

**STARH COMPLIANCE
REPORT
(OCT 2001 – MAR 2002)**

March 2002

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A Periodic Report from the STARH Program

**STARH'S MONITORING FOR COMPLIANCE WITH STANDARD PROVISIONS
OCTOBER 2001 – MARCH 2002**

“The best decisions about family planning are those that people make for themselves, based on accurate information and a range of contraceptive options. People who make informed choices are better able to use family planning safely and effectively. Providers and programs have a responsibility to help people make informed family planning choices (Upadhyay 2001).”

I. INTRODUCTION

In spending US funds, STARH is obligated by US law, and by the terms of its Contractual Agreement with USAID, to meet certain requirements; and to take certain actions to ensure these requirements are met. These requirements are contained in the Standard Provision on Voluntary Population Planning, included in the Cooperative Agreement (for STARH) between JHU/CCP and USAID/Jakarta (see STARH 2001a: Appendix A). The Standard Provision for STARH was last modified on 18 April 2001, so as to incorporate the new language (reflecting the “Mexico City policy”) prescribed by the White House Memorandum dated 28 March 2001. Specifically, there are legal requirements pertaining to STARH’s family planning and family planning-related activities, which fall under 3 main categories:

- Informed choice and the Tiahrt Amendment;
- Voluntary Sterilization; and
- Abortion and the Mexico City Policy.

This document reviews what STARH has done to ensure all its activities – and, where relevant, those of its partners and contractors – have been in full compliance with all the stipulated requirements. The purpose of the document is to:

- summarize the standard provisions which apply to STARH;
- describe how STARH has monitored compliance with these standard provisions during the period 1 October 2001 until 31 March 2002;
- present the findings on compliance this period.

STARH activities aimed at ensuring compliance are of two kinds. First, in the context of the full range of STARH’s activities aimed at enhancing quality and choice in RH/FP, STARH seeks to identify weaknesses in existing service-providing and service-related systems and work with the GOI and other partners to strengthen them. Within this overall framework STARH identifies weaknesses and possible vulnerabilities with respect to the standard provisions, and, when considered necessary, takes appropriate action to rectify any deficiencies. Second, in the context of its regular monitoring and evaluation activities it checks systems and their outputs for compliance. The first kind of activity aims to make sure no violations occur in the first place; the second aims to detect whether, despite these efforts, occasional violations still occur. The two kinds of activity are complementary and need to be understood in relation to one another. STARH compliance reports give more attention to the second, however, since details concerning the first kind of activity are covered more comprehensively in STARH’s regular biennial reports.

II. INFORMED CHOICE AND THE TIAHRT REQUIREMENTS

The Tiahrt Amendment legislates specific requirements for family planning service delivery projects funded from USAID's Development Assistance account. These requirements were first enacted in 1998 as an amendment to the FY 1999 Appropriations Act, and re-enacted with the FY2000 and FY2001 Appropriations Acts. The amendment is intended to promote informed choice among family planning "acceptors" and protect them from coercion.

II.1. Standard Provisions

The Tiahrt Amendment requirements are specified (in part) in the CA as follows:

- "Service providers and referral agents in the project shall not implement or be subject to quotas or other numerical targets of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning."
- "The project shall not include the payment of incentives, bribes, gratuities or financial rewards to (i) any individual in exchange for becoming a family planning acceptor or (ii) any personnel performing functions under the project for achieving a numerical quota or target of total number of births, number of family planning acceptors, or acceptors of a particular method of contraception."
- "No person shall be denied any right or benefit, including the right of access to participate in any program of general welfare or health care, based on the person's decision not to accept family planning services offered by the project."
- "The project shall provide family planning acceptors comprehensible information about the health benefits and risks of the methods chosen, including those conditions that render the use of the method inadvisable and those adverse side effects known to be consequent of the use of the method. This requirement may be satisfied by providing information in accordance with the medical practices and standards and health conditions in the country where the project is conducted through counseling, brochures, posters, or package inserts."
- "The project shall ensure that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits" (USAID 2001: para b).

II.2. STARH Tiahrt-related Activities and Tiahrt Compliance

STARH has found no violations of the Tiahrt requirements, and is not aware of any. STARH is working with BKKBN, DepKes and other partners to enhance the principles of voluntarism and informed choice in the RH/FP program beyond the minimum standards required by Tiahrt, and to address any remaining weaknesses in these areas. On-going activities in these areas include:

Tiahrt Posters

Early in 2001 STARH, working with BKKBN, adapted the "Tiahrt poster" to the Indonesian situation and translated it into Bahasa Indonesia. STARH produced 50,000 copies of the poster and distributed them to all provinces (except Aceh and Maluku) for display in service delivery points. The USAID Assessment Team last year found the posters on display in the SDPs they visited (Riggs-Perla *et al.* 2001). In March 2002 STARH launched its District Strategy,

comprising activities organized at the district level aimed at improving quality and choice in both the supply of and demand for RH/FP (STARH 2002). As STARH rolls out component activities in the districts during the next reporting period it will monitor the distribution and display of these posters (and any other “tangibles” it has designed and distributed to promote more consistent provision of information to clients) more systematically.

Informed consent forms and procedures

Informed consent is a long-established practice in the national FP program, although there were times and occasions in the distant past when, in the opinion of some, the integrity of the process was compromised. In the case of surgical contraception the family planning movement actually pioneered informed consent in Indonesia long before it was required for other surgical procedures. Today the principle is fully institutionalized, and clients are asked to sign an informed consent form, not only for surgical contraception but also in the case of IUD insertions.

STARH has held a series of meetings with BKKBN (continuing through the last reporting period but commencing before it) to improve the informed consent forms and related procedures. In January a meeting was held at BKKBN with DepKes, IDI, POGI, and others, in which it was agreed that the forms should be revised, and that BKKBN would submit a proposal to support this activity to STARH. BKKBN are currently working on the proposal.

Client-provider interactions and Smart Patient

The quality of an informed consent process is determined largely by the nature of client-provider interactions, as well as by supporting policies, communication programs, access to services, and program leadership and management (Upadhyay 2001). STARH has continued planning activities during the last 6 months aimed at improving client-provider interactions, and at empowering clients in terms of exercising their reproductive rights. These activities are part of the SMART initiative, which will be implemented as part of the district strategy. STARH activities here are based on standards of informed choice which in fact go far beyond the minimal standards codified in the Tiaht Amendment.

QIQ

Plans for implementing the first round of the Quick Investigation of Quality (QIQ) were close to finalized during the reporting period. The survey is scheduled to commence in April. STARH will include a number of indicators that relate to Tiaht-type issues of informed choice and quality of care, for example:

- percentage of service delivery points (SDPs) with established mechanisms for acceptor and community feedback;
- number of SDPs with Tiaht poster (wallchart) displayed;
- percentage of providers following informed choice guide lines; and
- percentage of providers using IEC materials for counseling.

Monitoring activities and the District Strategy

The STARH Program is not a family planning service delivery project but focuses on providing technical assistance. Most activities to date have involved little, if any, direct contact with service delivery. Consequently there has been little opportunity in the routine activities of STARH to monitor the level of voluntarism and informed choice, or the level of compliance with Tiaht, in the way services are actually delivered to and received by clients. STARH expects to have many

more opportunities in the future, however; now that the district strategy has been launched STARH will be supporting more activities at service delivery points and in local communities. As the USAID Tiahrt Assessment Team noted, “Field visits present a good opportunity to interview service providers, supervisors, managers and acceptors, and to observe counseling sessions, all of which should help identify informed choice issues, including Tiahrt-specific ones, if they are present” (Riggs-Perla *et al.* 2001: 15). It is STARH policy that any member of STARH who observes a violation, or possible violation, of the Tiahrt requirements has a responsibility to report this to the STARH Program Team Leader, who will then take appropriate action.

Summary findings

Given the maturity of the Indonesian program, Tiahrt violations are expected to occur only extremely rarely, if ever. Current policies promote the principles of voluntarism and informed choice, and BKKBN has systems in place to ensure these principles are implemented. Nonetheless the *perception* that BKKBN is primarily a “population control” organization still exists among some Indonesians. STARH is working with BKKBN and other partners to ensure that voluntarism and informed choice are consistently applied in the program, and at a level significantly beyond the minimum standards required by Tiahrt. Under the SMART initiative STARH will soon be supporting more activities empowering clients to exercise their reproductive rights. STARH has no evidence of any Tiahrt violations during the reporting period, and has no reason to believe any will have occurred. STARH technical assistance in this area is designed to make a violation virtually impossible.

III. VOLUNTARY STERILIZATION

Additional requirements are specified in the CA in the case of voluntary sterilization.

III.1. Standard Provisions

As stated in the CA:

- “None of the funds made available under this award shall be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any individual to practice sterilization.
- “The recipient shall ensure that any surgical sterilization procedures supported in whole or in part by funds from this award are performed only after the individual has voluntarily appeared at the treatment facility and has given informed consent to the sterilization procedure. Informed consent means the voluntary, knowing assent from the individual after being advised of the surgical procedures to be followed, the attendant discomforts and risks, the benefits to be expected, the availability of alternative methods of family planning, the purpose of the operation and its irreversibility, and the option to withdraw consent anytime prior to the operation. An individual’s consent is considered voluntary if it is based upon the exercise of free choice and is not obtained by any special inducement or any element of force, fraud, deceit, or other forms of coercion or misrepresentation.
- “Further, the recipient shall document the patient’s informed consent by (i) a written consent document in a language the patient understands and speaks, which explains the basic elements of informed consent, as set out above, and which is signed by the

- individual and by the attending physician or by the authorized assistant of the attending physician; ...
- “The recipient must retain copies of informed consent forms and certification documents for each voluntary sterilization procedure must be retained by the recipient for a period of three years after performance of the sterilization procedure” (USAID 2001: para c).

III.2. Monitoring Activities and Findings

During the first part of 2001 STARH made an assessment of surgical contraception (sterilization) in the national FP program, focusing on three aspects – the policy environment, access to services, and the quality of these services. The assessment, undertaken to provide a basis for deciding whether STARH should provide support for surgical contraception, considered issues of voluntarism and informed consent (STARH 2001b).

The assessment team found no evidence of involuntary sterilization being practiced, or of the use of coercion or incentives. Surgical contraception acceptors in the national program are provided with comprehensible information; they are informed of the nature of the method (including its irreversibility), of the associated risks and discomforts, and of alternative methods available. Surgical contraception procedures are only carried out after the client has freely given his or her informed consent, and signed an informed consent form as evidence of this.

Based on the assessment team’s report, however, STARH does have reservations about the way the informed consent policy is implemented and documented. Counseling is typically given by the PLKB, and often without any additional counseling by a medically-trained provider at the service delivery point. Moreover the informed consent form is often signed by a program representative without necessarily being signed by the attending physician, or his or her authorized assistant. Informed consent is practiced, but the implementation could be improved significantly.

The results of STARH’s assessment have facilitated a significant shift in GOI policy regarding surgical contraception (see STARH 2002). The Minister of Health, for instance, is issuing a letter that suspends implementation of a former *surat keputusan* allowing *puskesmas* with overnight facilities to do tubectomies. Other revisions and reforms are in train, including improvements in counseling and informed choice. As mentioned before, BKKBN is also preparing a proposal to be submitted to STARH to improve informed consent forms. STARH has not made a final decision yet on whether to support surgical contraception, but it has made it clear it will only be able to offer support if the informed consent procedures are enhanced, and are made fully consistent with the standard provisions on this matter included in the CA.

IV. ABORTION AND MEXICO CITY

President Bush has re-instated the so-called Mexico City policy, and the 18 April 2001 Modification of the CA reflects the new language prescribed by the White House.

IV.1. Standard Provisions

As stated in the CA:

- “No funds made available under this award will be used to finance, support, or be attributed to the following activities: (i) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; (ii) special fees or incentives to women to coerce or motivate them to have abortions; (iii) payments to persons to perform abortions or to solicit persons to undergo abortions; (iv) information, education, training, or communication programs that seek to promote abortions as a method of family planning; and (v) lobbying for abortion.
- “No funds made available under this award will be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilizations as a means of family planning. Epidemiologic or descriptive research to assess the incidence, extent or consequences of abortions is not precluded.
- “The recipient agrees that it will not furnish assistance for family planning under this award to any foreign non-government organization that performs or actively promotes abortion as a method of family planning in USAID-recipient countries or that provides financial support to any foreign nongovernmental organization that conducts such activities. ...
- “The recipient may not furnish assistance for family planning under this award to a foreign nongovernmental organization (the sub-recipient) unless: (i) The sub-recipient certifies in writing that it does not perform or actively promote abortion as a method of family planning ...” (USAID 2001: para’s d & e).

IV.2. Monitoring Activities

The STARH Program has to date neither provided any FP services, nor made any contract to “furnish assistance for family planning ... to any foreign non-government organization.”

In anticipation of a time when we work with NGOs providing RH/FP services (including advocacy), STARH has consulted with USAID on the implications of the Mexico City Policy for STARH, and is preparing a briefing paper to clarify the situation, especially for Indonesian counterparts and partners. The paper has 3 aims: (i) to summarize the main substance of MCP and its relevance to those working on RH/FP issues in Indonesia using USAID population funding; (ii) to recommend a principled strategy in response to the likely impact of MCP on RH/FP activities; and (iii) to establish practical guidelines regarding what we can and cannot do under MCP with our partners to improve the quality and consistent use of RH/FP services.

V. REFERENCES

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