ASSESSMENT OF THE IMPLEMENTATION OF THE TIAHRT AMENDMENT IN USAID/INDONESIA-SUPPORTED FAMILY PLANNING PROJECTS

Joy Riggs-Perla

Mark Rilling

Barbara Seligman

March 2001

TABLE OF CONTENTS

Page

Executive Summary

The principles of voluntarism and informed choice have been at the center of USAID's family planning assistance program since its inception in 1967 and have guided it ever since. In 1998, these principles were reaffirmed in an amendment to the FY1999 Appropriations Act. The Tiahrt Amendment (named for its author, Representative Todd Tiahrt of Kansas) legislates specific requirements for international family planning service delivery projects supported by USAID, which are intended to protect family planning users and acceptors[1] from coercion. The amendment was re-enacted with the FY2000 and FY2001 Appropriations Acts and is expected to remain part of appropriations law for the foreseeable future.

The specific requirements of the Tiahrt Amendment apply to projects that receive USAID Development Assistance to support (with funds, technical assistance or commodities) family planning service delivery projects. The Tiahrt Amendment prohibits the use of targets or quotas for service providers or referral agents; incentives for becoming acceptors or to program personnel; the denial of rights or benefits based on the acceptance of family planning; and requires the provision of comprehensible information to family planning acceptors. It also requires that studies of experimental family planning methods advise participants of potential health benefits and risks. The first four provisions were the focus of this assessment.

A single violation of the Tiahrt Amendment requirements must be reported to Congress except in the case of the comprehensible information requirement, when a pattern or practice of violations must be reported to Congress.

The Indonesia family planning program is regarded as one of the most successful in the world. Over the past 30 years contraceptive use in Indonesia has soared, contributing to significant fertility decline. Although hard hit by the Asian economic crisis, Indonesians have continued to use family planning, increasingly turning to the private sector to meet their contraceptive needs. In 1994 the national family planning policy shifted away from its early "top-down" approach to the new era (*Era Baru*) that embraces the principles articulated at the International Conference on Population and Development (ICPD), which focus on meeting the reproductive health needs of individuals.

To monitor Tiahrt Amendment requirements, a number of assessments in large, USAID assisted family planning programs have been conducted. In March 2001, a USAID/Washington team visited Indonesia to assess possible vulnerabilities with respect to the Tiahrt Amendment requirements in the family planning service delivery programs and to make recommendations for addressing any potential vulnerability.

[1] The Tiahrt Amendment uses the term "acceptors." USAID prefers the term "clients", which is consistent with its focus on individuals and empowering them to take an active role in evaluating their family planning options, rather than passively accepting a family planning method. In order to be consistent with the language in the statute, however, we use the term "acceptor" in this paper.

The team found no evidence of Tiahrt violations and concluded that USAID's assistance to the family planning program, particularly through STARH, was compliant with the Tiahrt Amendment. The STARH Program, in fact, was established to help Indonesian service providers, both public and private, improve the quality of care including informed choice and voluntarism. Current policies in Indonesia are highly consistent with the principles of the Tiahrt Amendment and the ICPD Program of Action. The team made suggestions for improving the quality of comprehensible information and for strengthening the monitoring of Tiahrt compliance.

The following is a summary of findings and recommendations:

- **Targets and Quotas**

Findings: The assessment team did not find evidence of the use of targets and quotas as defined by the Tiahrt Amendment. It became evident that the program's primary challenge currently is meeting existing unmet demand, especially for implants and injectables, rather than in creating new demand. Quantitative estimates are used for planning purposes based on information that is collected by village volunteers in annual enumeration of families to estimate demand. It was consistently reported across the provinces, districts and sub-districts visited by the team that targets are not predetermined or assigned to village volunteers or to service providers. Nor do there appear to consequences associated with meeting or not meeting the estimates used for planning at the subdistrict health facilities (*PUSKESMAS*). Interviewees referred to the "safari" services that occur today as outreach events where family planning services are available free of charge, but the "safari" practiced today has a different meaning and application than in the past, when it did present potential for abuse.

Recommendation: USAID/Indonesia and its CAs, along with *DepKesKeSos* and *BKKBN*, should continue to monitor the annual family planning enumeration exercise to ensure that the demand fulfillment process does not take on the characteristics of target-setting or lead to coercive activities. In addition, USAID and its partners should continue to monitor the provision of "safari" services to ensure that they do not permit situations in which coercion could occur.

- **Incentives**

Findings: The assessment team found no incentives as defined by the Tiahrt Amendment provided by the program. Managers and providers do not receive incentives for providing family planning services or for recruiting family planning acceptors, nor do acceptors receive incentives for choosing to use particular methods. Promotional activities such as savings clubs or small fund collection pools take place to encourage continuous participation in monthly activities such as the village health meeting (*Posyandu*), but participation is open to all regardless of one's family planning acceptance status or the number of children one has.

Recommendation: USAID/Indonesia and its partners should monitor the policies and practices to ensure that incentives continue not to be used, particularly as *BKKBN* focuses more of its emphasis on the poorest individuals. The greater programmatic vulnerability at this point is ensuring services for those who cannot afford to pay.

- **Denial of Rights or Benefits**

Findings: The assessment team found no evidence that policies permit the withholding of rights or benefits or that such rights or benefits are being withheld from individuals who do not accept family planning or a specific method of family planning. The team found managers, service providers, village volunteers and acceptors who were both married and not married, who accepted family planning and who did not. None reported any right or benefit that is not equally available to non-acceptors.

Recommendation: USAID/Indonesia and its partners should help monitor the policies and practices to ensure that rights and benefits do not become tied to acceptance of family planning or any particular method in the future.

- **Comprehensible Information**

Findings: Service providers appear to be knowledgeable about and experienced with providing information to acceptors, and have accurate and consistent information about the health benefits and risks, inadvisabilities and the side effects of available methods. The Tiahrt compliant wall charts had been distributed to the program areas visited by the team. Moreover, acceptors who were interviewed by the team accurately reported back information they had received about the selected method, indicating that they not only received the information but understood it. This means that the program is exceeding the requirements of the Amendment, which makes no reference to their comprehension of the information. To facilitate the transfer of information jobs aids (e.g. flip charts etc.) were observed only in a few NGO facilities. While these job aids exist in Indonesia they are not widely used.

Recommendation: A review of the compliance of existing training and IEC materials with the Tiahrt requirements should be included in the review of such materials that the STARH program is planning. Such a review would be helpful for the development and distribution of cue cards and other job aids to assist providers in informing acceptors, an activity that the team would advise be given high priority.

- **Use of Experimental Contraceptive Drugs and Devises**

USAID/Indonesia does not finance use of or research studies involving experimental contraceptive drugs, devices or medical procedures and therefore this provision is not relevant to the program.

The team recommended a number of ways to strengthen monitoring and evaluation, many of which were planned for within STARH and none of which require burdensome or special systems. The team also recommended that USAID/Indonesia and STARH program staff explore with their Indonesian partners ways in which civil society organizations or other appropriate entities can become more involved in helping acceptors voice their opinions and exercise their rights with respect to family planning and other health services.

In summary, the team found that Indonesian family planning policy has undergone a dramatic change since the 1994 International Conference on Population and Development and that current policies are highly consistent with USAID policies of informed choice and voluntarism. An impressive effort has been made and is continuing to be made to inculcate the new paradigm (*Era Baru*) thinking into all levels in the program. USAID can play an important supportive role to help the Indonesian government as services become increasingly decentralized to the District level, to improve the availability and quality of services and protect the principles inherent in the Tiahrt Amendment. Continued attention to information needs of family planning users along with strengthened systems for getting community and acceptor feedback will be important elements of this transition in the program.

Ringkasan Utama

Prinsip-prinsip voluntarisme/kesukarelaan dan *informed choice* telah menjadi fokus dari program bantuan keluarga berencana USAID sejak diperkenalkannya pada tahun 1967 dan telah dijadikan acuan sejak saat itu. Pada tahun 1998, prinsip-prinsip ini dipertegas kembali melalui sebuah amandemen anggaran belanja 1999. Tiahrt Amandemen (diambil dari nama penyusunnya, Todd Tiahrt seorang senator dari Kansas) mengatur persyaratan khusus bagi proyek-proyek pelayanan KB bantuan USAID secara International, yang ditujukan untuk melindungi akseptor KB dari pemaksaan. Amandemen ini diaktifkan (*re-enacted*) kembali dalam anggaran belanja 2000 dan 2001 dan diharapkan tetap menjadi bagian dari undang-undang anggaran belanja di masa-masa mendatang.

Persyaratan-persyaratan khusus dari Tiahrt Amandemen ini berlaku bagi proyek-proyek penerima Bantuan Pembangunan USAID untuk (baik bantuan dana, tehnis atau komoditi) proyek-proyek pelayanan Keluarga Berencana. Tiahrt Amandemen melarang penggunaan target atau kuota bagi '*service provider'* atau tempat-tempat rujukan; insentif bagi calon akseptor atau staf program; penolakan hak atau keuntungan-keuntungan dalam menerima KB; dan penyediaan informasi yang dapat dimengerti bagi akseptor-akseptor KB. Persyaratan ini juga berlaku bagi studi-studi eksperimental metode KB yang mengharuskan memberi tahu calon peserta KB mengenai segala potensi risiko dan keuntungannya. Hanya empat persyaratan pertama yang menjadi fokus dalam asesmen ini.

Adanya satu saja pelanggaran dari persyaratan Tiahrt Amandemen sudah perlu dilaporkan ke *Congress*. Khusus untuk persyaratan "informasi yang dapat dimengerti", bila pelanggaran tersebut menjadi suatu pola - perlu dilaporkan ke *Congress*.

Program keluarga berencana Indonesia telah dikenal sebagai salah satu program yang paling berhasil di dunia. Selama lebih dari 30 tahun pelayanan kontrasepsi di Indonesia berkembang pesat menyumbang pada angka fertilitas yang cukup bermakna. Walaupun diterpa oleh krisis ekonomi Asia, rakyat Indonesia tetap menggunakan KB, dan bahkan telah berkembang pula ke sektor swasta dalam memenuhi kebutuhan pemakaian kontrasepsi mereka. Dalam tahun 1994 kebijakan KB nasional telah beralih dari pendekatan yang *'top-down'* ke paradigma baru yang merangkul prinsip-prinsip yang dianut dalam *International Conference on Population and Development (ICPD*), dengan fokus pada pemenuhan kebutuhan-kebutuhan kesehatan reproduksi setiap orang.

Untuk memonitor persyaratan-persyaratan Tiahrt Amandemen, sejumlah kajian secara luas, telah dilakukan bagi program-program pelayanan KB bantuan USAID. Pada bulan Maret 2001, sebuah Tim USAID/Washington telah berkunjung ke Indonesia untuk menilai kemungkinan terjadinya kerentanan yang berkaitan dengan persyaratan Tiahrt Amandemen dalam program-program pelayanan KB bantuan USAID dan membuat rekomendasi untuk mengatasi kemungkinan pelanggaran yang dapat terjadi.

Tim tidak menemukan bukti pelanggaran Tiahrt dan menyimpulkan bahwa program bantuan USAID dalam pelayanan KB, khususnya melalui STARH, telah sejalan dengan Tiahrt Amandemen. Sebenarnya Program STARH, diadakan untuk membantu *service provider*, pemerintah maupun swasta, dalam memperbaiki mutu pelayanan yang meliputi *informed choice* dan kesukarelaan. Kebijakan di Indonesia saat ini, sangat konsisten dengan prinsip-prinsip Tiahrt Amandemen dan Program *ICPD*. Tim mengajukan usulan untuk memperbaiki mutu informasi yang dapat dimengerti dan memperkuat sistim monitoring ketaatan terhadap Tiahrt.

Berikut ini adalah ringkasan temuan dan rekomendasi Tim USAID.

- **Target dan Kuota**

Temuan: Tim asesmen tidak menemukan bukti-bukti penggunaan target dan kuota seperti yang didefinisikan dalam Tiahrt Amandemen. Ternyata tantangan utama program yang ada saat ini adalah bagaimana memenuhi kebutuhan (unmet needs), terutama implant dan suntik, ketimbang menciptakan kebutuhan baru. Estimasi kuantitatif dilakukan untuk kepentingan perencanaan berdasarkan informasi yang dikumpulkan oleh kader di desa, dengan menggunakan hasil pendataan keluarga untuk perkiraan tingkat kebutuhan. Hal ini telah dilaporkan secara konsisten oleh seluruh propinsi, kabupaten dan kecamatan yang dikunjungi oleh Tim, bahwa target tidak pernah ditetapkan sebelumnya atau diwajibkan bagi kader atau *service provider*. Juga tidak nampak adanya sanksi yang diterapkan terhadap dipenuhi atau tidaknya perkiraan perencanaan tersebut di Puskesmas. Responden mengutarakan "pelayanan safari" yang terjadi saat ini adalah untuk kepentingan memperluas jangkauan dimana pelayanan KB disediakan secara gratis, namun demikian safari KB yang dilakukan sekarang mempunyai praktek dan arti yang berbeda dengan masa lalu, dimana saat itu ada potensi untuk disalah gunakan.

Rekomendasi: USAID/Indonesia dan para *CA (Cooperating Agency*), bersama dengan DepKesKeSos dan BKKBN, perlu terus memonitor pelaksanaan pendataan KB tiap tahun untuk menjamin bahwa penentuan perkiraan permintaan masyarakat tidak mengarah pada upaya penentuan target atau tindakan pemaksaan. Selain itu, USAID dan mitra kerjanya perlu terus memonitor ketentuan pelayanan 'safari' untuk memastikan bahwa tidak terjadi situasi dimana pemaksaan dapat terjadi.

- **Insentif**

Temuan: Tim asesmen tidak menemukan insentif sebagaimana yang didifinisikan oleh Tiahrt Amandemen. Baik petugas lapangan (manajer) dan *provider* tidak pernah menerima insentif untuk pemberian pelayanan KB atau mendapatkan akseptor KB, sebaliknya akseptor tidak pernah menerima insentif untuk memilih metode KB tertentu. Kegiatan-kegiatan promosi seperti arisan atau pengumpulan dana dilakukan untuk memantapkan keikutsertaan dalam kegiatan bulanan seperti Posyandu. Keikutsertaan ini terbuka bagi siapapun, tanpa memandang keikutsertaan dalam KB atau jumlah anak yang dimiliki.

Rekomendasi: USAID/Indonesia dan semua mitra kerjanya perlu memonitor kebijakan dan pelaksanaannya untuk memastikan bahwa insentif tetap tidak dipergunakan, terutama dengan difokuskannya program BKKBN bagi yang tidak mampu. Tantangan/ kerawanan program saat ini adalah bagaimana menjamin pelayanan bagi mereka yang tidak mampu.

- **Pengingkaran atas Hak dan Keuntungan**

Temuan: Tim asesmen tidak mendapatkan bukti adanya kebijakan yang membolehkan penundaan hak atau keuntungan, atau dikuranginya hak dan keuntungan tersebut dari individu-individu yang tidak mau menggunakan KB atau metode KB yang ditentukan. Tim telah menemui para petugas lapangan (manajer), *provider*, kader (tenaga sukarela desa*)* dan akseptor baik yang telah menikah maupun belum menikah, yang menggunakan KB maupun yang tidak. Tidak ada satupun laporan tentang adanya perbedaan hak ataupun keuntungan yang tidak setara bagi non-akseptor.

Rekomendasi: USAID/Indonesia dan semua mitra kerjanya perlu terus memonitor kebijakan dan pelaksanaannya untuk menjamin bahwa hak dan keuntungan tidak dikaitkan pada penerimaan KB ataupun metode KB tertentu pada masa mendatang.

- **Informasi yang dapat dimengerti**

Temuan: *Provider* tampaknya mempunyai pengetahuan dan pengalaman cukup dalam memberi informasi kepada para akseptor, secara konsisten dan akurat mengenai risiko dan keuntungan kesehatan, hal-hal yang tak dianjurkan dan efek samping dari metode-metode KB yang tersedia. Poster Tiahrt telah didistribusikan di semua wilayah program yang dikunjungi Tim. Lebih jauh, para akseptor yang diwawancarai oleh Tim dapat melaporkan kembali dengan akurat tentang informasi yang telah mereka terima mengenai metode yang dipilih, mengindikasikan bahwa mereka tidak hanya telah menerima informasi itu tetapi juga memahaminya. Ini menunjukkan bahwa program telah melampaui persyaratan-persyaratan Amandemen, yang tidak mensyaratkan pemahaman atas informasi tersebut. Namun, diluar LSM, Tim tidak melihat contoh dari materi komunikasi sederhana, yang dapat berguna bagi kader (tenaga sukarela desa) dan para akseptor/calon akseptor.

Rekomendasi: Kajian akan kesesuaian materi pelatihan dan KIE dengan persyaratan Tiahrt perlu diikutkan dalam kajian materi yang direncanakan oleh program STARH. Kajian semacam itu akan berguna bagi pengembangan dan diseminasi ‘lembar balik’ (*cue cards*) untuk membantu provider dalam memberikan informasi kepada para akseptor. Tim mengusulkan agar kegiatan tersebut dijadikan prioritas penting.

- **Penggunaan obat kontrasepsi dan alat KB untuk uji coba.**

USAID/Indonesia tidak mendanai penelitian yang mencakup ujicoba obat-obat kontrasepsi, alat-alat KB ataupun prosedur medis, oleh karenanya ketentuan ini tidak relevan untuk program.

Tim merekomendasikan beberapa cara untuk meningkatkan sistim monitoring dan evaluasi, yang telah dirancang dalam STARH yang tidak perlu menjadi tambahan beban atau sistim khusus. Tim juga merekomendasikan bahwa USAID/Indonesia dan Staf program STARH bersama dengan mitra kerja Indonesia untuk menggali cara-cara dimana organisasi-organisasi kemasyarakatan (madani) dan organisasi lain dapat lebih terlibat dalam membantu para akseptor menyuarakan pendapat dan mendapatkan hak-hak-nya selain KB dan pelayanan kesehatan lainnya.

Sebagai rangkuman, Tim berpendapat bahwa kebijakan KB Indonesia telah berubah drastis sejak ICPD 1994 dan kebijakan saat ini sangat sejalan dengan kebijakan USAID mengenai informed choice serta kesukarelaan. Upaya yang mengesankan telah dan masih dilakukan secara berkelanjutan untuk menerapkan pemikiran Era Baru kedalam semua tingkatan dalam program. USAID dapat menjalankan peran penting dalam mendukung pemerintah Indonesia pada saat terjadinya desentralisasi pelayanan ke tingkat kabupaten, untuk meningkatkan ketersediaan dan kualitas pelayanan sambil menjaga prinsip-prinsip dalam Tiahrt Amandemen. Menjadi unsur penting dalam masa transisi untuk mempertahankan perhatian pada kebutuhan informasi pemakai KB sejalan dengan penguatan sistem umpan balik dari akseptor dan masyarakat.

I. INTRODUCTION

A. Background on Tiahrt Amendment and reasons for assessing vulnerability in Indonesia

The principles of voluntarism and informed choice have been at the center of USAID's family planning assistance program since its inception in 1967. In 1982, USAID issued a policy paper on population assistance, which clearly states its commitment to voluntarism and informed choice. More recently, in 1994, the International Conference on Population and Development highlighted these principles and their implementation by incorporating them into the Conference Programme of Action. One hundred seventy-nine governments endorsed the Programme of Action, including the United States and Indonesia. In 1998, Congress enacted the Tiahrt amendment (named for its author, Representative Todd Tiahrt of Kansas) to the FY1999 Appropriations Act. The Tiahrt Amendment legislates specific requirements for international family planning service delivery projects supported by USAID, which are intended to protect family planning acceptors from coercion. The amendment was re-enacted with the FY2000 and FY2001 Appropriations Acts and is expected to remain part of appropriations law for the foreseeable future.

A.1. Requirements of the Tiahrt Amendment

The specific requirements of the Tiahrt Amendment apply to family planning service delivery projects funded from USAID's Development Assistance account. Under the Tiahrt Amendment, a project is "a discrete activity through which a governmental or nongovernmental organization provides family planning services to people" and for which Development Assistance funds, or goods or services financed with such funds, are provided. The Tiahrt Amendment requires that in family planning projects:

- Service providers and referral agents not implement or be subject to quotas relating to numbers of births, family planning acceptors, or acceptors of a particular family planning method;
- No incentives be offered to individuals in exchange for becoming acceptors[2] or to program personnel for achieving targets or quotas for numbers of births, acceptors, or acceptors of a particular family planning method;
- Rights or benefits not be withheld from persons who decide not to become acceptors;
- Acceptors be given comprehensible information on the health benefits and risks of the family planning method chosen, including the conditions that might make the method chosen inadvisable, and known side effects; and
- Provision of experimental family planning methods occurs in the context of a scientific study in which participants are advised of potential risks and benefits.

A single violation of the Tiahrt Amendment requirements must be reported to Congress except in the case of the comprehensible information requirement, for which a pattern or practice of violations must be reported to Congress.

[2] The Tiahrt Amendment uses the term "acceptors." USAID prefers the term "clients", which is consistent with its focus on individuals and their empowerment to take an active role in evaluating their family planning options, rather than passively accepting a family planning method. In order to be consistent with the language in the statute, however, we use the term "acceptor" in this paper.

A.2. Brief History of the Indonesian Family Planning Program

The Indonesian family planning program is generally regarded as one of the most successful in the world. The contraceptive prevalence rate, which was about 10% in the early 1970s, is now at 54.7% for modern methods according to the 1997 Indonesia Demographic and Health Survey. The primary government agencies involved in the family planning program are the National Family Planning Coordinating Board (*BKKBN*) and the Ministry of Health and Social Welfare (*DepKesKeSos*). With the recent decentralization of health services, the Ministry of Home Affairs at the provincial, district and subdistrict levels, will soon become the key institution in the financing and provision of family planning services. In the arena of service delivery, BKKBN is responsible for procuring and distributing contraceptive supplies, community education and estimation of acceptor demand, and maintaining a national information system on family planning services. *BKKBN* operates an extensive network of rural fieldworkers throughout the country. The Ministry of Health and Social Welfare is responsible for the provision of clinical services. Both entities share responsibility for counseling and acceptor education. For the last ten years, *BKKBN* has sought to promote *KB Mandiri* (family planning self sufficiency) to encourage acceptors to purchase their services, either from government facilities, or directly from private providers.

The program offers a range of methods including IUDs, injectables, implants, oral pills, and condoms (a "cafeteria" approach). Voluntary sterilization has been widely available for many years but is not a *BKKBN* "program" method. Pills and injectables are the most widely used methods although the demand for other methods, especially implants, is substantial. With the on-set of the Asian financial crisis, which affected Indonesia more severely than its neighbors, the availability of certain methods such as injectables and implants through the government program was reduced due to cost. Current *BKKBN* family planning policy, called "New Era", stresses the importance of ICPD principles including responding to acceptor demand, informed choice, and respecting reproductive rights.

A.3. USAID/Indonesia's Family Planning Service Delivery Program

USAID/Indonesia has supported the national family planning program for over 30 years, working principally with *BKKBN*, but also with the Ministry of Health and non-government organizations. The most recent project, the Service Delivery Expansion Support (SDES) project, began in 1994 and ended in 2000. SDES assisted *BKKBN* to increase the availability, quality and utilization of contraceptive services, especially long-term methods, improve the sustainability of the program, increase the availability of services and family planning information in hard-to-reach areas and increase the role of NGOs. The current family planning activity is entitled Sustaining Technical Achievements in Reproductive Health/Family Program (**STARH Program**). Funding for this program is obligated through a bilateral Strategic Objective Agreement (SOAG), and implemented through a cooperative agreement with Johns Hopkins/Center for Communications Programs (JHU/CCP) working in partnership with JHPIEGO, JSI, MJM and YKB. The program emphasizes technical assistance and capacity development through the following components:

(1) Enhanced Policy for Quality Care with an emphasis on assisting the government with decentralization, improving service delivery policy and assistance related to U.S. legislation, namely the Tiahrt Amendment, and other policy requirements.
(2) Improving Service Support Systems including quality assurance, contraceptive self-sufficiency, human resource development through clinical reproductive health training, improved logistics, and improved provider performance.
(3) Advocacy and Communication, including work to improve acceptor decision-making, acceptor and provider educational materials development, NGO advocacy, reducing high discontinuation rates, and increasing community participation, including strengthening women's role in decision-making.
(4) Other Activities: The program also has components concerned with strengthening donor and government partner involvement, monitoring and evaluation (including monitoring of quality of care), and reaching special populations such as young adults.

The program activities will focus in nine of the most densely populated provinces in Indonesia: East Java, Central Java, West Java, *Banten*, Jakarta, North Sumatra, South Sumatra, *Bangka* and *Lampung*[3]. The STARH agreement with JHU was signed in August 2000 and work started immediately, with the full team in place in January 2001. The first annual work plan was being finalized during the time of the Tiahrt assessment team visit.

In addition to STARH, the SOAG provides population funds for **Healthy Indonesia 2010**, an activity implemented through JHU/CCP to help the Ministry of Health implement a communications and advocacy campaign for national health development. A coalition of private companies and local foundations has been formed to help promote a broad range of health themes including reproductive health, breast and cervical cancer screening and preventing violence against women. Major Indonesian and multilateral firms have signed on to the coalition making it a high profile and potentially powerful advocacy group for health issues. USAID support for Health Indonesia 2010 does not involve family planning service delivery activities.

The third activity receiving USAID/Indonesia population funds is the **Maternal and Neonatal Health Program**. Population funds are being used for post-abortion care activities, which are part of a broader strategy to reduce maternal morbidity and mortality. JHPIEGO is the prime contractor for this activity in partnership with JHU/CCP, PATH and CEDPA. Some technical assistance personnel are shared across both STARH and the MNH programs. The MNH program works in West Java, East and Central Java, with possible future sites in South Kalimantan, South Sumatra, South Sulawesi and West Sumatra.

[3] The original program design was for seven provinces. Banten and Bangka were recently made provinces by subdividing West Java and South Sumatra respectively.

B. Tiahrt Assessment Scope of Work

To monitor implementation of the Tiahrt Amendment requirements, the Office of Population in USAID's Global Bureau recommended that assessments be conducted in countries with large, highly visible family planning programs, which may, in the past, have been associated with practices that could be inconsistent with the Tiahrt requirements. As one of the largest and most successful programs where USAID has worked, the Indonesian family planning program was among those recommended for such an assessment. Plans for conducting this assessment began in September 2000 at the time of the Indonesia HPN Senior Review. The assessment team members included: from USAID/Indonesia, Pamela Wolf, Family Planning Team Leader, Carol Rice, Adviser for Family Planning and Reproductive Health, Bambang Samekto, Project Management Specialist; Natalie Freeman, Regional Legal Adviser; and from STARH, Fitri Putjuk, Communication Adviser and Dr. Bimo, Medical Adviser. The USAID/Washington team was Joy Riggs-Perla, Director, Office of Health and Nutrition in the Global Bureau; Mark Rilling, Indonesia Country Coordinator and Barbara Seligman, Senior Policy Adviser, both from Global Bureau, Office of Population.

The scope of work for the team was to assess possible vulnerabilities with respect to the Tiahrt Amendment requirements in USAID/Indonesia-supported family planning service delivery programs and to make recommendations for addressing any vulnerability that might be found.

B.3. Methodology

In preparation for the USAID/Washington team's visit, STARH Program did a policy review and prepared a briefing paper on Tiahrt Amendment requirements affecting USAID assistance to the Indonesian national family planning program[4]. The STARH team also compiled relevant background materials and together with *BKKBN* and *DepKesKeSos* provided logistical support for the assessment team.

Prior to arrival in Indonesia, the USAID/Washington team members were briefed by the former POLICY Project long term adviser to the *BKKBN*, Dr. William Emmet, on the introduction of a acceptor driven ("demand fulfillment") approach to managing family planning activities and by Dr. Neeraj Kak, who conducted an extensive evaluation of the SDES Project, the Mission's vehicle for providing family planning assistance for service delivery activities prior to the award of the STARH program. The USAID/Washington team also benefited from briefings by USAID/Washington staff who had participated in Tiahrt vulnerability assessments in other countries, notably India. The team conducted an extensive review of documents and reports on the "New Era" policy of the BKKBN, voluntarism and quality of care initiatives in Indonesia.

Once in Jakarta, the team met with USAID Mission management and HPN staff, national level *BKKBN* and *DepKesKeSos* officials, STARH Program staff, and representatives of leading family planning NGOs. The team developed protocols for interviewing acceptors, providers and supervisors to ensure consistency in the subjects covered during

[4] Hayes, Adrian, "The Indonesian National Family Planning Program and the Tiahrt Amendment of the US Congress", STARH Program, 6 March 2001 Jakarta

the field visits. The team divided in two for field visits. One group traveled to *Semarang* and *Yogyakarta* in Central Java and the other to the *Deli Serdang* and *Dairi* subdistricts, and to NGO facilities in *Medan*, all in North Sumatra. The two provinces, Central Java and North Sumatra, were selected because they represent programs with relatively strong and weak family planning programs, respectively. One of the sites in North Sumatra was located in a rural area where physical access to the subdistrict health clinic (*PUSKESMAS*) was difficult for many in the catchment population. During the site visits the teams met with *BKKBN* provincial, district and subdistrict officials and health care providers from the most senior, doctor in the subdistrict health clinic (*Dokter PUSKESMAS*) to the field level provider, (e.g. village volunteers (*kaders*), village midwives (*bidan di desa*) and acceptors). The team conducted interviews at subdistrict health clinics, village health posts and birthing huts, village volunteer's homes, a district hospital and NGO clinics. The team assessed all of the service delivery components of the Mission's family planning program: public sector, private sector (NGOs) and private providers in these two provinces.

II. ANALYSIS OF TIAHRT COMPLIANCE

A. TARGETS and QUOTAS

A.1 Tiahrt Requirements

The Tiahrt Amendment requires that "service providers and referral agents 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." However, programs can use quantitative estimates or indicators for planning and budgeting purposes. In USAID's "Guidance" for implementation of the Tiahrt requirements in field programs, a quota or target is defined as a predetermined number of births, family planning acceptors, or acceptors of a particular method that a service provider or referral agent is assigned or required to affect or achieve.

A.2. Background

Indonesia's family planning policy and program has changed over time in keeping with the country's changing political and economic environment. From about 1945 to 1965, the GOI's policy reflected a pronatalist belief that a large population would propel Indonesia's development. By the late 1960s it was clear that a large population would constrain the desired development. Demographic and normative goals were included in the first national Five-Year Development Plan (1969-1974), and *BKKBN* was established in 1970. For the next twenty-plus years, government programs worked to socialize the practice of family planning, promote the concept of "the small, happy and prosperous family" with a two-child norm, and ensure that family planning services and contraceptives were provided to married couples. National five-year plans through the late-1980s included targets for acceptors and providers, including sometimes for specific methods. The 1990 population census indicated that more than 90% of eligible married couples or married women of reproductive age accepted the concept of family planning. In 1992 Indonesia law provided that couples have the right to choose whether and how to regulate the number and spacing of their children. *BKKBN* announced in 1994 the

abandonment of numeric targets in the family planning program, and substituted the concept of "demand fulfillment" for planning and program performance monitoring. Demand fulfillment is based upon an annual *BKKBN*-conducted national enumeration of families to determine current family planning use status, fertility desires, unmet need and other socioeconomic information. The enumeration is used to plan field visits, provider case-work, information provision, and estimate procurement and distribution needs for family planning and many other health services. During the mid- to late-1990s, observers of Indonesia's family planning program debated whether the shift by the central level from targets to demand fulfillment (based upon client-stated demand) had been embraced in field programs.

A.3. Findings: No Evidence of Targets or Quotas in Planning and Performance Monitoring

Staff at the management, clinic and village levels knew of the change in focus from target or quota setting to demand fulfillment. Their description of activities was consistent with the change in focus. In addition, acceptors of health services did not indicate any knowledge of targets or quotas in the program.

Recent changes in the political and economic environment (e.g. financial crisis, new government, decentralization, etc.) prompted *BKKBN* to rethink and formulate a new strategy for the period 2000 through 2015. Among other things, this strategy includes the following elements as part of its long-term mission: empowering communities to develop quality families, improving the quality of family planning and reproductive health services, educating communities about their reproductive rights consistent with ICPD, and women's empowerment.

In a speech delivered in February 2001, the State Minister for Women's Empowerment and Chairperson of *BKKBN* outlined challenges facing *BKKBN*. She included among them implementing a rights-based approach to family planning, changing its traditional program focus on family planning and fertility reduction to a broader focus on reproductive health and family development issues, and shifting *BKKBN's* style from heavy reliance on centrally-directed, "top-down" approach to "bottom up" planning, implementation and program evaluation. While setting a goal of eliminating unmet need for family planning by 2015, she cautioned:

> "In attempting to reach this benchmark, demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients."

The central, provincial, district and subdistrict officials that the teams interviewed indicated that the new political reality in Indonesia, democratization, prevents them from setting client- or provider-based targets, or even issuing guidance that is too specific. Doing so, they claimed, would result in demonstrations against the programs and their services, and communities would ignore such directions.

a. No evidence that planning figures are predetermined. Quantitative estimates are used for planning purposes based on information that is collected by village volunteers in an annual enumeration of families, which includes questions about family planning acceptance, methods, source of supply (private and public), pregnancy status, and desire to space or limit future childbearing. Village volunteers and service providers develop their objectives for field visits, case-load (new information and/or re-supply), and contraceptive requirements based upon this information. The team found no evidence of the use of predetermined targets to guide activities at the district or subdistrict levels.

b. No evidence that planning estimates are translated into targets that are assigned to providers. It was consistently reported across provinces, districts and subdistricts that targets are not assigned to village volunteers or service providers for number of acceptors, what kinds of individuals should be acceptors (e.g. families with two or more children), or number of acceptors for any particular contraceptive method. Rather, the village volunteers refer to the results of their enumeration to identify women or men who may have new contraceptive needs (e.g. because of the birth of a child) or who have expressed a desire to have no more children but who are not currently using family planning. Volunteers choose to visit those individuals based on the information that they themselves have provided. Village volunteers and service providers offer information to any who desire it to help them select the best method for themselves (including no method at all), but the acceptor (sometimes in consultation with a doctor) decides whether and what family planning method to use.

c. No evidence planning estimates are enforced. Managers, service providers and village volunteers uniformly reported that there were no repercussions if planning estimates for family planning services are not met. Because planning estimates are based upon acceptor-stated desires, they can change over the course of a year as acceptors change their expressed desires (e.g. because of pregnancy, family decisions, health, or availability of methods). If managers determine that provider performance is poor, a supervisory visit will occur to correct performance. If managers determine that provider performance is good, or even exceptional, the provider may be fast-tracked for promotion and may receive a certificate (from the organization) and/or pin (from the community) to show appreciation. In effect, there are no consequences for not meeting planning estimates and very modest rewards for excellent performance, which are not tied to family planning acceptance.

During the 1970s and 1980s, family planning outreach or "safari" services[5] were perceived and reported to be target driven and had the potential or the risk of coercion. For example, in many areas the Army provided transport to safaris, but was not involved in community organization or identification of participants. Clients still use the term "safari" to refer to services that occur today as events in a *puskesmas* even though they bear no resemblance to the outreach, festival style IUD oriented events of the past. While none were observed during this assessment visit, several recent safaris were described. They either occurred at a health center or NGO facility, where they are very popular

[5] "Safari" refers to events in which mobile family planning and sometimes other services are brought to primarily rural areas.

because the "new safari" ensures the availability of free services and adequate supplies of family planning commodities. In some cases the military offers transport to those who may need it. (Military involvement seems to continue to be associated with the "safaris" in North Sumatra where facilities are spread out and transportation more difficult, but not in Central Java, which has greater availability of facilities and better transport systems. The military provides transport to service delivery points as part of its social obligation once a year.)

While the official terminology of "targets and quotas" has given way to "demand fulfillment", it is still possible to find the use of the term "targets" in planning and budgeting. Likewise, the "safari" services still occur, but with a very different meaning and application than in the past.

A.4. Conclusion

The assessment team did not find evidence of the use of targets and quotas as defined by the Tiahrt Amendment.

A.5. Recommendation

USAID/Indonesia and its CAs, along with *DepKesKeSos* and *BKKBN*, should continue to monitor the annual family enumeration exercise to ensure the demand fulfillment process does not take on the characteristics of target-setting or lead to coercive activities. In addition, USAID/Indonesia and its partners should continue to monitor the provision of safari services to ensure that they are not provided based upon targets or with coercion.

B. INCENTIVES

B.1. Tiahrt Requirements

The Tiahrt Amendment requires that

> "the project shall not include payment of incentives, bribes, gratuities, or financial reward to (A) an individual in exchange for becoming a family planning acceptor, or (B) program personnel for achieving a numerical target or quota of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning."

The term "program personnel" applies not only to service providers and referral agents, but also to persons who manage or perform other functions for an organization that implements a service delivery project. The clause does not bar the provision of non-financial, small value items that are provided across the board to project personnel or to individuals to acknowledge general good performance. This clause does not bar provision of special training or promotions for project personnel who are considered good performers.

B.2. Background

As indicated above, there is a long history of the promotion of family planning in Indonesia. In the very early days of the program, some report that incentives[6] were sometimes given to family planning providers and acceptors. Program managers reported that the practice of offering incentives to providers or acceptors was discontinued long ago because: it was found to have little impact on increased utilization, it was difficult to administer, and it introduced distortions into the program (providers and managers reported more progress and utilization than was found to be the case when service statistics were compared to census or survey data). Today the challenge facing the Indonesia family planning program seems to be meeting existing demand rather than generating new demand for information and services.

B.3. Findings: No evidence of incentives or financial rewards for providers or acceptors.

The assessment team found no evidence of incentives in the management or implementation of family planning services. During the recent economic crisis there was only a marginal reduction in contraceptive prevalence, with an estimated decline of 2.8% drop in the absolute numbers of users. Many public sector acceptors responded to stock outs by turning to the private sector for family planning services and supplies (estimated users in the private sector rose from 9.4 million to 13.8 million). As BKKBN struggles to meet the continuing demand for family planning, the strategy for the future will include shifting as many acceptors as possible to the private sector for services and supplies. As family planning users increasingly pay for the services they seek, there is little reason to offer incentives.

The assessment team found no evidence that acceptors receive any incentives or financial rewards for becoming family planning acceptors or for accepting one method rather than another one.

As indicated above, high performing managers, service providers and village volunteers receive modest recognition for their work, but do not receive incentives or rewards of more than minimal financial value. One village volunteer reported receiving a bed cover and a baby-weighing scale from the community where she worked in appreciation for a job well done. Some service providers and village volunteers receive transport compensation for visiting distant villages and sub-villages.

A number of promotional activities take place to encourage continuous participation and build loyalty to monthly village health events. The team observed the use of "*arisan*" (a type of savings plan) for this purpose. Each of the families participating contributed a small amount of money to a pool that would be given to one family at the end of the meeting based upon a drawing. The assessment team was told that this is a common practice.

[6] Incentives in the past may have included various forms of social recognition, ceremonial honors and small value items for continuing family planning users. The purpose of such incentives is reported to have been to promote social norms for using family planning to space and limit childbearing.

Also, as part of *BKKBN's* mandate to develop small, happy and prosperous families, *BKKBN* has established a relationship with *Bank Rakyat Indonesia* (*BRI*) to support a sort of savings club and credit club for community groups at the village and sub-village levels. Savings accounts and loans are extended to individuals in the context of a community women's group. It was reported that these opportunities are available equally to family planning acceptors and non-acceptors alike, and regardless of number of children in the family.

B.4. Conclusion

The assessment team found no incentives as defined by the Tiahrt Amendment provided by the program. Managers and providers do not receive incentives for providing family planning services or for recruiting family planning acceptors. Acceptors do not receive incentives to accept family planning or any specific method of family planning.

B.5. Recommendation

USAID/Indonesia and its Cooperating Agencies along with *BKKBN* and *DepKesKeSos* should continue to monitor policies and practices to ensure that incentives or financial rewards are not used. This is especially the case as *BKKBN* focuses more of its emphasis on the poorest acceptors most dependent on the public sector. The greater programmatic vulnerability is reduced access to family planning services by those who cannot afford to buy it in the private sector due to a general shortage of contraceptive supplies in the public sector. Decentralization may pose problems if there is a general preference for curative rather than preventive health care services.

C. DENIAL OF RIGHTS OR BENEFITS

C.1. Tiahrt Requirements

The Tiahrt Amendment requires that:

> "the project shall not deny any right or benefit, including the right of access to participate in any program of general welfare or the right of access to health care, as a consequence of any individual's decision not to accept family planning services."

C.2. Background

Observers of Indonesia's family planning program have indicated that during the 1970s and 1980s some local authorities were reported to have established a family planning test as a condition for access to certain benefits, such as gaining a child's admission to school, obtaining a child's graduation certificate, obtaining a citizen's identity card, or having access to other health services. In the cases where these reports were found to have some validity, *BKKBN* at the time viewed them as aberrations and deviations from policy and took corrective actions. The former Chairman of *BKKBN*, Professor Haryono Suyono, addressed these concerns in a 1994 speech at a meeting of the Population Association of America:

> "at times there is an inadvertent conflict at lower levels between the care objective and the demographic objective. Usually it takes the form of a well-meaning but not well-understanding local leader getting carried away, and 'encouraging' a little too strongly. A better quality program should have mechanisms in place to rapidly and efficiently follow up any rumors of such problems, and to make clear such action is not condoned. And a better quality program should also be looking for ways of addressing such problems in a broader more systematic way. In Indonesia, we have both – an immediate follow-up system and a broader strategy."

C.3. Findings – Rights or benefits are not being denied based on the acceptance of family planning or any specific family planning method.

The assessment team found no evidence that policies permit the withholding of rights or benefits or that in actual practice rights or benefits are being withheld from individuals who do not accept family planning or any specific method of family planning. The team found managers, service providers, village volunteers and acceptors who were married and not married, who accepted family planning and who did not. None reported any right or benefit that family planning acceptors receive that is not equally available to non-acceptors of family planning. The team only learned of one situation where acceptors were distinguished from non-acceptors: a village volunteer could achieve the status of model village volunteer (the benefit is in title only) if she were also an acceptor, had 15 years of service and met other criteria.

C.4. Conclusion

There is no denial of rights or benefits for non-acceptance of family planning.

C.5. Recommendation

USAID/Indonesia and its Cooperating Agencies along with *DepKesKeSos* and *BKKBN* should monitor the policies and practices to ensure that rights or benefits do not become tied to the acceptance of family planning or any particular method of family planning.

D. COMPREHENSIBLE INFORMATION

D.1. Tiahrt Requirements

The Tiahrt Amendment requires that family planning service delivery projects will "provide family planning acceptors comprehensible information about the health benefits and risks of the method chosen, including those conditions that might render the use of the method inadvisable and those adverse effects known to be consequent to the use of the method." Information may be provided according to the medical practices and standards and health conditions of the setting where the project is implemented through counseling, wall charts and other IEC materials. In its technical guidance on the comprehensible information provision, USAID/Washington recommends that programs follow an approach that calls for 1) doing all possible to promote informed choice and good provider-acceptor interaction through program implementation (e.g. counseling,

supervision, training, mass media and print materials) and 2) providing tangible interventions, such as wall charts and job aids for field workers at each service delivery point of contact.

D.2. Background

USAID/Indonesia has provided longstanding support for interpersonal counseling and communication (IPC/C), quality of care and training activities aimed at strengthening informed choice among public and private sector providers. Their activities have been aimed at improving both provider knowledge and counseling skills as well as educating acceptors to seek information and ask questions of their providers. Both are necessary for improving provider-acceptor interaction, which is a cornerstone to informed choice and a central feature of the STARH Program. A principal component of the STARH Program is aimed at strengthening informed choice through materials development, IPC/C and community education efforts to help acceptors improve their understanding of their family planning options before they visit a clinic. All acceptors, with the exception of condom users, are expected to see a medical provider (midwife or doctor), often in a clinic setting, the first time they receive a family planning method.

Service providers at the field level (village volunteer, village midwife and field supervisor) are trained to provide information on a range of family planning methods (e.g. injectables, implants, oral contraceptives, and condoms) including health benefits and risks, possible adverse side effects, and inadvisabilities. Under the SDES Project, which operated from 1994 through September 2000, more than 25,000 providers and village volunteers were trained in counseling. The STARH Program has a major emphasis on counseling, informed choice and quality of care. One of its first activities was to develop, field test, produce and distribute 50,000 wall charts in *Bahasa Indonesia* that specifically address the Tiahrt Amendment requirements for comprehensible information for all principal methods of family planning available in Indonesia, including non-"program" methods.

D.3. Findings: Acceptors are receiving comprehensible information about the method they select.

Service providers are knowledgeable about and experienced with providing information to acceptors, and have accurate and consistent information about the health benefits and risks, inadvisabilities and side effects of available family planning methods. Many of the service providers interviewed, including the village volunteers, field supervisors and village midwives, had been in their positions for many years and seemed to have good rapport with their acceptors. Providers who were interviewed reported that they routinely advised acceptors of the health benefits, risks, and inadvisabilities of the method they selected. The consistency of responses from providers in different settings to questions about the information they provided about family planning methods indicates that they are well trained and supervised. Moreover, the consistency in the information providers offered in interviews with team members was encouraging in view of the more difficult program conditions in North Sumatra compared to Central Java.

The wall charts mentioned above were posted in counseling areas in all of the subdistrict health clinics, district hospital and most of the NGO facilities[7] that the team visited. Wall charts were even posted in the home of one of the village volunteers, in the area where she typically meets acceptors, in village birthing huts, village health posts and used in outreach events. Village volunteers, who are described as the "face of the public sector program" because they are often the first point of contact for new family planning acceptors, seem to receive good support and supervision from the field supervisors. Samples of contraceptive methods were also available and used to inform acceptors about methods. However, the teams did not see examples of simple job aids that might be helpful to village volunteers or other village midwives in discussing methods with acceptors. Information materials besides the wall chart, especially information materials that would be appropriate for low literacy audiences such as the village providers and acceptors, were also scarce in the public sector facilities, though available in the urban NGO sites. All of the providers interviewed indicated that they referred questions they could not answer to the doctor in the subdistrict health facility.

D.4. Conclusion

Acceptors are receiving information about the method they select and therefore the program is in compliance with the Tiahrt Amendment.

D.5. Recommendation

A review of the compliance of existing training and IEC materials with the Tiahrt requirements should be included in the review of such materials that the STARH Program will be undertaking. The activities that STARH has planned for developing and distributing cue cards and other job aids to assist providers in informing acceptors should be given top priority. This will help continue to reassure everyone of the program's compliance with the Tiahrt requirements while further supporting the service providers in remembering key messages about specific methods.

E. USE OF EXPERIMENTAL CONTRACEPTIVE DRUGS AND DEVICES

E.1. Tiahrt Requirements

The Tiahrt Amendment requires that family planning service delivery projects that support use of experimental contraceptive drugs, devices and medical procedures do so only "in the context of a scientific study in which participants are advised of potential risks and benefits."

E.2. Background

Official policy at BKKBN and *DepKesKeSos* stipulates that researchers responsible for experimental trials must issue a *Formulir Persetujuan* describing the goals of the trial and informing potential participants of any risks and benefits, and acceptors (and sometimes their husbands, too) must sign an Informed Consent Form (*Surat Pernyataan Persetujuan*) in the presence of an authorized witness before participating as a subject in the trial.

[7] Not all of the NGOs visited displayed a wallchart.

USAID/Indonesia does not finance use of or research studies involving experimental contraceptive drugs, devices or medical procedures[8]. In the event that it were to support such studies, it would be required to follow U.S. government guidelines for human subjects research, which encompass (and exceed) the Tiahrt Amendment requirements.

E.3. Conclusion

This provision of the Tiahrt Amendment is not relevant to USAID/Indonesia's program.

III. TIAHRT MONITORING and REPORTING

Ensuring compliance with the Tiahrt Amendment requirements in the USAID-assisted family planning service delivery activities of the Indonesian family planning program is the responsibility of USAID/Indonesia with the assistance of its key partners, CAs and counterpart agencies. Continued monitoring of Tiahrt Amendment requirements should be incorporated into existing monitoring activities, and documentation of Tiahrt implementation activities should be maintained.

A. Current and Proposed Monitoring

The STARH Program will be key in helping the Mission monitor implementation of its family planning service delivery projects. In addition the Mission supports a number of mechanisms for on-going assessment of Tiahrt compliance.

A.1. Regular updates for Mission partners.

The Mission hosted a meeting for CAs working on family planning service delivery programs in Indonesia on the Tiahrt Amendment requirements in 1999 when the amendment first went into effect. As its partners change, it would be helpful to offer brief reminders or refreshers about the Tiahrt Amendment requirements and other U.S. policy issues at partners' meetings. The USAID/Indonesia FP Team leader has functioned as the point person for Tiahrt Amendment and other population policy issues and in this capacity has maintained records of the Mission's Tiahrt implementation and has collaborated closely with the contracts management office to ensure that the provisions are included in all relevant agreements. USAID/Washington will continue to keep the team apprised of relevant developments related to the implementation of statutory and policy requirements affecting population assistance in other countries.

A.2. STARH Program monitoring system

The RFA for the STARH Program (issued March 2, 2000) asked bidders to respond to a number of specific requirements related to the Tiahrt Amendment. To the best of the team's knowledge, no other Mission has taken such steps to ensure that Tiahrt

[8] Many Indonesian health facilities that are assisted by USAID/Indonesia family planning projects offer the one rod contraceptive implant, Implanon®. Implanon® is approved for use by the Indonesian government and by many countries, including European regulatory agencies. Implanon® is provided to women in health facilities as a family planning method, not as part of a scientific study.

Amendment implementation is built into the scope of work of its principal family planning technical assistance activity.

STARH has proposed to monitor a number of illustrative indicators that directly relate to informed choice and quality of care, including several that are directly relevant to specific Tiahrt Amendment requirements. They include, for example:

- Percentage of facilities with established mechanisms for acceptor and community feedback;
- Number of facilities with information poster (Tiahrt wall chart) displayed;
- Percentage of providers following informed choice guidelines; and
- Percentage of providers using IEC materials for counseling.

It would be helpful to consider adding an indicator that measured the sufficiency of information an acceptor has received about the method s/he is using with respect to the comprehensible information requirements. Acceptor reports of the information received would help corroborate provider reports of the information given. It would also be helpful to add to indicators in STARH's monitoring system, as appropriate, that would capture Tiahrt-related issues involving the use of targets or quotas, incentives or financial rewards, and denial of rights or benefits.

A.3. Other Mechanisms for on-going assessment of Tiahrt Compliance

The Team recommends that the Mission consider adapting its existing mechanisms for program monitoring to provide on-going assessments of Tiahrt vulnerability.

1) **Field visits.** 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. Trip reports should include a section reporting on any relevant observations about the implementation of the Tiahrt Amendment requirements. STARH, CAs, USAID Mission staff
2) **Feedback.** STARH has proposed a number of initiatives to improve and expand mechanisms for community and acceptor feedback concerning family planning services. During the assessment visits it was unclear to what extent mechanisms existed for registering such feedback; moreover, it was very clear that the notion of registering feedback was not well understood. Questions about mechanisms for registering feedback should be asked as part of routine monitoring visits to the field (see Tiahrt Interview Protocol). STARH, CAs, USAID Mission staff
3) **Special studies and surveys.** The 2001/2 DHS and data collection activities coordinated by STARH will provide important opportunities to collect additional information about Tiahrt-related issues. Such studies, particularly some of those that STARH has planned, may include questions to assess the adequacy of information that acceptors receive, for example. STARH, CAs, USAID Mission staff
4) **Linkages with civil society organizations and women's groups.** Although the assessment team did not meet with human rights or women's rights groups (primarily because it was not clear that any such groups were addressing issues of

voluntarism and informed choice in family planning programs), future monitoring of Tiahrt compliance would benefit from periodic discussions with representatives of such groups, especially as more and more efforts are made to encourage them to address reproductive health issues through STARH and other initiatives. Linkages with USAID/Indonesia's Healthy Indonesia 2010 and the Democracy and Governance program should also be explored. STARH, CAs, USAID Mission staff

A.4. Action steps for handling vulnerabilities or suspected Tiahrt-related problems.

The Mission will need to be prepared for handling reports of Tiahrt-related problems. If a problem is reported, the Mission, STARH or CA staff will need to consider whether (1) the reported situation is credible (e.g. is the event one that could reasonably occur?) and (2) that it is reported by a credible source. If the answer to both is yes, the situation needs to be reported to the USAID Mission HPN staff. The USAID HPN staff should discuss the report with all concerned parties (e.g. the group that received or learned of the feedback), including the USAID Regional Legal Advisor, and decide on whether further investigation or verification is required and by whom. If a serious problem or violation is confirmed, then the HPN Mission staff and its relevant partners (STARH, CAs, *DepKesKeSos*, *BKKBN*, MOWE and relevant NGOs) should decide on and take actions to correct the problem as soon as possible. USAID Mission staff should also assess whether the situation is an isolated case or not. The Mission should be sure to document the problem, verification measures, and corrective actions. USAID/Washington should be informed of the serious problem or violation as soon as it is identified. The Agency Administrator will make the final determination about whether a violation has occurred.

B. DOCUMENTATION

Thorough documentation of steps taken to implement and monitor compliance with Tiahrt requirements must be done by all Missions. The team worked with the HPN office to ensure that its Tiahrt file was complete.

IV. Other Tiahrt-Related Issues

A. National Family Planning Policy

Indonesian family planning policy has undergone a dramatic change since the 1994 International Conference on Population and Development (ICPD) in Cairo. Indonesia along with other nations agreed that population programs were an integral part of development and should focus attention on individual needs rather than on demographic targets. Governments agreed to give special attention to reproductive health services, girls' education, the health of women and young children, and the empowerment of women. These principles were reaffirmed in the 1999 Indonesia State Policy Guidelines that set forth a new paradigm for family planning called "New Era". The vision changed from "a small, happy and prosperous family norm" to "quality families in the year 2015". The State Minister for Women's Empowerment, Hj. Khofifah Indar Parawansa, in a February 2001 address to the 11th International Meeting of the Society for the Advancement of Reproductive Health Care, stated that BKKBN's new mission is:

- to empower the community in developing small and quality families,
- to cultivate partnerships to increase the welfare, self reliance and family resilience,
- to improve the quality of family planning and reproductive health services,
- to enhance promotion, protection and efforts to fulfill people's reproductive rights,
- to enhance efforts on the empowerment of women to achieve gender equality through family planning programs, and
- to prepare quality human resources, beginning at the time of conception in the womb all the way to old age.

The current BKKBN policies are highly consistent with USAID policies of informed consent, acceptor choice and reproductive rights as well as with the intent of the Tiahrt Amendment.

Before departing Jakarta for the field, the Tiahrt team was told that, while a number of meetings had been held for *BKKBN* staff to disseminate the new policy, in our travels to the provinces we might find those who were not fully knowledgeable about the "New Era" principles. The team actually found a surprising degree of knowledge regarding the principles of the "New Era" among the *BKKBN* provincial, district and subdistrict staff, although sometimes the "New Era" term was not used. We recognize, however, that we only visited two provinces and one special area, *Yogyakarta*; the team, therefore, cannot comment on the degree to which programs in other areas have shifted away from earlier policies and practices and embraced the "New Era" principles.

Recommendation:
Because Indonesia is a huge country with multiple languages and cultures and with many remote service sites, USAID should help support efforts by *BKKBN* to disseminate "New Era" policies, particularly within the nine key provinces assisted by the STARH program. The work plan for the STARH Program should include assistance for the design and production of materials for "New Era" reorientation; the distribution of these materials should also receive appropriate attention and effort.

B. Acceptor Feedback about Services
During our field visits, the Tiahrt team attempted to learn about the systems, if any, that are in place to allow acceptors to provide feedback if they have issues with the quality of care provided. The question was often poorly understood by acceptors and detailed questioning often produced responses related to what the acceptors would do if they experienced a side effect from using a contraceptive method. Our impression was that acceptors were generally satisfied if they were able to receive the particular contraceptive service requested. Questioning of subdistrict health clinic staff, however, did reveal several potential mechanisms for registering dissatisfaction. In *Semarang*, in one subdistrict health facility, staff had heard about an organization called *Forum Lintas Pelaku*, an NGO which helps patients deal with problems related to general services received in hospitals and clinics. We were not able to obtain any detailed information about this organization. In another health clinic in *Yogyakarta*, we were told that they

had instituted a suggestion box. The only kinds of feedback received to date were related to long waiting times. In several other places we heard that BKKBN organizes monthly meetings of service providers to talk about problems and issues arising from community and health center service delivery but acceptors are not involved in these meetings. *PKBI*, the IPPF affiliate visited in *Yogyakarta*, has developed a simple brochure entitled "*Hak-Hak Konsumen Keluarga Berencana*" (Rights of Family Planning Clients) which serves as a useful module for educating consumers about their rights.

Recommendation:
USAID and STARH program staff should continue to explore the question of how acceptor feedback can be dealt with, whether they are Tiahrt-related or general quality of care problems. This topic is consistent with *BKKBN's* concern with improving the quality of services and with STARH's mandate to assist *BKKBN* in this regard. There may also be opportunities through USAID's Democracy and Governance Program's work with local civil society organizations to strengthen their capacity to deal with such issues.

C. *DepKesKeSos* Family Planning Policy

Upon arrival in Indonesia, the team received a policy briefing paper drafted by Adrian Hayes of the STARH program entitled "The Indonesian National Family Planning Program and the Tiahrt Amendment of the US Congress," dated March 2001[9]. The paper presents a highly useful and insightful review of Tiahrt requirements and current *BKKBN* policy. While current Indonesian law emphasizes choice on the part of couples in family planning, it is not clear with the advent of decentralization of services how such policies will be implemented by local governments assuming responsibility for the financing and provision of services[10].

Recommendation:
STARH program staff should continue to work with *BKKBN* and *DepKesKeSos* to analyze and monitor the transition to decentralized services in the STARH provinces to ensure that local implementation of national policies are in compliance with Tiahrt requirements. The STARH program should stay abreast of the formulation and implementation of local policies by decentralized health authorities to monitor consistency with the Tiahrt Amendment requirements.

V. KEY FOLLOW-UP ACTIONS RECOMMENDED FOR USAID/INDONESIA

The Mission, along with its partners, may wish to undertake the following activities, many of which are already proposed:

- Continue to observe use of planning figures to ensure that they remain free of coercion, considering both actual practices as well as perceptions by the community.

[9] Dr. Hayes' excellent paper, which was prepared for the STARH Program, is available by request. Dr. Hayes may be reached at ahayes@jhuccp.or.id.
[10] BKKBN has been exempted from decentralization for three years. One reason for this decision was BKKBN's strong bottom-up management.

- Assist *DepKesKeSos* and BKKBN to monitor policies and practices to ensure that they remain free of inappropriate incentives and financial rewards, and do not discriminate against non-acceptors of family planning, looking at actual behavior as well as perceptions.

- Monitor Tiahrt vulnerabilities as a part of any field visit, adapting the attached interview protocol as appropriate, to ensure that each of the Tiahrt requirements is covered as well as broader quality of care and informed choice issues. Include a Tiahrt-specific section in trip reports, consultant reports, workplans, surveys and data collection.

- Review available IEC materials regarding family planning methods to ensure that they address the Tiahrt Amendment requirements (e.g. health risks and benefits, side effects, and inadvisabilities of family planning methods), and, as necessary, develop and disseminate easy to use job aids directed to providers, especially village providers.

- Ensure that acceptors receive comprehensible information on the health risks and benefits, side effects and inadvisabilities of family planning methods whether through the general media, community meetings, discussions with family planning fieldworkers or service providers, counseling sessions with medical personnel, or tangible materials.

- Convene regular meetings at appropriate intervals to ensure that each USAID partner is knowledgeable about, and understands, the Tiahrt Amendment and other relevant U.S. policy issues affecting population assistance and their relevance to USAID-supported activities in Indonesia.

- Ensure that program documents include appropriate Tiahrt Amendment clauses. Maintain a flow chart describing Mission activities that are subject to such requirements.

- Continue to support the Mission point person on Tiahrt-related issues so that s/he stays apprised of relevant Tiahrt and other U.S. policy developments relevant to the Indonesian program.

- Explore the use of mechanisms for receiving feedback from acceptors, e.g. through civil society organizations and/or women's groups. Such feedback systems would help promote informed choice and quality of care practices and deter the use of coercive practices.

- Continue to work at the policy and implementation levels to ensure that decentralization of authorities, responsibilities and resources does not weaken the Indonesian resolve regarding improved quality of services, informed choice or voluntarism, and at the same time does not weaken the Indonesian commitment to eliminate unmet need and secure improved reproductive health for families.

Attachments

Attachment 1

Acronyms and Translations

Arisan	Type of village savings plan
Bidan	Midwife
Bidan di Desa	Village Midwife
BKKBN	National Family Planning Coordinating Board
CA	Cooperating Agency
DepKesKeSos	Ministry of Health and Social Welfare
Era Baru	New Era
GOI	Government of Indonesia
HPN	Health, Population and Nutrition Office (AID)
IBI	Indonesian Midwives Association
IDI	Indonesian Doctors Association
IEC	Information, Education and Communication
IPC/C	Interpersonal Communications and Counseling
JHU/CCP	Johns Hopkins University/Center for Communication Programs
Kabupaten	District
Kecamatan	Sub-District
MJM	PT. Manggala Jiwa Mukti
MOWE	Ministry of Women's Empowerment
Muhammadyah	Religion Based NGO with Service Delivery Structure
NGO	Nongovernmental Organization
PKBI	Indonesian Family Planning Association
PKMI	Indonesian Association for Permanent Contraception
PLKB	BKKBN Family Planning Field Workers
PPLKB	BKKBN Field Worker Supervisors
Polindes	Village Birthing Huts
POGI	Indonesian Association of Obstetricians and Gynecologists
Posyandu	Village Health Posts
Propinsi	Province
PUSKESMAS	Subdistrict Health Centers
RFA	Request for Application
SDES	Service Delivery Expansion Support
STARH	Sustaining Technical Achievements in Reproductive Health/Family Planning
YKB	Kusuma Buana Foundation

Attachment 2

Acknowledgements

The members of the assessment team would like to acknowledge the excellent support we received from a variety of people in carrying out this assessment.

BKKBN

The team benefited enormously from the briefings and the thoughtful explanations to our questions that were provided by staff both at *BKKBN* headquarters and at the provincial, district and subdistrict levels. We appreciate the time given to the team by senior *BKKBN* officials in Jakarta, especially Mr. Lalu Sudarmadi, Principal Secretary of *BKKBN*, and the other *BKKBN* senior staff at the provincial and district levels. We were also provided excellent logistical support for our field visits. *BKKBN* field staff, including the *PPLKB, PKLB,* and *kaders,* was generous with their time and open to responding to our questions.

DepKesKeSos

DepKesKeSos personnel in the Directorate for Community Health in Jakarta as well as all of the service providers at the field level greatly facilitated our understanding of the current family planning service delivery system, including the way in which acceptors and providers interact. We benefited greatly by interviewing doctors and midwives (*bidan*) at the Health Centers and from visiting the Village Midwives (*bidan di desa*) at the Birthing Huts (*Polindes*).

STARH Program Staff

The team is grateful to all of the STARH program staff who provided hours of time and volumes of documents to help facilitate the work of the team. We appreciate the support and detailed information provide by Gary Lewis, Adrian Hayes, Russ Vogel and the rest of the STARH team. Special thanks go to Dr. Bimo and Ibu Fitri Putjuk for the extraordinarily helpful role they played during the field visits in translating and skilled interviewing to extract accurate information to sometimes difficult and awkward questions posed by the team.

USAID/Indonesia

The team is grateful Terry Myers, USAID/Indonesia Director, and Sharon Cromer, Deputy Director, for their support and cooperation for this assessment. We are thankful for the very useful input from Leslie Curtin, Molly Gingerich and other members of the dedicated HPN team. We are particularly grateful for the help provided by Natalie Freeman, Bambang Samekto, Pam Wolf and Carol Rice who were important and active members of the team during the field visits.

Attachment 3

Tiahrt Assessment Team
Schedule
March 12-23, 2001

Day 1 – Monday, March 12

AM – 9:30 Briefing by and for Team

Purpose: To introduce team members, introduce resource team, review agenda, establish schedules, and discuss preliminary assignments.
Place: US Embassy
Participants: USAID/W Team, USAID/I Team, STARH Team, *BKKBN* and *DepKesKeSos* counterparts,

PM – 12:30 Lunch for presentation participants

1:30 – 3:30 Presentation by team on Tiahrt and other US government policies

Purpose: To review the content of policies and current thinking on response to policies for country reproductive health programs. To help service delivery organizations understand the policies so that they can make an informed decision on their response.
Place: *BKKBN* Auditorium
Participants: *BKKBN*, USAID/I, *DepKesKeSos*, STARH, NGOs (*POGI*, *IBI*, etc)

Day 2 – Tuesday, March 13

AM – 8:30 Meeting with STARH to review and finalize agenda, logistics, workplan

Purpose: To finalize plans, make logistical arrangements, and allocate responsibilities.
Place: STARH Office
Participants: Tiahrt Assessment Team, STARH support team

Meet with STARH

Purpose: to discuss activities and program plans which support the Tiahrt agenda.

- Policy
  - Informed choice
  - Targets
  - Incentives
  - Access to other health services
- Training
- Supervision and service guidelines
- Communication initiatives
- Research

Place: BKKBN
Participants: Tiahrt Team, STARH Team, others

AM - 11:00 Meeting with *DepKesKeSos*

Purpose: To formally introduce the team to *DepKesKeSos* and to initiate a discussion of the policy and operational status of *DepKesKeSos* in support of Tiahrt.
Place: *DepKesKeSos*
Participants: Tiahrt team, STARH resource team, *DepKesKeSos* staff to be determined

Day 3 – Wednesday, March 14

AM – 9:00 Meet with NGOs

Purpose: To use a focus group style to allow NGO service providers to discuss Tiahrt related issues.
Place: STARH Office
Participants:

- *POGI*
- *IBI*
- *YKB*
- *PKMI*
- Tiahrt Team

PM – 2:00 Meeting with BKKBN

Purpose: To formally introduce the team to *BKKBN* and initiate a discussion of the policy and operational status of *BKKBN* in support of Tiahrt
Place: *BKKBN*
Participants: Tiahrt Team, STARH resource staff, *BKKBN* echelon 1 and 2

Day 4, 5 and 6 –Field, March 15-17

Purpose: Hold discussions with provincial, *Kabupaten* FP and Health officials, public sector service providers, and to visit clinics in one subdistrict.
Place: Province East Java and North Sumatra. Two subdistricts to be selected (one rated as good performance based on service statistics, and one rated as poorer). Subdistricts will be selected in discussions with *BKKBN Kanwil*
Participants:

- *PLKB*
- *Bidan di desa*
- *Bidan di Puskesmas* and *puskesmas* site visit
- Provincial *BKKBN* office

Teams:

- Team 1 – Riggs-Perla, Rilling, Rice, Samekto, Bimo (Central Java)
- Team 2 – Seligman, Wolf, Freeman, Putjuk (North Sumatra)

Day 7 – Sunday (Off), March 18

Day 8 – Monday, March 19

AM 8:30 Team Meeting

Purpose: To discuss field observations, identify issues, develop report structure, identify background information for report, identify follow up interviews resulting from field observations, prepare the report outline, and make writing assignments:
Place: *BKKBN*
Participants: Tiahrt Team, Resource persons as required.

PM Team meeting

Continue morning agenda as required, carry out additional interviews, start writing.

Day 9 - Tuesday (all day), March 20

Report writing and presentation preparation

Day 10 – Wednesday, March 21

AM Report writing and presentation preparation

PM **12:00** Turn over draft report.
12:00 Meet with Health staff at USAID
2:30 Joy RP meet with Molly Gingrich at TIFA
3:30 Barbara Seligman to meet with USAID Lawyer
5:30 Team meeting with Jet Riparip and Alene Gelbard at Mandarin on Healthy Indonesia 2010 Program

Day 11 - Thursday, March 22

AM 11:00 Preliminary discussion of report, findings and presentation

Purpose: To provide an opportunity to review findings, contextualize results for program-action recommendations, discuss presentation, and prepare a plan for options on "next steps."
Place: STARH Office
Participants: Tiahrt team, resource people as required.

PM Presentation Dry-Run by Team

2:30 Barbara Seligman to meet with Adrian Hayes, STARH Policy Adviser

Day 12 - Friday, March 23

AM 9:00 Presentation

Purpose: To provide an opportunity to present findings, discuss the issues, and open a dialog on follow-up planning.
Place: *BKKBN*
Participants: Tiahrt team, *BKKBN*, *DepKesKeSos*, USAID/Jakarta, resource people as required.

PM 3:15 Meeting at USAID with Terry Myers and Sharon Cromer

Attachment 4

Persons Contacted

Jakarta

USAID/Indonesia
Terry Myers, Director
Sharon Cromer, Deputy Director
Natalie Freeman, Regional Legal Advisor
Leslie Curtin, Chief, HPN Office
Molly Gingerich
Pam Wolf
Alene Gelbard
Carol Rice
Bambang Samekto

STARH Program
Gary Lewis, Program Director
Russ Vogel
Dr. Bimo
Fitri Putjuk
Adrian Hayes
Anne Pfitzer

Healthy Indonesia 2010
Jet Riparip

BKKBN
Mr. Lalu Sudarmadi, Principal Secretary
Mr. Risman Musa, Advocacy and IEC Director
Mr. Mazwar Noerdin, Deputy Director for Program Planning and Family Information

DepKesKeSos
Dr. Wibisono Wijono
Dr. Kesga

NGOs

YKB
Dr. Firman Lubis

Muhammadiyah
Dr. Toha Muhaimin

PKBI
Dr. Zarfiel Tafal

POGI
Dr. Biran Affandi

IBI
Mrs. Wastidar Musdir
Mrs. Mustika Sofyan

PKMI
Mr. Suharto

Semarang, Central Java

Dr. Djoko Rusmoro, Chairman, BKKBN Central Java
Drs. Nengah, Head, Family Planning Services Division, BKKBN Central Java
Dra. Wati Broto, Chief, BKKBN, Kota Semarang

Dr. Siti Zubaedah, Medical Doctor, Puskesmas Poncol, Semarang Tengah, Semarang
Ms. Kusdiati, Bidan (midwife), Puskesmas Poncol, Semarang Tengah, Semarang

Ms. Ristiyah, Staff, Health Office, Semarang
Ms. Maimunah, PPLKB/BKKBN, Kecamatan Semarang Tengah, Semarang
Ms. Dwi, PPLKB/BKKBN, Kecamatan Semarang Tengah, Semarang
Mr. Teguh, Motivator/BKKBN, Kecamatan Semarang Tengah, Semarang
Ms. Mustain, Family Planning Volunteer, Kecamatan Semarang Tengah, Semarang
Ms. Nurachmah, Family Planning Volunteer, Kecamatan Semarang Tengah, Semarang

Dr. Lidya, Chief, Puskesmas Kagok, Kecamatan Candi Sari, Semarang
Ms. Sri, Midwife, Puskesmas Kagok, Kecamatan Candi Sari, Semarang
Ms. Heko Suwari, Family Planning Volunteer, Kelurahan Kaliwiru, Kecamatan Candi Sari, Semarang

Yogyakarta

Dr. Siswatiningsih, Chairman, BKKBN Yogyakarta
Drs. Ponimin, Head, Information and Motivation Section, BKKBN Yogyakarta
Dra. Roosmiyati, Head, Family Planning Services Section, BKKBN Yogyakarta

Dr. Lucia Sri Redjeki, Puskesmas Imogiri I, Bantul, Yogyakarta
Ms. Ning Sri Suryani, Midwife, Puskesmas Imogiri I, Bantul, Yogyakarta

Ms. Weni Hayuningsih, Village Midwife, Polindes Musthiko Weni, Desa Wukirsari, Imogiri, Bantul, Yogyakarta

Ms. Nari, Executive Director, PKBI, Yogyakarta
Mr. Nasrun, Head, Study Center for Sexuality, PKBI, Yogyakarta

Ms. Subiyati, Midwife, Puskesmas Kota Gede II, Bantul, Yogyakarta
Ms. Tugiyah, Family Planning Client, Kota Gede, Bantul, Yogyakarta
Ms. Indayati, Family Planning Client, Kota Gede, Bantul, Yogyakarta
Ms. Supriyati, Family Planning Client, Kota Gede, Bantul, Yogyakarta
Dr. Bambang, Physician, Public Hospital, Bantul, Yogyakarta

Drs. Suripto, Chief, BKKBN Kulon Progo, Yogyakarta
Drs. Basari, Head, Family Planning Services, BKKBN Kulon Progo, Yogyakarta
Mr. Sukidjo, Village Head, Desa Glagah, Kecamatan Temon, Kulon Progo, Yogyakarta
Ms. Sari Dewi, Village Midwife, Polindes Permata Hati, Desa Glagah, Kecamatan Temon, Kulon Progo, Yogyakarta

Mr. Netro Hartono, Head, Sub-village Mlangen, Desa Paliyan, Kecamatan Temon, Kulon Progo, Yogyakarta

Ms. Rubinem, Posyandu Kader, Sub-village Mlangen, Desa Paliyan, Kecamatan Temon, Kulon Progo, Yogyakarta
Ms. Wagiyem, Posyandu Kader, Sub-village Mlangen, Desa Paliyan, Kecamatan Temon, Kulon Progo, Yogyakarta

North Sumatra

Drs. Hartono, SmHk, Chairman of BKKBN Provincial, Medan, North Sumatera
Drs. Hardiyanto, Vice chairman, Medan, North Sumatera

Drs. H. Zakaria Lubis,Chairman of BKKBN District, Deli Serdang, N. Sumatera

Drg. Magdalena Barus, Chairman of Puskesmas, Sub District Tanjung Morawa
Suroso, FP Field Worker Supervisor (PPLKB), Sub District Tanjung Morawa
Ichrataini, Bidan, Puskesmas Tanjung Morawa
Masdiana, FP Field Worker, Sub District Tanjung Morawa
Zulaika, Kader, Tanjung Murawa

Johni Ginting, SH, Chairman of BKKBN District, Dairi
Dr. Johannes Tarigan, Chairman of Puskesmas, Dairi
Sihar Simorangkir, PPLKB, Sub-District Sumbul, District Dairi
Rotua Pandiangan, FP Field Worker/Bidan, Sub-District Sumbul, District Dairi

Dr. Safrina, Vice-Chair of IDI clinic, Medan
Midwife Nur, Chair of Aisyah clinic, Medan
Dr. Safrina, Chair of PKBI clinic, Medan

Attachment 5. Draft Interview Protocol

Providers

[*Pkb*, staff at *PUSKESMAS*, private providers, *bidans*, *kaders*]

1. How do you know how many acceptors you are supposed to serve? E.g. do you have a workplan? How many do you need to see or serve this month? What is the breakdown by family planning method?

2. Who determines how many acceptors you are supposed to serve?

3. What happens if you don't serve the number of acceptors [or meet the target] indicated in your workplan?

4. What happens if you serve many more acceptors [exceed your target] in one month than the number indicated in the workplan?

5. Have you ever received a gift or any other item for serving many family planning acceptors? If so, when and under what circumstances?

6. What requirements are there for being a *kader*?

7. Are there *kaders* who are not currently using family planning methods?

8. What information does an acceptor need to know about a method?

9. When you talk to women do you use educational or other materials?

10. If a woman wants a family planning method that is inappropriate for her, what do you do?

11. How do women/acceptors register complaints about services?

12. Observed a practice counseling session.

13. Verified placement of wall chart check.

Attachment 5. Draft Interview Protocol (continued)

Acceptors:

[at clinics, *POSYANDUS*, with *kaders*/fieldworkers]

1. Has anyone ever offered you a gift or any other item in exchange for accepting a family planning method?

2. If so, please explain.

3. Has any provider ever told you that you could not have a certain service, e.g. health care services, if you did not accept a family planning method?

4. Do you belong to a *kukesra* [credit scheme] or *takesra* [savings program]? If so, why did you join? Could you join if you were not using a family planning method or if you had a large number of children?

5. Do you belong to a family planning user group? Why did you join? Please explain.

6. Now I would like to ask you a few questions about your family planning use. Is that okay?

7. Are you currently using a method?

8. If yes, which one?

9. When did you first receive the method?

10. Who provided it for you?

11. Why did you choose the method?

12. Did you have questions about the method?

13. If so, who did you ask about those questions?

14. If you had a problem with your method [e.g. heavy bleeding] and wanted to do something, what would you do?

15. If you were not happy with or did not receive proper information [from your provider], what would you do?

16. Are safari *kb* services offered in your village?
    Probe: Have you participated in such a safari or do you know anyone who has? Did you or she feel that you were pressured to participate? If they are not offered, when were they last available?

Attachment 5. Draft Interview Protocol (continued)

Supervisors:

[*PPLKB, PLKB, BKKBN* and *DepKesKeSos* local staff, NGO local staff]

1. How do you determine how many acceptors a provider is expected to see in a month?
2. What happens if she does not see the expected number?
3. How do you evaluate the performance of providers?
4. How do you reward superior performance?
5. How do you correct poor performance?
6. How is your own performance evaluated?
7. Do you think that method switching is a problem in your program? If so, why do you think method switching is happening?
8. Do you think that method discontinuation is a problem in your program? If so, why do you think women stop using methods?

Attachment 6

References

BKKBN 1994. *A Situation Analysis of the Government Run Service Delivery Points for Family Planning in Indonesia*. Jakarta: BKKBN.

GOI 1992. *Law of the Republic of Indonesia Number 10 of 1992 Concerning Population Development and the Development of Happy and Prosperous Families*. Jakarta: State Ministry for Population/National Family Planning Coordinating Board.

GOI 1994. Address by Dr. Haryono Suyono State Minister for Population/Chairman, National Family Planning Coordinating Board Republic of Indonesia to the Meeting of the Population Association of America May 5,1994. Jakarta: State Ministry for Population/National Family Planning Coordinating Board.

GOI 1999. *Healthy Indonesia 2010, The New Vision, Mission and Basic Strategies of the Ministry of Health, Republic of Indonesia*. Jakarta: Ministry of Health.

GOI 2001. Keynote Speech by Hj. Khofifah Indar Parawansa State Minister for Women Empowerment and Chairperson of the National Family Planning Coordinating Board at the 11th International Meeting of the Society for the Advancement of Reproductive Health Care. Bali: Ministry for Women Empowerment/BKKBN

Hayes, Adrian C. 2001. *Policy Briefing Paper: The Indonesia National Family Planning Program and the Tiahrt Amendment of the U.S. Congress*. Jakarta: STARH Program

Hoesni, H.R. Hasan Moehammad 2000. *The National Family Planning Coordinating Board (BKKBN) Central-Level Policy Review*. Jakarta: The Policy Project/ The Futures Group International

H.R. 4328 1998. *Omnibus Appropriations for FY 1999*. Washington, D.C.: Congressional Record, October 19, 1998, Pp. H11085 and H11356.

Hull, Terrence H., and Valerie Hull 1997. *"Politics, Culture and Fertility: Transitions in Indonesia." In The Continuing Demographic Transition,* ed. By G.W. Jones, R.M. Douglas, J.C. Caldwell, and R.M. D'Souza. Oxford: Clarendon Press. Pp. 383-421.

Kak, Neeraj 1999. *SDES Evaluation Report: Key Findings.* Jakarta: Pathfinder International.

Knowles, James 2000. *New Era Strategic Analysis for the National Family Planning Coordinating Board (BKKBN) 2000-2015*. Jakarta: BKKBN.

Lewis, Gary, Young-Mi, Kim, Putjuk, Fitri, Basuki, Endang 2001. "Smart Patient" Coaching in Indonesia: A Strategy to Improve Client and Provider Communication Presented at the SARC Meeting. Bali: STARH Program.

STARH-Program 2001. STARH Workplan for Year One (August 2000 – December 2001). Jakarta: STARH Program/JHU/CCP.

Sutomo, Sumengen 2000. *Service Delivery Expansion Support Project Indonesia 1994 – 2000 Project Summary*. Jakarta: Pathfinder/SDES Project

USAID/AA/PPC, Thomas H. Fox 1999. Voluntary Family Planning – New Standard Clause/Provision and Guidance to Implement Tiahrt Amendment Requirements in USAID Assistance. Washington, D.C.

USAID/Indonesia 2000. Request for Application: Sustaining Technical Achievements in RH/FP. Jakarta.

USAID/M/OP, Rodney W. Johnson 1999. *Voluntary Family Planning – New Provisions to Implement the Tiahrt Amendment.* Washington, D.C.

USAID 1999. Technical Guidance on the "Comprehensible Information" Paragraph of the Tiahrt Clause. Washington, D.C.

Attachment 7. Photos

Wallchart in Kendal District

Role Playing Counseling in Kendal Puskesmas

PLKBs and Wallchart in Kendal Puskesmas

BKKBN Office in Yogyakarta