Revitalization

The focus of this report has been on future functions and the organizational changes to address these changing functions. However many traditional functions and current organizational structures will continue. To illustrate this we have taken BKKBN's research capacity and looked at the continuing functions and capacities that will operate in a revitalized RH/FP program and BKKBN.

The list of research activities is very specific because it was produced by reviewing the Strategies for places that research skills would contribute to designing and implementing activities.

- In developing partnerships with NGOs, BKKBN should support and participate in a formal evaluation of programs. The evaluation will serve several purposes: it will identify and document best practices; it will help determine the projects potential and limitations for scaling up; it will determine the NGOs monitoring and documentation capacity; it will identify technical support needs, and it will help identify NGO capabilities that can be used to support other NGOs.
- BKKBN needs to develop and test indicators of quality of care in NGO and private clinics. The assessment tools would facilitate self assessment, peer assessment, organizational quality assurance, and possibly local government evaluations of quality. With the tools developed, BKKBN would be expected to help NGOs, professional organizations, and local governments apply and benefit from their use. (This includes what I was

going to propose to be in: RH/FP worker competence assessment.)

- For there to be informed discussions and policy making on abortion their needs to be and understanding of levels, current practices, social costs, personal costs, reasons for use, characteristics of users, social and geographic variations in practices, health consequences, as well as the likely impacts of any changes in policy. BKKBN should be involved in the research necessary to answer these questions and provide an empirical basis for policy review.
- BKKBN should design and support an exercise for district-level mapping of pharmacies. Districts would then use the mapping data to ensure all communities have reasonable access to a pharmacy.
- It is clear that the needs of young and unmarried for RH/FP information an services are not being met. To determine if and what actions need to be taken, there needs to be considerably more data on needs, levels, successful preventive interventions, the roles of community/family/peers, social costs, personal costs, health consequences, as well as the likely impacts of any changes in policy.
- BKKBN should be involved in the research necessary to answer these questions and provide an empirical basis for policy and program development.
- To provide support quality RH/FP services, BKKB should have the capacity to do data collection and analysis to: provide empirical testing of new interventions, help setting priorities, justify going to scale, publish and disseminate findings, and do cost effectiveness analysis to determine the efficiency of various approaches. Providing the empirical support for improving quality of care could require a large number of studies, using a range of methodologies (qualitative and quantitative), implementing with a large number of partners. A few

quality-of-care research issues from the Strategies, include couple satisfaction with sterilization; defining informed consent, predicting method failure, reasons for discontinuing use, attitudes towards providers, and costing of services.

- BKKBN needs to do analysis of existing data (ex. IDHS, Census, Susenas) to help identify provinces districts and populations with the greatest unmet need for family planning and highest risks for maternal mortality and morbidity. These data would be used to target resources and technical assistance.
- An inventory should be done of private employers that provide health services to employees. Data on type of services provided, costs, employee characteristics (gender, ages, marital status), common health risks of employment, residential characteristics (dormitories, group houses, community), etc. The inventory would be used to help BKKBN build partnerships with employers to improve the RH/FP status of employees and the community.
- If method mix is to shift towards long-term methods, BKKBN will have to undertake a substantial study of IUD use and the reasons for its decline. The study will have to include former IUD users, a comparison group of never users, providers that insert the IUD, a comparison group that do not, and women from the groups that have the highest rates of IUD use (the wealth and the best educated). Information on knowledge, attitudes, experience, and misinformation should be collected. (What research response must be taken should there be introduction of new method?)

ANNEX 3

The Hull and Mosley Recommendation

The earlier Revitalization Family Planning in Indonesia report by Hull and Mosley made some organizational recommendations after an intense review of the latest data. It is worthwhile to summarize their points (in bold), link them to the operational strategies the Lewis and Haripurnomo report, and add any points of clarification.

Reformulate the Vision, Mission and Values

All of the strategies proposed call for changes in vision, mission, and values. The recommendations above reflect the still open question of whether BKKBN is willing to make the changes.

If "Form Follows Function," the reformulation should be for the RH/FP Program and then the implementing organizations should be structured to the program's mission, vision and values.

Build Technical Competencies in Family Planning for Decentralized and Mixed Public Private System

See Capacity Building, Private Sector, and Decentralization Strategies.

We agree that these technical competencies are needed at all level of the Program, but some of the recommended technical skills are "old" program competencies. Policy formulation at the national level is less relevant in program administered

in the private sector and in the districts. Monitoring at the district level has proved to be almost impossible due to decentralization, private sector service provision, the large number of districts, and inexperience local staff. Reporting is incomplete and of questionable accuracy. Even if monitoring were to identify an issue, there is currently limited capacity to respond. National-level monitoring (IDHS, SUSENAS) households needs to be continued, but totally new approaches that districts can install, operate, and use are needed. In the absence of national policy forcing districts to report, BKKBN would probably have to use a supervision approach, collecting qualitative and quantitative data in spot check on districts. An even more difficult question - how would you monitor the thousands of private providers in any useful way? Until these issues are resolved building capacity in Monitoring is useless.

Develop a Senior Leadership Advisory Structure

This recommendation parallels the Partnership and Organizational Change observations above. Greater roles for partners in the management and priority setting for BKKBN would help build partnerships. Given the history and the divergent interests and perceptions of the stakeholders, the structure might be politicized. How to give adequate representation to the private sector would also be an issue.

Initiate Leadership Capacity Building District and Municipalities

See Capacity Building and Decentralization Strategies

First, Hull and Mosley frame this recommendation in terms of leadership, but it may be more useful to consider political leadership (bupati, NGOs, DPR-D, etc.) and technical leadership (FP offices), since these are different people with different capacity-building needs. Second, the roles of district and municipal leaders requires the same change in mind set on the Vision/Mission/Values as do the national leaders (as discussed above). Districts also need a similar set of skills to seek partners, work with the private sector, play a role in improving quality of care, monitor for problems and successes (best practices), serve the disadvantaged, and protect reproductive rights.[27]

[27] *Experience suggests that some districts seem to be much more open to these changes than their national counterparts. It is rare to attend a district RH/FP event and not see a large representation from IBI (midwives association). There seems to be much more day-to-day cooperation between district family planning, health, and planning offices than there is in Jakarta. A good example of a district who understood its role and the need for partnerships occurred in 2005 when an East Java district tested new tools for assessing contraceptive security. They found three problems and appropriate solutions. 1) Unequal access to pharmacies was addressed by making a policy that required all new pharmacy licenses to be approved only if the pharmacy was to go into and underserved area. 2) Pharmacies were unwilling to carry contraceptive brands with limited demand, so the problem was addressed with the local pharmacist association by setting up central referral pharmacies that carried all brands. 3) Lack of access to sterilization was addressed by putting a small annex on the district hospital that did sterilizations and trained family planning providers. One solution required simple cooperation with a partner; another required a policy change for the private sector, and only one required action and expenditure by the district government.*

Strengthen The Role of The New District Offices

See Capacity Building and Decentralization Strategies

Promote Increased National and Local Access to Long Acting Method (IUD Implant, Sterilization)

See Method Mix, High Risk, and Equity Strategies

Greater access to long term methods must also be accompanied by superior quality of care, protection of reproductive rights, improved counseling and informed choice.

Formulate Programs Policies and Develop Operational Strategies in Collaboration with The Ministry of Health By: (a) Reaching Disadvantage Women, (b) Engaging The Private Sector, (c) Preventing Unsafe Abortion and Providing Post-Abortion Care

See (a) Equity, (b) Private Sector; (c) High Risk Strategies, and Ministry Discussion Above

The Ministry of Health and BKKBN have different missions, visions, mandates, structures and priorities; and even shared mandates often lead to territorial disputes. As a consequence, collaboration has often been difficult. The implemented Revitalization Strategy can facilitate collaboration by identifying unique capabilities and priorities and allocating activities appropriately. Where activities cross organizational

lines (ex. method mix, equity, high risk) a procedure for cooperation should be laid out and activities allocated based on comparative advantage. It is also important to remember that the most important cooperation at the operational level is between the district Office of Health, Office of Family Planning, and Office of Planning.

On the three specific topics mentioned: In serving disadvantaged women, the Ministry health centers and hospitals have the mandate and play a critical role in primary health care and critical care, but will probably play a small role because access and price are not a constraint, knowledge and attitude change, and not services, are often going to be the first step with disadvantaged populations, the private sector is just as or even more accessible in many areas, and the public sector's comparative advantage in subsidized clinical long-term methods is lost with first time users. With regard "to engaging private sector," this will be a difficult change in mind-set for all government agencies. If the agencies can see the private sector as a partner that implements national health policy and deserves support, operational strategies should follow quickly. With regard to preventing abortion and providing post-abortion care, almost everything the Government has done in RH/FP over the last forty years has contributed to preventing the unwanted pregnancies that result in abortion. Addressing the safety of abortion is difficult for the Government when it is defacto illegal. Post abortion care is a quality issue and is well within the mandates of the Government to ensure that any abortion complication is addressed and future pregnancies are wanted. Ultimately, abortion is a larger social and policy issue.

Place a High Priority on Monitoring Public and Private Performance with Rapid Feedback to District and Municipalities

See Knowledge Management iscussion in the Annex-1

Develop National Communication Strategy Focusing on the Major Unmet Needs and Un-Reached Groups

See Communication and Equity Strategies

Test and introduce innovations through grants to universities, private organizations, and NGOs

See Partnership and Knowledge Management Discussion in The Annex-1.

This paper often mentions the allocation of resources human and financial. Many NGOs, professional organizations, and universities carry out functions vital to the health of Indonesia, and often save the Government the cost of providing the services. Grants to these organizations would help build partnerships, and indicate a mature program that can recognize and reward contributions to the RH/FP health of the nation. These grants could be used to buy management or technical support, expand programs, test new approaches, support volunteers, train staff, etc.

Innovate and Strengthen District and Municipal Programs through Block Grants

As Decentralization transferred responsibilities to the districts, a number of funding mechanisms were also set up to fund these responsibilities. There is confusion among the experts that consider broader issues of decentralization and health funding (World Bank, University of Indonesia), over how much funding flows and how it is allocated once it gets to the district. So funding may not be a constraint to operations and block grant may not help. Grants should be considered very carefully, and allocated to support specific research, innovations to programs, or to support linkages to national priority programs when local funding does not allow participation.

Advocate Nationally and Internationally Based on Data Analysis

See Knowledge Management Discussion in the Annex-1

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