

# **KELUARGA BERKUALITAS**

**STRATEGI  
KOMUNIKASI  
DAN ADVOKASI**

**2001-2006**

**National Family Planning  
Coordinating Board (BKKBN)**

**STARH Program  
(funded by USAID)**

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## I. INTRODUCTION

In the last three decades in Indonesia, the National Family Planning Coordinating Board (BKKBN) has achieved great success in its family planning (FP) program. The program's performance is recognised internationally with most of the advancements made through a strong centrally driven program. With the economic crisis in 1997 devastating the social, political and financial structures within the country, some areas of Indonesia have witnessed a reduction in the ability to access basic health services, including family planning. With the new government administration in 1999, government functions have recently been decentralized to local and district government offices and leaders. Decentralization provides local authorities with significantly greater control over the planning and fiscal management, leaving the reproductive health (RH) program subject to the opportunities and challenges of devolution. The program faces new challenges as it broadens its mission to address a more comprehensive definition of reproductive health, reproductive rights, and women's empowerment.

BKKBN's New Era thinking outlines a new vision that encompasses these changes. The *New Era* articulates the established 1994 International Conference on Population and Development (ICPD) goals where reproductive rights of women and couples are protected through the provision of broadened quality RH/FP services. BKKBN, through the *New Era*, will have the opportunity to strengthen the shift in the family planning paradigm from a demographically driven national developmental goal to a broadened focus on women's reproductive health. This new strategy seeks to sustain gains in RH/FP while, at the same time, evolving to a decentralized program that focuses on improving reproductive rights, defining broader family development, and strengthening relations with other government and non-government organizations.

By expanding its definition of reproductive rights, BKKBN will reform its core business by focusing on new opportunities to improve RH and reproductive rights, especially for women, adolescents, children, and special populations. The new strategic thinking of BKKBN will focus on two main strategic objectives. First, as its core message, BKKBN will promote the idea and support the growth of a *Quality Family*, at the heart of which is empowering families with the ability to plan and decide when and how many children to have. This objective will be supported within an advocacy and communication strategy that positions BKKBN as a resource in helping families succeed in providing for their own needs. Second, through a comprehensive communication strategy, BKKBN will promote improved quality and choice in reproductive health service delivery programs. Only with a client-centered focus and active participation and empowerment of clients and communities, will BKKBN create opportunities for families to make individual decisions about their own RH/FP needs.

Overall, the range of demographic indicators that BKKBN might consider for monitoring and evaluating the effectiveness of the *Quality Family* campaign would include (please see Attachment D for information on programmatic indicators):

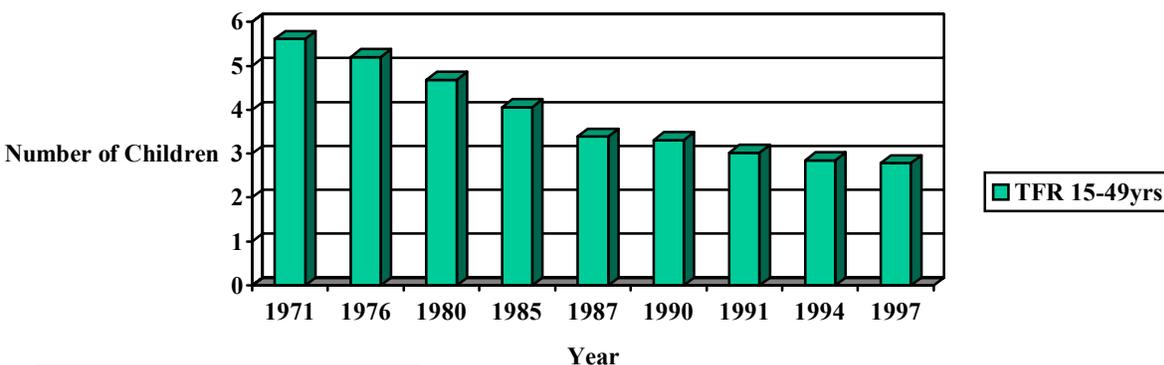
- Increased contraceptive prevalence rate (CPR);
- Increased spousal communication about reproductive health issues (i.e. family planning, HIV/AIDS, maternal mortality, etc.);
- Increased number of facilities certified for quality service delivery;
- Increased number of family planning clients receiving their preferred methods;
- Increased number of facilities providing high-quality counseling;
- Reduced number of adolescents in high-risk behaviours (i.e. lowered STD/HIV rates, unwanted pregnancies, smoking, etc.);
- Reduced under-5 child mortality ratio;
- Reduced maternal mortality ratio;
- Increased mean number of years of schooling completed by women aged 20-24.

Depending on the priorities that BKKBN may wish to pursue in the next five years, these indicators could be linked with interventions that BKKBN would implement, in collaboration with other key stakeholders. In essence, BKKBN will need to choose from the range of indicators listed above and identify goals for each indicator that are appropriate at different stages within this five year strategy.

## II. OVERALL REPRODUCTIVE HEALTH SITUATION IN INDONESIA

In the past thirty years, the Indonesian government has made important and impressive achievements in addressing fertility and increasing contraceptive prevalence. From 1971 to 1997, the country's total fertility rate decreased from 5.6 to 2.8, nearing replacement fertility (see Figure 1). Overall, contraceptive prevalence rates in Indonesia have increased over time from 50 percent in 1991 to 55 percent in 1994 and then 57 percent in 1997. The use of injection, now one of the program's most popular methods, has increased substantially while the IUD, pill, condom and male sterilization have decreased in recent years. As a result of the wider acceptance and use of FP to space and limit births, maternal, infant and child mortality have all decreased.

Figure 1. Total Fertility Rate (TFR) from selected resources, Indonesia 1971-1997<sup>1</sup>



<sup>1</sup> IDHS, 1997.

While significant advances have been documented, the program continues to face strong challenges. On the whole, adolescents are underserved and lack basic information on RH/FP. Even though most adolescents have heard about family planning and HIV/AIDS, they do not have the correct information about how to protect themselves from pregnancy or transmission of sexually transmitted diseases (STDs). In one study, 45 percent of young adults reported that HIV/AIDS was curable and only 33 percent of single young adults understood that HIV/AIDS could be transmitted through sexual intercourse.<sup>2</sup> While HIV and AIDS have not reached epidemic proportions in Indonesia, low use of condoms and awareness of their protective effect against STDs works to perpetuate growing numbers of STD cases.

Improving the quality of RH/FP services has been a challenging task for BKKBN. In a recent project evaluation, observed bidans were following 75 percent or more of the standards set forth to provide quality counseling while others were following 50 percent or less of the standards required. Clinical standards, such as washing hands and wearing gloves, are not always followed by many providers. Provider performance needs to be enhanced in the IUD insertion process, discussing possible side effects, informing clients about follow-up visits.<sup>3</sup> As a likely consequence, many FP users have reported high discontinuation rates due to side effects within the first 12 months of use. The injection and pill are reported as methods with the highest discontinuation rates due to side effects.

### **III. KEY CHALLENGES UNDER THE *NEW ERA* OF BKKBN**

Evidence is accumulating worldwide that projects and national programs emphasizing informed choice and increased quality FP services not only improve client satisfaction but also contribute to increased FP practice and decreased dropout rates. The *New Era* provides a strategic framework for BKKBN, moving the organizational focus beyond promoting the two-family/small family norm. In order to ensure that quality and informed choice are the centerpieces of BKKBN's *New Era* program and affect change, the organization must first change itself.

The needs of Indonesian families can only be addressed through a program that is considerably broader than BKKBN's traditional focus on FP and fertility reduction. BKKBN's *New Era* vision and mission represents a broader approach to FP and RH in order to adequately address the longer-term and dynamic nature of the needs of Indonesia's families and ensure that quality and informed choice are central to its RH/FP program.

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<sup>2</sup> IDHS, 1997.

<sup>3</sup> Kak, 1999.

BKKBN's long-term vision is for "*Quality Family in the Year 2015*". BKKBN defines family needs broadly since all segments of the population, and consequently all family members, are facing significant challenges. BKKBN defines a *Quality Family* as one that<sup>4</sup>:

1. Is prosperous (i.e. able to at least meet its main material needs);
2. Is healthy (including physical, spiritual and social health);
3. Is progressive (i.e. committed to economic and human development);
4. Is independent (i.e. not dependent on others, including the State);
5. Has an ideal number of children (i.e. ideal from the standpoint of the family's own preferences and its capacity to nurture children);
6. Has an advanced outlook (i.e. individuals are broadly knowledgeable, capable, concerned and creative in their efforts to improve the condition of their families and of the community in which they live);
7. Is responsible (i.e. concerned by issues affecting the community);
8. Is harmonious (i.e. family members do not quarrel among themselves or with other members of the community), and;
9. Is God-fearing (i.e. fulfills the family's religious obligations and demonstrates good character and strong morals).

BKKBN's broadened vision in the *New Era* rests upon a long-term mission that includes the following elements:

1. Supporting empowered communities to develop *Quality Families*;
2. Building effective partnerships with other organizations;
3. Improving the quality of RH/FP services and related social services that contribute to building *Quality Families*;
4. Educating individuals, families and communities about their ICPD-articulated reproductive rights and other related rights that may affect *Quality Families*;
5. Empowering women to achieve gender equity and justice;
6. Promoting human development throughout the life cycle for all.

BKKBN's long-term strategy is designed to mobilize its unique organizational resources to address many of the current and anticipated future challenges influencing its *Quality Family 2015* vision. The long-term strategy is organized around five main themes or "pillars". These "pillars" include: *integration, decentralization, partnerships, empowerment, and focus*. Building upon each of these pillars will require fundamental changes that will transform BKKBN's organizational direction, culture and identity. In general terms, these changes will involve the following:

- Full implementation of a modern reproductive rights approach to RH/FP that highlights quality and choice, as opposed to BKKBN's pre-1994 demographic/development approach;

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<sup>4</sup> Knowles, 2000.

- Gradual evolution in its traditional *program* focus on RH/FP and fertility reduction to a broader *organizational* focus on RH/FP and family development issues;
- Shifting organizational style from heavy reliance on centrally directed, top-down approaches toward decentralized, participatory approaches that allow BKKBN to provide technical and leadership support to local management at the province and district levels, and;
- Shifting from a *coordinating* role with respect to other organizations to one involving true *partnerships* with governmental and non-governmental organizations in promoting the *Quality Family 2015* vision.

### **A. Integration**

One of BKKBN's highest priorities is to integrate FP services into a broader package of RH services. The potential synergies among these services include saving women's lives by reducing exposure to complications associated with pregnancy and childbirth, and helping couples achieve their desired family size with fewer births. Safe motherhood contributes to reduced maternal mortality and morbidity and to reduced levels of neonatal mortality, an important component of infant mortality. Moreover, adolescent RH/FP programs help protect young women from HIV/AIDS as well as reduce unwanted pregnancies. Reducing unwanted pregnancies among adolescents in turn reduces the risk of life-threatening illegal abortions and enables young women to remain in school longer, further contributing to their overall human development and empowerment. BKKBN will also integrate RH/FP with other parts of its program (e.g. family welfare activities), and the programs of other governmental and non-governmental organizations.

### **B. Decentralization**

The decentralization of many central governmental activities to the province and district levels will be one of the biggest challenges that BKKBN faces as an organization. It will require BKKBN to develop new and/or strengthened partnerships with local governments. BKKBN managers will need to learn how to use a mix of advocacy, training, IEC, and material incentives to achieve the necessary levels of cooperation and partnership with local government institutions in order to implement their programs successfully. BKKBN can support decentralization by assisting with the development of bottom-up capacity for policy formulation and program implementation at the village level. BKKBN staff will need to "listen to the voices of the people" and adapt programs to reflect these needs.

### **C. Empowerment**

Indonesian women and men need to understand their reproductive rights and what they can do if these rights are violated. Governmental officials, especially health workers, need to be aligned in understanding reproductive rights. Moreover, promoting reproductive rights includes placing a strong emphasis on quality and informed choice so that people are informed and have access to FP methods that meet their particular needs. BKKBN can play a key role in developing and sharing appropriate advocacy and IEC materials and monitoring service delivery sites to ensure that both public and private service delivery providers are adhering to established quality standards. BKKBN recognizes the need to develop cost-effective systems to monitor quality of care and

respect for reproductive rights and identify ways to strengthen provider incentives to deliver high-quality services. An additional long-term objective is to empower communities through implementing a participatory approach to policy formulation, implementation and evaluation at the village level and activities in support of a broader program of women's empowerment. To accomplish this, BKKBN staff must improve their skills in relation to community participation and identify ways to adapt needed social innovations to local traditions and constraints.

#### **D. Partnerships**

BKKBN's long-term strategy includes the need to build mutually beneficial partnerships with a wide range of institutions. Whereas past BKKBN partnerships primarily involved organizations that were in a position to only promote FP, BKKBN's future partnerships will be oriented toward the promotion of its broader *Quality Family* vision. Potential partners include: the communities, village midwives and other private providers, the Ministries of Health, Education, Women's Empowerment and other governmental agencies, local governments, NGOs, professional organizations (e.g. midwives, doctors, pharmacists), universities and other research organizations, religious leaders, parliamentarians, women's organizations, and various non-medical private sector organizations.

#### **E. Focus**

In addressing a broad range of challenges to its *Quality Family* 2015 vision, it will be very important for BKKBN to keep its program focused appropriately on a limited number of high-priority activities. BKKBN must focus on demand-side approaches which build upon the organization's unique strengths while avoiding competition or conflict with current or potential partners. BKKBN will need to strengthen its capacity in participatory approaches in community participation while maintaining familiarity with the broad range of social problems facing Indonesian families. One important function of BKKBN's research program will be to monitor the changing nature of the challenges confronting Indonesia's families, thereby enabling BKKBN's program focus to be evidence-based and research driven. Effective monitoring and evaluation of ongoing programs and activities will also help BKKBN to determine what is and is not working so that promising new programs can be more easily introduced by removing older programs that are found to be less effective.

### **IV. A COMPREHENSIVE AND MULTI-PHASED ADVOCACY AND COMMUNICATION STRATEGY**

BKKBN and its partner agencies have, in the past, demonstrated the capacity to launch national programs driven by strong communication components (e.g. "Dua Anak Cukup," "KB Mandiri," "Blue Circle," and "Keluarga Sehatera" programs). These programs, however, even as they contributed to the success of the Indonesian population program, were launched under a strong centralized system allowing for only minimal participation of implementing field units and communities in the planning and designing

stages. As the country moves toward greater democracy and increasing decentralization of government functions, the challenge is how to position family planning as a program that is not driven from the top, but as one that is truly responsive to the maturing needs and changing aspirations of the Indonesian people. These maturing needs and changing aspirations in the context of family planning programs can best be described in two words: **Quality** and **Choice**. In the broader context beyond family planning, BKKBN has articulated this vision as *Quality Family* 2015.

BKKBN's strategic approach to developing a comprehensive communication and advocacy strategy in the next five years include the following key features:

- Multi-phased over five years built around the idea of *Quality Family*;
- Combines communication and advocacy to achieve synergy;
- Integrated and multi-channel, combining community participation, interpersonal communication and mass media at central and district levels;
- Advocates and promotes high-quality services through the decentralized public system and private sector;
- Focuses on building capacities at decentralized levels, and;
- Addresses the needs of special populations.

Overall, this holistic approach will facilitate the transformation of the program toward greater consumer orientation, thereby increasing participation of men, empowering women, clients and communities in shaping program decisions. Through a decentralized system, this approach will weave the national and local level mass media components, community mobilization initiatives and improved client-provider counseling and interactions into a seamless whole reinforcing each other.

#### **A. A multi-phased strategy built around the concept of *Quality Family***

The *New Era* concept of *Quality Family* will be articulated to the public using a “petal” strategy (see Figure A). ***At the heart of the petal is the idea of Quality Family as a planned family, empowered to plan and decide the number and spacing of children and taking responsibility for acting on that decision.*** Around this core will be the spokes of the petal representing the eight other attributes of a *Quality Family* as defined by BKKBN. This petal visual imagery reflects the fundamental idea that a family must be empowered to plan its own human reproduction for it to successfully plan other desired goals such as the education of children, protecting the family's health, providing for material needs and contributing to the welfare of the family and the community.

This petal strategy would also allow for a consistent and unified core message for five years, around which other priority messages related to the eight attributes will be incorporated in strategic phases over time (Please see Figures A, B, C, D and E). The proposed phasing of the petal strategy is broken into three phases that include:

**Phase I (Year 1-2).** Articulation of the core message plus three key support messages. The three support messages could be: 1) right to choose, ask questions, and receive the method preferred by the client (Responsibility, reproductive rights/demand for quality); 2) equal treatment of opportunities for boys and girls, especially in education (Progressive, gender/education); 3) increased spousal communication (Harmony, women empowerment).

**Phase II (Year 2-3).** Articulation of the core message plus three key support messages. The next three key messages could be: 1) increased access to quality services and willingness to pay (Independence, self-reliance); 2) zero tolerance for mothers dying in childbirth (Forward Thinking, maternal mortality); 3) increased participation in welfare programs (Prosperity, poverty alleviation).

**Phase III (Year 4-5).** Articulation of the core message plus three key support messages. The next three key messages could be: 1) combination of right to choose and access to quality (Responsibility, reproductive rights); 2) adolescents avoiding high-risk behaviors (Spiritual, moral values); and, 3) protecting health of couples and children (Health, HIV/AIDS).

The above illustration of the strategic phasing is, in effect, agenda setting to focus attention on a fewer set of issues at a given time. This would primarily be achieved by using mass media, principally television and radio, which can reach the largest number of people at the least cost and could also reach large numbers of policy makers not only at the central level but particularly at decentralized levels. This agenda setting exercise does not preclude the use of other appropriate fora and channels (e.g., public relations, magazine articles, dialog with parliamentary members at all levels, and networking with the civil society represented by NGOs) to discuss and articulate the full meaning of BKKBN's *Quality Family* initiative.

This phasing is also deliberate in that it focuses first on enhancing and improving the quality of RH/FP service delivery systems, the supply side, which is then followed by communication activities that increase demand and raise expectations for those services, continually reinforcing the need for quality RH/FP systems. This arrangement is purposeful in that phase one calls on the BKKBN and private providers to adapt new strategies for RH/FP service provision as outlined in the *New Era*. Additionally, structures will be developed that will showcase RH/FP quality health facilities through a quality improvement/certification program. On the demand side of quality, the focus will be on the clients' right to choose, ask questions, and receive their preferred family planning method. Research findings in Indonesia show that clients are 40 percent more likely to continue using family planning if they receive the method they prefer.<sup>5</sup> As the *Quality Family* program gains momentum, phases two and three will work to build client demand for high-quality services as clients and communities will better understand their role and rights in the new RH/FP system. As active consumers, clients will be more

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<sup>5</sup> Pariani, 1991.

qualified and empowered in participating in a RH/FP service delivery system that provides services that fit their needs.

BKKBN should retain flexibility in the actual sequencing of the priority messages over time to take into consideration major opportunities that may be available in the field in collaboration with other related programs launched by other sectors, or based on changing political realities.

**Involving and increasing private sector's role.** As integration and decentralization are realities for the new BKKBN, the implementation of these phases through coordinated efforts with both local governments at the district levels and private sector organizations will provide BKKBN with the opportunity to fully expand the *Quality Family* initiative. Providing quality services through a national program of certifying qualified facilities will be a major component of the *Quality Family* initiative. The private sector will be a major component of this national certification program (please see section D. "Increasing Access to Quality Services"). In 1997, the private sector's contribution to the provision of family planning methods was 57 percent and BKKBN anticipates that this will increase as resources grow increasingly scarce in the public sector.<sup>6</sup> Private facilities and providers will compliment existing public sector services in achieving the goals of the program for audiences that can afford to pay for family planning services. The private sector's active participation is critical to sustaining continued advancements. As the certification program starts, it is anticipated that a larger proportion of private sector facilities will qualify, thus underscoring the continuing importance of the private sector's participation.

**Developing a symbol of *Quality Family*.** To help unify sight, message and even sound, a symbol for *Quality Family* should be designed which lends itself to the following principles:

- Easily described on radio (audio logo)
- Easily adaptable for animation
- Flexibility for different creative uses
- Interactive
- Potential for "strong legs"

A promising design should be able to lend itself to greater interactivity to suggest many different ideas: spousal communication, client-provider communication, community-program interaction, parent-child communication, etc. The design should also easily lend itself to be used in common interactions between people. An especially powerful symbol can develop "strong legs". In advertising, having "strong legs" means that the concept of a *Quality Family* can last longer and elicit more responses and additional uses than originally planned.

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<sup>6</sup> IDHS, 1997.

## **B. Combining Advocacy with Communication**

This strategy combines a two-pronged approach whereby external advocacy activities are addressed to both central and local policy makers, influential groups and internal advocacy are for BKKBN's central office, field networks and partner agencies, paralleling a communication strategy designed to change the behaviors of individuals, families and communities. The idea is to exploit synergies that can be derived from the two approaches. Effective advocacy to policy makers on the *Quality Family* approach will help improve the overall political environment which new BKKBN RH/FP programs can be implemented. The articulation of the *Quality Family* program in the communication strategy using the mass media will short cut and reinforce the process of socializing BKKBN's own staff, field networks, cadres, and partner agencies, as well as private sector organizations toward a team wide understanding of what the *Quality Family* program means.

**Internal advocacy: the socialization process.** The shift by BKKBN towards the *New Era* approach and the *Quality Family* 2015 program implies new ways of thinking and doing within BKKBN. BKKBN itself has close to 40,000 PLKBs, an estimated 900,000 volunteer cadres and tens of thousands more partner-agency field personnel. Private sector midwives also has a considerable presence at the field level. There is a need for both vast network to reach a team-wide understanding of the *New Era*'s vision and mission as well as a uniform understanding of the meaning of *Quality Family* and its practical implications in their day-to-day work. This team-wide understanding will be achieved by a broadened socialization process that will include activities that promote a greater understanding of BKKBN's shared goals, program priorities, language, and constantly changing environment in delivering high-quality RH/FP services.

### **Key Activities:**

- Develop a simplified primer describing the meaning and attributes of *Quality Family*. Link the characteristics of a *Quality Family* as defined by BKKBN, with programmable issues in family planning, reproductive health, family health, gender, safe motherhood, poverty alleviation, etc. ( For reference, please see strategic phasing above);
- Prepare briefing materials (in Powerpoint presentations, transparencies, and flipcharts) as job aids to field workers in explaining the *Quality Family* program;
- Develop a 20-minute video articulating key aspects of the *Quality Family* program;
- Post all briefing materials, job aids, and other key documents in the BKKBN web site for downloading by interested staff within the BKKBN network, and develop a dissemination plan for all advocacy materials to both local government and private RH/FP service providers.

**External advocacy: influencing the influentials.** As Indonesia undergoes the transition process from authoritarian rule to democracy and governance, the country's commitment to a strong family planning program will be questioned, debated, challenged or supported, as part of the democratic process. For RH/FP to remain a top priority concern for the country, it needs to develop a multiplicity of constituencies among policy makers at the national, provincial and district levels. Moreover, for the policy makers to support the *New Era* BKKBN and its *Quality Family* program, there is a need to deepen and expand its support especially from legislators at all levels and from the civil society.

**Key activities:**

- BKKBN's strategic approach to advocacy is to form an alliance of population, health, women's and environmental NGOs, (including professional societies, university centers, poverty alleviation and democracy and governance groups) to collectively advocate for: a) increased funding for RH/FP at the national, provincial, and district levels; b) availability of high quality services ( the poor have the same right as the rich to affordable quality services); c) women's and community participation in the design and implementation of programs, and; d) the goals of the *Quality Family* program;
- Work closely with the Healthy Indonesia 2010 (HI2010) Coalition to achieve synergies in the goals of BKKBN and the Coalition;
- Develop and distribute easily understood packets of information and presentation materials for national, provincial, and district parliamentarians showing how the *Quality Family* program and family planning can reap big dividends in saving the lives of mothers, infants and children and how it contributes to the slowing of population growth and its cost-benefit to the country. Conduct comparative analysis with other countries related to the comparative advantages of a country's development potential given a declining fertility and slowing population growth;
- Solicit individual and collective statements from key political figures from different political parties, religious leaders, key NGOs (including private sector RH/FP organizations), Professional Societies (IDI, POGI, IBI, etc), highly respected business leaders and celebrities. These statements supporting the *Quality Family* program should be released in conjunction with such events such as World Population, Ibu Kartini or Family Days to attract media attention;
- Develop a media advocacy program to increase coverage of key population and family planning events, activities related to improving quality services, women's issues, and research and policy findings related to *Quality Family* at national and district levels and to the contribution of RH/FP to health and national development;

- Work with Yayasan Kusuma Buana (YKB) to develop a training program for NGO advocacy and sustainability, building on the already established and internationally recognized YKB “NGO Sustainability and Management Training Program”; provide special attention to NGOs which have branches in most parts of the country such as PKBI, Muhammadiyah and Nadlahtul Ulama (NU) to receive special support in strengthening their advocacy capabilities especially at the district levels;
- Revisit existing policies related to RH/FP access, costing, special populations, etc. with the view of providing high quality of service and expanding services.

### C. Integrated and multi-channel communication strategy framework

BKKBN is well known worldwide for pioneering some of the more innovative programs in demand generation and communication. Given the complex nature of BKKBN’s current challenges, it is imperative that the communication strategy is comprehensive in that all the parts and elements reinforce each other to achieve maximum impact at national and district levels, especially in influencing behavior change. To ensure proper preparation into decentralization the role of the central level BKKBN should focus on providing the overall strategy, including guidelines on communication programs, thematic messages, and develop national prototype materials that local governments can adapt and adjust based on their needs and conditions. To ensure the success and sustainability of *Quality Family*, BKKBN at the central level will need to develop the capacity of the provinces and districts to develop locally specific materials, advocate to local parliaments and other influential groups, conduct local radio programming, build quality improvement teams, conduct interpersonal communication and counseling and implement community mobilization and participation . Overall, this comprehensive framework includes the following key features (see Figure F):

1. Communities, women’s groups, cadres and beneficiaries as **active participants** rather than just recipients of the program;
2. The interpersonal communication network represented by change agents and fieldworkers (e.g., PLKB, public and private sector health providers and Bidan de Desa) will be the **critical link** of the program to the communities, ensuring that the programs are sensitive and responsive to the needs and concerns of the intended audience.
3. This interpersonal network in the field will be supported with **performance improvement tools** such as job aids, interpersonal communication and counseling training (with self assessment and peer review) reorientation of job functions to better fit program goals and availability of client materials to distribute;
4. TV will serve as the national **anchor medium** not only to set the agenda and reach large numbers of people but also to reflect the issues and concerns of communities and women’s groups; radio will be used as a support medium especially to reach remote rural areas; BKKBN’s mobile vans at the local level will further deploy key campaign messages, and; print materials like magazines, newspapers, posters, stickers, leaflets, and flyers, including billboards, will be used to reinforce messages

across all the other channels. Mass media will also be programmed to improve the image of field workers and to model key elements of *Quality Family*.

**Communities and women's groups as active participants.** While communities and women's groups participated in the program in the past, they participated more as program recipients than active participants. Under decentralization, increasing community participation requires a shift from the old model of central government decision-making to decision-making by stakeholders at the local level. Historically, many community-based organizations were quasi-governmental and followed mandates dictated from the central level. While the central government will continue its role of setting standards for RH/FP service delivery and creating new policies and approaches such as the *Quality Family* program, the districts will now assume responsibility for funding decisions, oversight, and maintaining RH/FP services. The communities will need to be invested in the process of improving quality and promoting choice. Women, as the primary RH/FP clients, are central to this process.

To date, efforts to improve the quality of services have traditionally focused on strengthening clinicians' skills while community participation in defining/improving quality of care has been minimal. Women's participation has been particularly weak in decision-making roles. BKKBN will work with local NGO partners to increase women's participation, help the districts prioritize their goals for improving quality of care, create local demand for quality services at the community level and advance the goals of the *Quality Family* program.

Tools and approaches that facilitate a favourable environment toward community participation are essential. BKKBN will select appropriate NGO partners to develop approaches and provide technical assistance to the districts, for example, *Yayasan Melati*, Indonesian Women Coalition for Justice and Democracy, *Perhimpunan Pengembangan Pesantren*, and *Pusat Kejian Wanita*. At the central level, BKKBN will work with MOWE, DEPKES other partner agencies to assist in identifying local partners, especially women's groups which can contribute to the implementation of the program's community mobilization strategies.

BKKBN will establish coordinating mechanism at the local level to work with other donors and projects (i.e. MNH, HI 2010) and the *Jamiman Mutu* to create local action teams that will advocate for and coordinate *Quality Family* activities at the district level. These teams will include representatives from women's groups (i.e. PKK, Muslimat NU, BKOW /Coordinating Body of Women's Organization), religious groups (*Muhammadiyah*, *Nahdatul Ulama*, *Aisyiah*), professional organizations (IBI, IDI), NGOs and the GOI.

BKKBN will adapt community participation methodologies such as the Appreciative Inquiry (AI) and the Participatory Learning Action (PLA) methodologies (used by JHU/CCP in the Philippines and in Peru) and other approaches that focus on community strengths and assets to create a vision of the future that leads to action for individuals and organizations. By focusing on what is successful, participants (stakeholders) can provide positive suggestions about what they want from the *Quality Family* program, and not spend endless energy focusing on what is wrong.

Lastly, indirect exposure to campaign messages about FP method use through NGO groups by word-of-mouth channels will also be facilitated. Research in other countries has concluded that groups that have not directly been exposed to campaign messages can be indirectly exposed to the same messages through individuals who were directly exposed.<sup>7</sup> BKKBN should measure the extent to which groups not directly exposed to the *Quality Family* campaign are exposed through individuals who were directly exposed. Programmatically, NGO groups should facilitate discussions about RH/FP can work to increase exposure within the community, influence RH/FP knowledge, and raise overall contraceptive use.

#### **Key Activities:**

- Conduct an assessment of organizations and resources within the community, including community organizations and partner organizations, for the development and implementation of community-based *Quality Family* activities.
- Reorient and strengthen PLKB's role and skills in generating community participation;
- Strengthen the role of the 900,000 cadres in building on the growing social norm for small planned families and RH/FP practice; consider taking out a group insurance scheme to cover cadre death and injury benefits as an incentive to continued activity and participation;
- Develop tools and strategies to increase women's participation in the design and implementation of local programs;
- Conduct an assessment of RH/FP services with stakeholders, including community perceptions of quality of care, expectations of quality service, community satisfaction with RH/FP services, providers' perception of their role in the community, and providers' self-assessment of performance.

**Interpersonal communication networks as critical link to the communities.** The human face of the program in the field is the network of field workers and health providers (in the public and private sector) who interact with the community and the clients on a daily basis. They are the bridge of the program to the community. In effect, the frontlines of the program are represented by three major groups: 1) the PLKB and the cadres they supervise; 2) the health providers in both the public and private sector facilities, and; 3) the bidan de desa (village midwife). They all play a critical role in implementing key components of the *Quality Family* program.

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<sup>7</sup> Boulay et al., 2001.

This frontline of the program is not only critical in influencing behavior change and in ensuring informed choice, but also in reducing high discontinuation rates (even discounting for “acceptable” discontinuation due to couples deciding to have another baby or users shifting to a more effective or long-term methods). BKKBN must address discontinuation by confronting the issue of fear of side effects (15 percent), health concerns (16 percent) and method failure (11 percent) through improved client-provider interactions. These remain the most commonly cited reasons for discontinuation.<sup>8</sup> Discontinuation is also method-specific. Health concerns and side effects are mentioned frequently for implants and injections while method failure is associated mostly with discontinuing traditional methods and the pill. The challenge in dealing with these issues is the implementation of a program that produces well-informed, insistent and satisfied clients using effective and reliable methods. A major component of this program is to ensure that counseling is client oriented, not method-oriented, that couples receive the methods of their own choice. A 1991 East Java study showed that among women who were granted their method choice only nine percent discontinued, whereas women who were denied their choice, 72 percent discontinued.<sup>9</sup>

#### **Key activities:**

- Provide PLKB and private sector midwives with leaderships skills to lead in the front, in the middle and from the back (in the front, to reach families which need PLKB expertise beyond what the cadres can provide; in the middle, by working through other agency fieldworkers to achieve common goals; and from the back, by advocating local officials and community leaders to provide excellent support to BKKBN programs);
- Develop and test an effective interpersonal communication and counseling training curriculum on RP/FP: update the curriculum with state of the art lessons learned in Indonesia, incorporating peer review and self-assessments tools that help sustain effective health provider behaviors as a result of training; institutionalize updated version as part of the national clinical training network; reduce barriers and explore appropriate method use by training providers about WHO eligibility criteria; emphasize the need for clients to receive the family planning methods of their choice (in the absence of contraindications); focus on developing skills to counsel on side effects and health concerns as well as in changing provider attitudes toward clients;
- Ensure that health providers and village midwives receive counseling training or reinforcement; adapt training curriculum to the changing needs and roles of the PLKB, cadres, and private sector RH/FP providers;
- Ensure that the PLKB, cadres, private RH/FP providers are accountable for measurable outputs that can easily be monitored;
- Consider developing a national radio or TV-based continuing distance education program to improve the skills of the more than a million cadres, PLKBs, bidan de desa and other health providers.

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<sup>8</sup> IDHS, 1997.

<sup>9</sup> Pariani, 1991.

**Performance improvement tools to improve client-provider interactions.** Beyond equipping the field network with interpersonal communication and counseling skills, peer review and self-assessment tools, and leadership skills specifically for the PLKB and RH/FP private sector providers, they should also be provided with other performance improvement support materials. Additionally, supervisors will be equipped and apply performance improvement approached in supporting service providers improved interpersonal skills.

**Key activities:**

- Equip and train health providers, PLKBs and bidans with job aids such as flipcharts and cue cards, to improve their abilities to conduct motivation, provide counseling or explain the *Quality Family* concept;
- Make available the Tiaht-compliant wall chart on different family planning methods as part of the overall program to provide “comprehensible” information on all methods;
- Produce a set of materials (posters, flyers and cards) about client’s rights building on the set of materials previously developed by JHU/CCP for BKKBN; develop method-specific client materials that can be referred to by the clients at their convenient time;
- Produce low-cost client-oriented materials on a variety of topics related to the *Quality Family* program;
- Train supervisors on performance improvement in monitoring, management, and supervision skills of service providers under their supervision.

**TV as anchor and agenda setting medium.** TV will be used effectively to reach a national audience. TV has the widest reach of any mass media in the country, with 78 percent of women watching TV weekly<sup>10</sup>. A most recent evaluation of a national communication campaign, the Suami Siaga (Alert Husbands) project on reduction of maternal mortality, showed that TV, when used effectively, can reach a national audience at very minimal costs. In addition, TV is ranked slightly higher than doctors as an appropriate source of information about family planning, 78 percent vs. 76.5 percent<sup>11</sup>. In coordination with TV, at the decentralized levels, BKKBN should rely on its extensive mobile van network to further promote campaign messages.

**Key activities:**

- Use TV spots to role model what *Quality Family* means in stages, focusing on a group of attributes from one stage to another; because TV has wide reach, it also sets the agenda of which aspects of *Quality Family* are being focused on for the particular stage of the campaign;
- Develop a TV drama series which model and dramatizes the attributes of what a *Quality Family* is;

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<sup>10</sup> IDHS, 1997.

<sup>11</sup> IDHS, 1997.

- Develop the equivalent of video news release (VNR) to elaborate on more complex issues related to the concept of *Quality Family*;
- Use radio to reinforce TV but principally to reach remote rural areas;
- Use the print media (newspapers and magazines) to generate support for programs from policy makers and other influential groups;
- Synchronize use of BKKBN's large number of mobile audio-visual vans to reinforce community-based activities and events.

#### **D. Increasing access to quality services**

There is growing evidence worldwide that projects and national programs that emphasize informed choice and increasing the quality of family planning services, not only improve client satisfaction but also contribute to increasing family planning practice and decreasing dropout rates. One of the most prominent examples of this is the impact of the Gold Star program in Egypt that contributed to increasing contraceptive prevalence from 47.9 percent to 54.5 percent between 1995 and 1997. Adopting the lessons learned in designing and implementing the Gold Star program, and using other best practices such as Brazil's Pro-Quali and the Philippines' Sentrong Sigla (Centers of Vitality), Indonesia can lead the way in establishing an innovative program that focuses on quality and choice in a decentralized system (see Attachments B&C for more information on Gold Star and ProQuali).

BKKBN and partner organizations are familiar with the concept of a quality certification program and express great interest in implementing a certification scheme in reproductive health service delivery programs. BKKBN, in close collaboration with DEPKES, should take the lead in developing a national program that defines, certifies and brands the meaning of quality, in the cultural context of Indonesia. The "brand" development process will engage clients, women's groups and communities in defining what the quality "brand" means. In Egypt, a total of 101 indicators and sub-indicators make up the Gold Star quality brand. Social modeling through mass media of key elements of this "brand" (e.g., washing of the hands, boiling of instruments, clean physical environment, courteous and friendly providers, availability of counseling, adoption of infection prevention practices, etc.) will develop expectations of how services should be provided and how providers should behave, thus, developing social norms of practice and behavior that are sustainable in the long term.

For quality and informed choice to be the centerpiece of the Indonesian RH/FP program in the next five years, gaining the involvement and commitment of key government institutions (BKKBN, DEPKES and MOWE) as well as the Indonesian Doctor's Association, the Indonesian Midwives Association, NGOs with national presence, including key private sector organizations, is critical. Groups will need to reach consensus on the design of the model to be implemented and the quality standards required for facility certification. Additionally, through BKKBN's strong field presence, community involvement in setting standards, as well as performance feedback mechanisms, will contribute significantly in developing a quality improvement program.

As the certification program matures, so will the participation of health facilities and individuals that are keen on gaining the recognition and reputation for providing quality services. Early on, it is anticipated that a larger proportion of health facilities that would be certified would largely be private sector clinics. As a result, this certification program will not only promote recognition and demand for quality but will also enhance more private sector participation and, therefore, greater self-reliance for the program.

### **Key Activities:**

- Create an inter-institutional taskforce, with participation from key government institutions (BKKBN, DEPKES, MOWE), key medical organizations and associations, as well as private sector and community groups to define the certification program and evaluate progress;
- Establish a nationwide system that rewards high quality health facilities through certification, public recognition, and promotion in the community. Base certification on the Quick Inventory of Quality (QIQ) tools that have been developed and tested to assess quality systems in providing family planning. (Three tools are included in the QIQ assessment packet. These include: 1. Facility Audit with Manager; 2. Observation of Client-Provider-Interview, and; 3. Client Exit Interview.) (Please see Attachment 1).
- Develop a promotion strategy to brand and promote quality services in both the public and the private sectors; focus on the district level where strong accountability for quality of services needs to be built and encouraged; support private sector's role as it could serve as a stimulus to the government;
- Recognizing the important role of midwives in Indonesia, improve the image of midwives and promote their services; (Since the midwives have primary roles in providing both family planning and safe motherhood services, synergies can be achieved between the family planning and maternal and neonatal programs);
- Involve local communities, women's groups and religious leaders as joint stakeholders of the development of quality services; give local leaders prominent roles in ceremonies "awarding" the local clinics the brand of quality.

### **E. Building capacities at decentralized levels**

The decentralization process in Indonesia is giving districts a much more prominent role in nation building. This rapid devolution of power to the district level, however, has not been matched by increasing capacities at the district level to plan, manage, implement and monitor their own programs. BKKBN should prepare and equip its district offices within the next three years to assume greater responsibility and autonomy in advocating for its own program and in planning, implementing and evaluating its communication activities.

### **Key Activities:**

- Build on the progress achieved by BKKBN in using data and research findings to develop and pre-test communication materials; provide special training programs, and coaching by doing, to district action teams to continue institutionalizing the “P” process, a systematic approach to communication planning. (This tool uses data and research findings in the analysis and design phase, and pre-testing of materials in the implementation phase. Training will focus on developing materials with strong cues to action, moving people from awareness, to knowledge, to intention, to practice).
- Establish district action teams or local alliances and coalitions to support *Quality Families* program with participation from key government and civil society stakeholders;
- Develop advocacy skills of district staff to educate and influence local parliaments and influential leaders.

### **F. Reaching special populations**

This communication and advocacy strategy will address three special audiences: men, adolescents and internally displaced people (IDPs).

**Men.** Meaningful male participation can be achieved through three approaches. First, improve and enhance husbands’ support for family planning and his role in achieving *Quality Family*. While a great majority of husbands support family planning, husband opposition still accounts for 16 percent of women ages 15-29 not using a contraceptive method and who do not intend to use in the future<sup>12</sup>. Second, promote spousal communication and caring, understanding partnerships. Research in several countries has shown that spousal communication is a high predictor of family planning practice. Care however should be taken in positioning increased male involvement. Emphasis on male involvement could produce unintended effects of men taking over decision making on family planning from their wives. Third, promote the use of male methods. Use of condoms can have dual protection benefits of protecting partners from unwanted pregnancy and STD/HIVAIDS infection. Although vasectomy has been difficult to promote in most countries worldwide, organizations that specialize in this service could be provided technical assistance in developing innovative communication interventions.

### **Key activities:**

- Conduct a secondary analysis of IDHS data to locate the concentration of husbands opposing use of contraceptives and conduct qualitative research studies to probe the issues surrounding husband opposition; develop messages based on the findings and integrate them into the overall communication strategy;

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<sup>12</sup> IDHS, 1997.

- Include key messages in the overall communication campaign to reinforce values about husbands supporting their wives' practice of FP; include messages promoting spousal discussions about FP, RH and quality of care issues;
- Seek leveraged partnerships with local condom manufacturers to promote condoms for family planning use and HIV protection; coordinate with other donor supported AIDS prevention project and look for synergies in condom promotion;
- Develop special programs (within the larger multi-media campaigns) focusing on husbands as caring and understanding partners (CUP) and use male-oriented events such as soccer tournaments to reach men.

**Adolescents.** Overall, adolescents in Indonesia between the ages of 15-24 comprise 18.4 percent of the total population.<sup>13</sup> Studies demonstrate that adolescents lack basic reproductive health information, particularly regarding the variety and effectiveness of family planning methods as well as STD transmission and prevention. In 1999, the Survey of Young Adult Reproductive Welfare in Indonesia reported that young adults do not readily discuss reproductive health with other people.<sup>14</sup> If any discussions do occur, it's more often with a trusted source of information, such as a teacher, versus a family member at home. Normally, when young adults share incorrect information on reproductive health, which has implications for protection against pregnancy and disease. For example, over 53 percent of young adults believe that it is not possible for a woman to become pregnant the first time she has sex. Additionally, 89 percent of girls and 74 percent of boys have heard about contraception, only 54 percent believe a woman is not able to become pregnant the first time she engages in intercourse. Knowledge about HIV/AIDS is also often limited and misguided. Young adults are only somewhat knowledgeable about the risk factors for contracting HIV/AIDS as only 42 percent believe they actually know about HIV/AIDS, 40 percent think HIV/AIDS cannot be contracted by someone who appears healthy, and 45 percent think that HIV/AIDS is curable.

In addition to their peers, adolescents also heavily rely on the media to receive information about reproductive health and most have universal access to various media sources. Research has found that young Indonesian girls preferred soap operas, movies and quiz shows while adolescent boys watched movies, sports, news and music programs.<sup>15</sup>

**Key activities:**

- Develop adolescent reproductive health advocacy kits (which should include policy paper that addresses relationship between providing reproductive health information and its effect on sexual behavior; case studies of countries that invest in adolescent reproductive health (ARH); policy fact sheets and briefs on demonstrated need for stronger ARH policies and services) to be used as a basis

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<sup>13</sup> IDHS, 1997.

<sup>14</sup> Demographic Institute, 1999.

<sup>15</sup> Situmorang, 2001

- to educate parliament members, journalists and other key stakeholders to develop policies and enabling laws which are youth friendly;
- Conduct an assessment of activities of ARH-friendly NGOs with the view of establishing a coalition of ARH organizations; the coalition can host a telephone hotline where the youth can get information or counseling on sensitive topics related to reproductive health issues; the coalition can also link up with the planned JHU teen website for Asia focusing on reproductive health;
  - Conduct an analysis of the Mexico City policy to determine ARH-NGOs that are eligible to work under USAID funded projects.
  - Engage celebrities who can become role models for the youth, using music and the entertainment-education approach to develop youth variety shows or TV programs that would link with youth friendly organizations and centers;
  - Build capacity to support ARH programs by providing management, counseling, and clinical skills to support new efforts director towards RP/FP needs of adolescents.
  - Establish ARH task force to focus on advocating for improved policies and supportive environment for ARH.
  - Develop and/or tie ARH messages into existing *Quality Family* campaign messages for district level campaigns.

**Internally displaced people (IDPs).** Indonesia is home to over a million internally displaced people. IDPs, by the very nature of their circumstances, call for special attention not only in terms of their economic and survival needs but also their reproductive health needs. They are at a particular risk for unwanted pregnancy, STD/HIV, and violence against women. The children are also more vulnerable to disease as a result of their disruption to access in the health system and the degrading environment in which they live. Their itinerant and tentative status makes it difficult for them to access basic health care. Support for IDPs is made more difficult because of the diversity of their experiences considering experience of camp, length of time at camp, and experiences with natural or man made disasters.

**Key activities:**

- Conduct an assessment of the overall IDP situation in Indonesia and visit selected sites with NGOs and donors who have worked in the area to assess the population's family health and reproductive health needs;
- Identify alternative sites and develop a package of interventions (services, training, counseling, etc.) uniquely suited to the area but consistent with appropriate elements of the *Quality Family* program;
- Help coordinate public sector agencies, NGOs, donors, and cross sectoral partners assistance to IDPs;
- Document experiences in working with IDPs so that best practices can be shared with other donors working in other area.

## G. Monitoring and Evaluating

In order to document the impact of the *Quality Family* program, BKKBN will need to routinely measure results of the goals of the program. BKKBN monitoring systems will link established, predefined indicators directly to behaviors and results relating to impact on: service delivery, improved quality, enhanced policy, building partnerships, community and NGO participation, and informed method choices.

### Key Activities

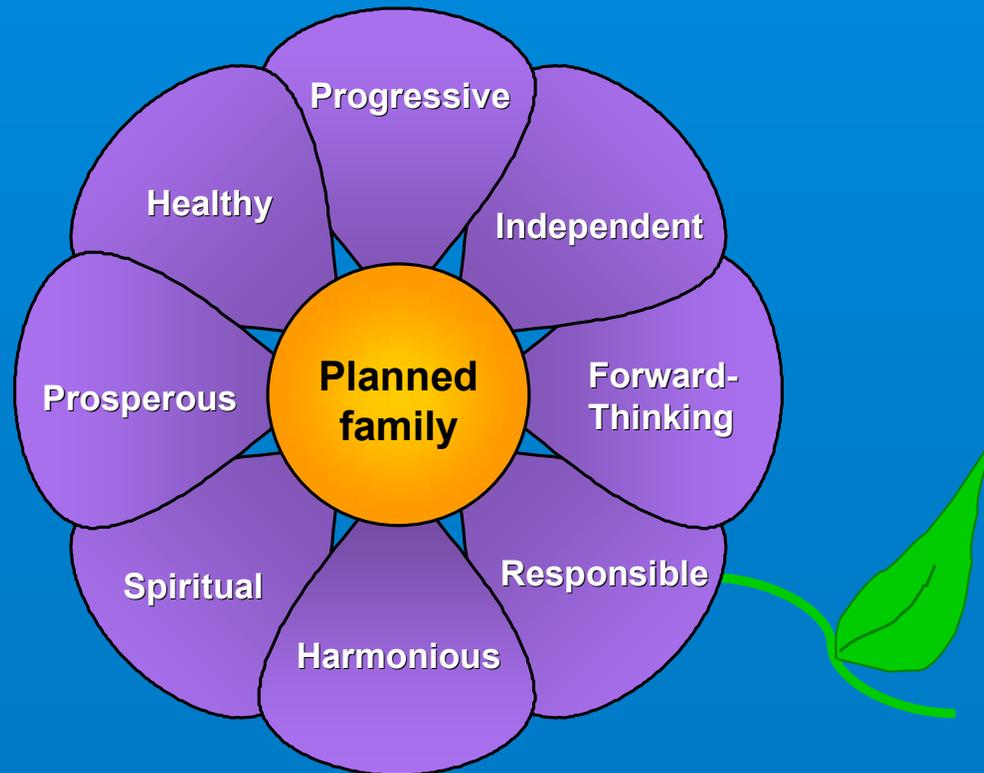
- Review, analyze, coordinate, and streamline existing and new data (such as BKKBN service statistics, BKKBN's annual census of users, the TIMS database, and commodity inventories and forecasts) so that they can be used to address specific local needs such as popular method preferences by geographic area, immediate training needs, budget priorities, client unmet needs, and compelling arguments to make the case for FP to local policy makers.
- Evaluate the direct and indirect impact of the *Quality Family* communication program exposure on the knowledge, attitudes, approval, intentions, practices and personal advocacy of the intended audiences. Include questions in upcoming DHS to evaluate program performance;
- Measure impact of advocacy campaign on: local government budget allocated to health; understanding and acceptance of the *Quality Family* campaign, and; number of NGOs and community-based group participation and support of *Quality Family* campaign;
- Work with local and NGO partners to bridge the gaps in the statistical records currently being maintained. Systems will be set in place to identify facilities that need supervision and providers who need upgraded clinical and non-clinical skills and to monitor service delivery sites that have met the basic standards. The focus will be on documenting achievable results while minimizing the data management burden at the districts and provincial level. Priority will be placed on the continuous use of data for planning, monitoring, and evaluating at the provincial and district level;
- Adapt Quick Investigation of Quality (QIQ) to monitor quality at the facility level to measure behavior of health care providers, clinic facilities, supervision, and client satisfaction and develop a system to monitor the growth of the quality improvement program;
- Conduct special studies to evaluate specific activities such as the quality of supervision, responsiveness of the logistics system (through LMIS), comparison of different training methodologies, effectiveness of various advocacy arguments, activities, and coalitions, and treatment of adolescents;
- Strengthen BKKBN's capacity to use data as a management tool to improve performance and share lessons, especially at the provincial and district levels;
- Ensure that there is timely analysis and dissemination of m/e data. All m/e results will be disseminated widely in user-friendly formats depending on the intended audiences. The m/e results, including "lessons learned", will be distributed to all levels of the program, including community groups, service delivery points, district province and central level.

## FIGURES

FIGURE A	Quality Family Illustration
FIGURE B	Phase I: Year 1-2
FIGURE C	Phase II: Year 2-3
FIGURE D	Phase III: Year 4-5
FIGURE E	Quality Family Matrix
FIGURE F	Integrated Multi-Channel Communication Framework

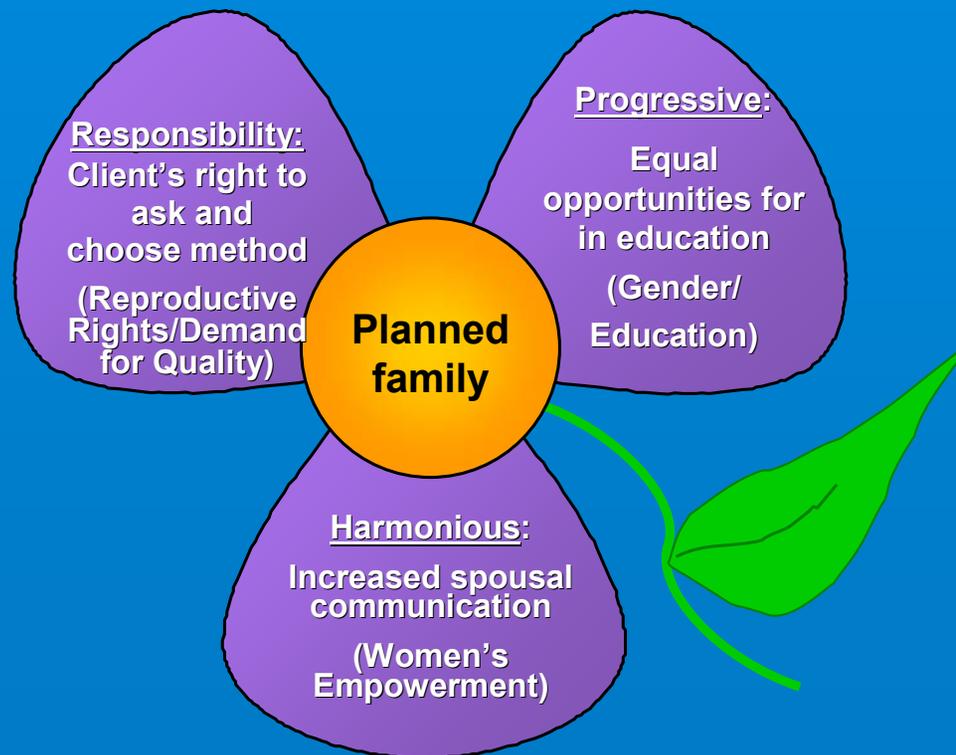
# Figure A

## Quality Family



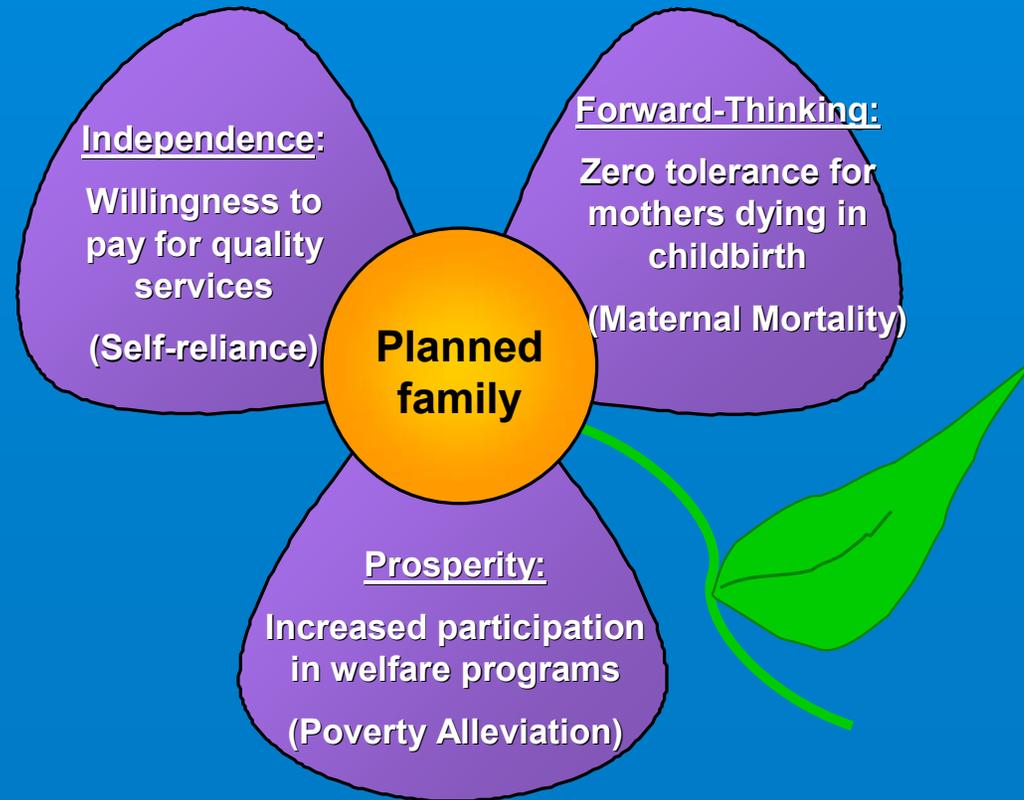
## Figure B

### Phase I: Year 1-2



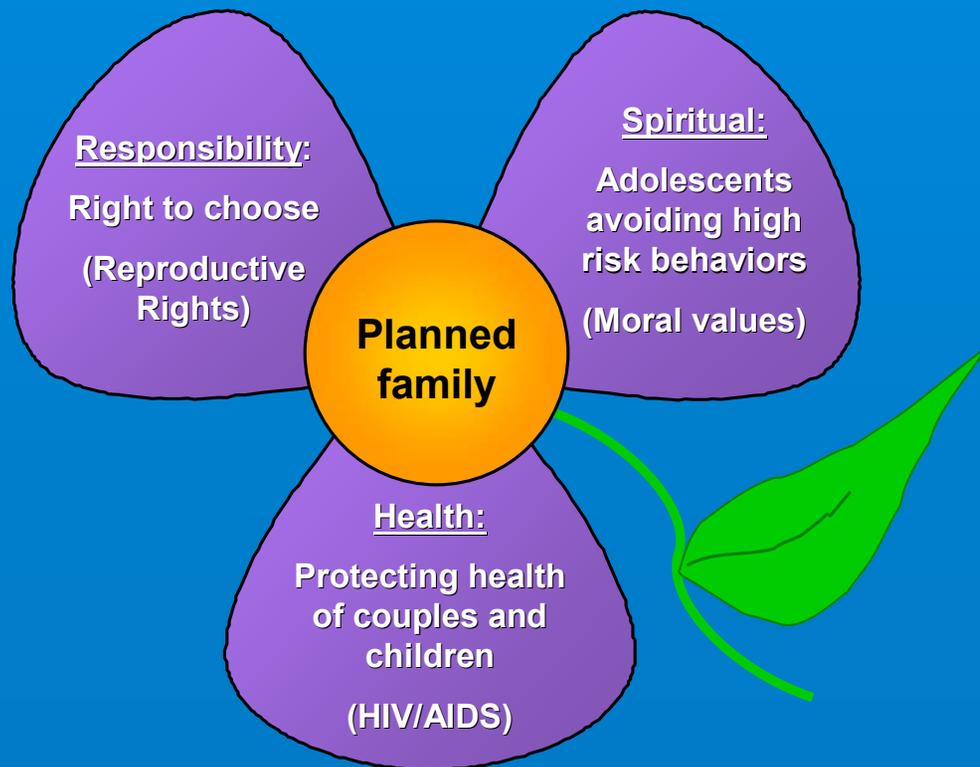
# Figure C

## Phase 2: Year 2-3

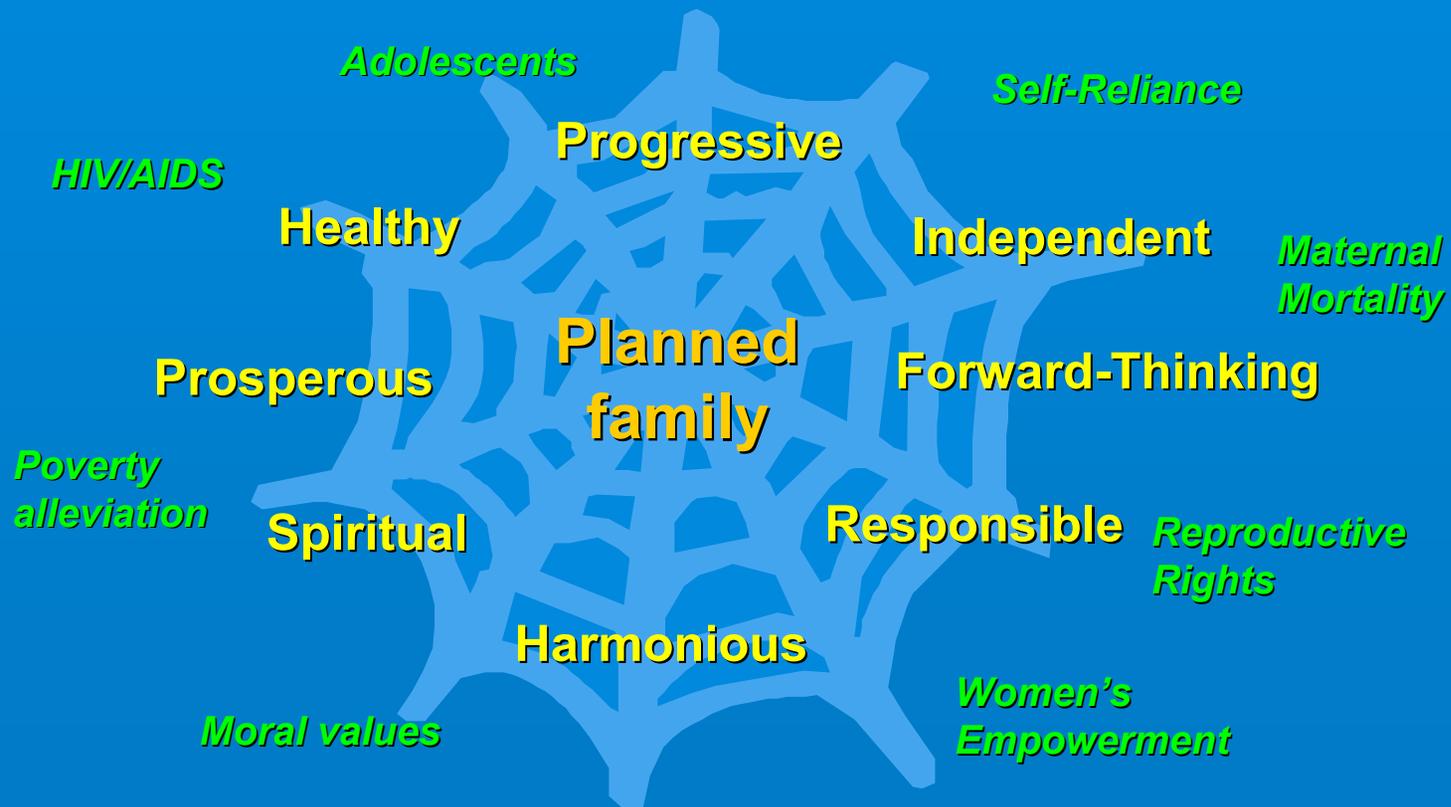


# Figure D

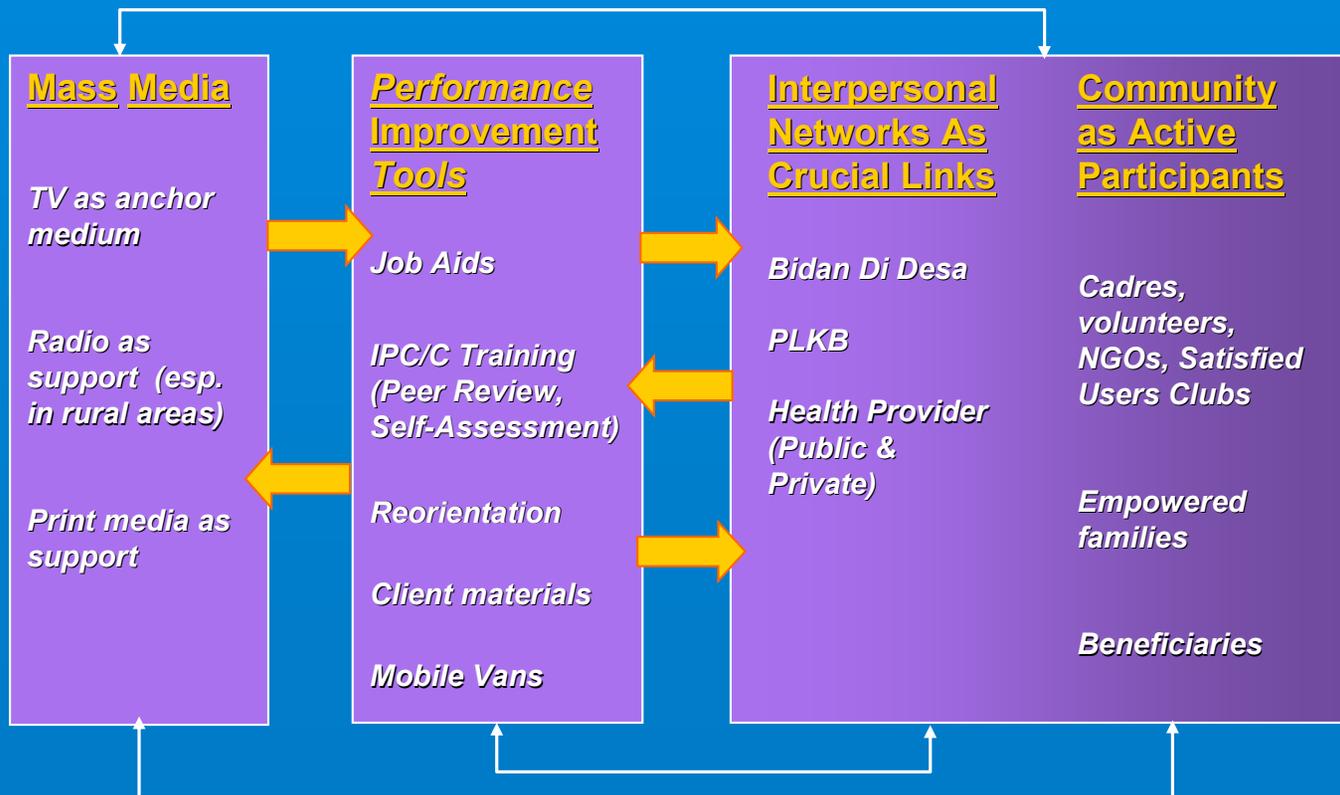
## Phase 3: Year 4-5



# Figure E Quality Family Matrix



# Figure F: Integrated Multi-channel Communication Framework



## ATTACHMENTS

- Attachment A Measure *Evaluation* Project and the Monitoring and Evaluation Subcommittee of the Maximizing Access and Quality (MAQ) Initiative. “Quick Inventory of Quality (QIQ).”
- Attachment B JHU/PCS, “Egypt’s Gold Star Quality Program Wins Clients and Communities.” *Communication Impact* November 1998, no. 4.
- Attachment C JHU/PCS, “PROQUALI Improves Health Services in Brazil.” *Communication Impact* August 2000, no. 10.
- Attachment D Illustrative Programmatic Indicators for the *Quality Family* Communication and Advocacy Campaign

## ATTACHMENT A

### Overview of the Quick Inventory of Quality (QIQ)

The Quick Investigation of Quality (QIQ), developed with support from USAID, identifies a "short list" of quality indicators to evaluate overall family planning service delivery program performance. The short list of indicators measure several aspects of quality using three data collection tools:

1. **Facility audit** includes selected questions for the program manager;
2. **Observation** of client-provider interactions and selected clinical procedures, and;
3. **Exit interview** with clients departing from the facility (who were previously observed).

In developing a national certification program that defines, awards and brands quality services in Indonesia, the QIQ provides BKKBN with a blueprint of tools that have been proven to measure quality efficiently and effectively in the shortest time and lowest cost. The QIQ tools can be the starting point for BKKBN to discuss and agree upon which quality indicators will be expected of clinics that apply for certification to be branded as high quality clinics. By adapting and instituting all or a combination of the three data collection tools within QIQ into a national certification program, BKKBN will be developing expectations of how quality family planning services should be provided and how providers should behave, thereby creating social norms that support quality and choice.

For a copy of the QIQ, please contact Fitri Putjuk, JHU/CCP Resident Advisor, at:

Johns Hopkins University  
Center for Communication Programs  
STARH Field Office  
TIFA Building, 5th Floor, suite 503  
Jl. Kuningan Barat 26  
Jakarta 12710  
525-2174, 525-2183  
[fputjuk@jhucpp.or.id](mailto:fputjuk@jhucpp.or.id)

## Attachment B



**“Behind every door are friends and family who care about you and your family.”**

—Slogan for Gold Star media campaign.



TV spots promote Gold Star clinics and health care providers in Egypt.

## Egypt's Gold Star Quality Program Wins Clients and Communities

The Egyptian Ministry of Health and Population (MOHP) and Ministry of Information (MOI) are showing the world how to put quality of care at the top of the national health care agenda. The Gold Star Quality Program is the largest public sector family planning (FP) quality improvement program in the world. It aims to upgrade the quality of Egypt's family planning services while creating among the public and service providers an expectation that services will meet the new standard of higher quality. It stimulates the *supply* of quality services through better training and supervision of health care providers and it stimulates *demand* by promoting these higher quality services to the public.

This USAID-supported Quality Improvement Program (QIP) helped increase the public sector's role in providing family planning services from 30% in 1992 to 40% in 1997. Between 1995 and 1997 the country's overall contraceptive prevalence rate increased from 47.9% to 54.5%.

### The Gold Star Quality Program

The Gold Star Program applies the **PRO Approach** (Promoting Professional Providers) to position, publicize, promote, and recognize individuals and work teams that provide higher-quality services and to encourage all service providers to make higher-quality services the norm. The three-step Gold Star strategy entails: 1) promoting quality family planning service providers as a means of enhancing their self-

image and job performance; 2) promoting certified clinics as sites for high-quality services; and 3) associating these high-quality sites and services with an easily recognized symbol.

Linking two important ministries, the innovative Gold Star Program partnership combines the extensive FP service delivery capacity of the MOHP with the strong communication skills of the MOI's State Information Service (SIS). The MOHP offers a national network of over 3800 outpatient service units, ranging from one-room rural units to multiple-room complexes in large urban hospitals. The MOHP system provides service access to the least well served, the poorest of the poor. Providers include nurses as well as physicians who may range from general practitioners to gynecology specialists. The MOI's SIS is recognized as a leader in family planning Information, Education, and Communication (IEC). It conducts campaigns using an effective mix of communications, ranging from counseling support materials at the clinic level, to spot advertising and entertainment formats in the mass media, to community outreach programs conducted through its national network of 62 local information centers.

### The Gold Star

Focus groups and pilot testing revealed that the Gold Star was an appropriate symbol for a high-quality health program. Thus a Gold Star now appears on accredited clinics and all

### To learn more about the Gold Star project, contact:

Dr. Moushira El Shaffie, or  
Dr. Hassan El Gebaly:

Population and Family Planning Sector  
Ministry of Health and Population  
3 Magless El Shaab Street, Cairo Egypt  
Fax: 20-2-355-7009

Carol Brancich, Jennifer Knox, or  
Carol Underwood:

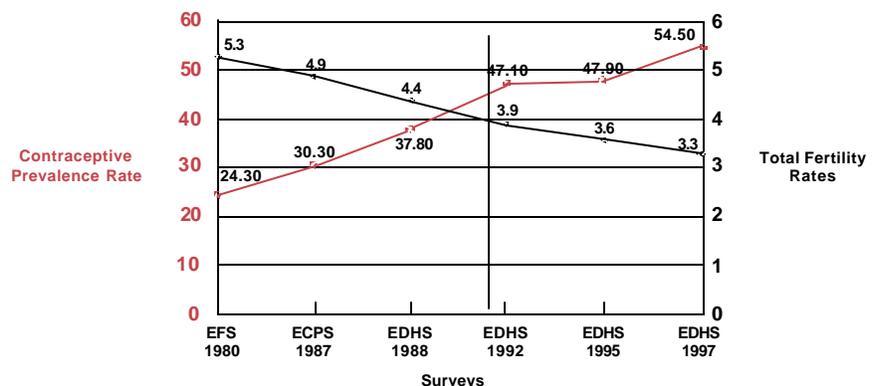
JHU/CCP, 111 Market Place, Suite 310,  
Baltimore, Maryland 21202-4012, USA  
Tel.: (410) 659-6300; Fax: (410) 659-6266  
Website: <http://www.jhucpp.org>  
E-mail: [webadmin@jhucpp.org](mailto:webadmin@jhucpp.org)

Or write Ron Hess, JHU/PCS

IEC Resident Advisor  
c/o Population Project Consortium,  
1 Aisha El-Taymouria St., 7th Floor,  
Apts. 71, 72, Garden City, Cairo, Egypt.  
Tel.: 20-2-355-8150/8151/8152

The Gold Star Program is implemented under the USAID Population/Family Planning III Project with technical assistance from the Population Project Consortium of Egypt.

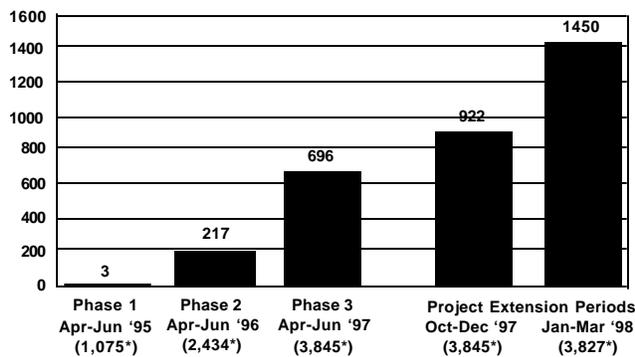
**Figure 1. Trends In Total Fertility Rates and Current Use of Family Planning: Egypt Gold Star Project, 1995-1998**



SOURCE: JHU/PCS

— Fertility Rate  
— Current Use

**Figure 2. Gold Star Units By Implementation Phases: National Quality Improvement Project Scale Up Egypt Gold Star Project, 1995-1998**



SOURCE: Egypt MOHP Systems Development Project (SDP) Quarterly Statistics  
NOTE: \*Total Number of Operating QIP Units



Seated left to right at the Gold Star launch, Dr. Ismail Sallam, Minister of Health and Population; Dr. Moushira El Shaffie, First Undersecretary of Family Planning; and Dr. Hassan El Gebaly, Executive Director SDPII.

promotional materials as a mark of quality. Clinics are supervised and rated each quarter according to a comprehensive checklist of 101 quality indicators. A clinic earns a Gold Star by attaining a 100% quality standards certification score for two consecutive quarters and retains its Gold Star by maintaining that score at successive quarterly evaluations. An MOHP clinic that earns and displays a Gold Star is considered among the best of the best.

### Gold Star Communication Campaign

In the multimedia communication campaigns, catchy television and radio spots call attention to the Gold Star clinic sites and providers. Family health weeks, clinic openings and other community events highlight the services available. Signs and displays show clients exactly where to go. Within the clinics, Gold Star posters, desk plates, and lapel pins reinforce the Gold Star image. And for individual counseling sessions, flip charts and method-specific procedures help clients make informed choices.

The initial campaign unfolded in two phases. A first wave of messages, aired when qualifying Gold Star sites were few, invited consumers to try the service. To encourage communities to place their trust in these services, the MOHP developed the slogan "Behind every door are friends and family who care about you and your family."

The second wave was launched after a critical mass of Gold Star clinics had begun to operate nationwide. It highlighted the Gold Star mark-of-quality and invited clients to use the nearest Gold Star clinics regularly. Communication workers from the SIS conducted Family Health Weeks, intensive week-long community mobilization and advocacy activities designed to build a sense of community partnership with the improved clinics.

### Impact

The success in the MOHP quality initiative to date can be measured in at least six different ways:

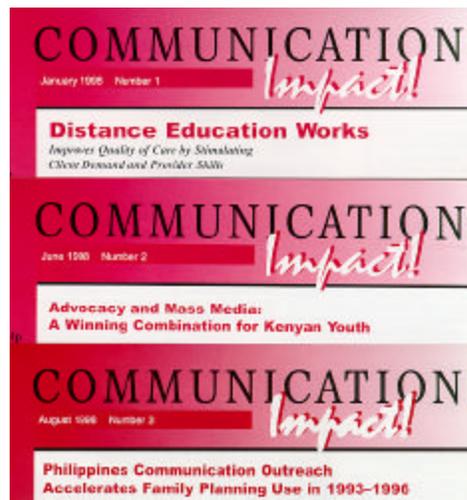
- 1<sup>st</sup> by the number of certified Gold Star clinics —1,450 by early 1998 (see Figure 2);
- 1<sup>st</sup> by the increase in the proportion of users of MOHP FP services from 30% of all FP users in 1992 up to 40% in 1997;
- 1<sup>st</sup> by contributing to the increase in contraceptive prevalence from 47.9% to 54.5%, over a two year period, for the first time exceeding half of the eligible population;
- 1<sup>st</sup> by the high levels of client satisfaction, especially with regard to waiting time, staff courtesy, and the amount of FP information provided (El Zanaty & Associates, in press);
- 1<sup>st</sup> by the high levels of exposure to the campaign after eight months, as reported by 87% of women ages 15-49 and by recognition of the Gold Star logo by 45% (Central Agency for Public Mobilization and Statistics—CAPMAS, Egypt, 1998); and
- 1<sup>st</sup> by the high levels of understanding among women (70%) and men (90%) that the Gold Star represents high-quality services and well-trained providers.

In addition to these quantitative measures, the success of the Gold Star approach is anecdotally confirmed at the political and community levels. State governors increasingly want to be involved as keynote speakers at the high profile Gold Star certifications and ceremonies. They too want to participate in the media coverage, movie star appearances, and performing arts celebrations that have made Gold Star clinics a source of community pride. And, in the few cases where clinics have lost their Gold Star status, village elders reportedly demanded an

explanation from local health officials and clinic personnel for this decertification and insisted that their clinics be brought back to the high-quality levels of a Gold Star clinic.

From every point of view—clients, communities, health care providers, and policy-makers—the MOHP Gold Star program is a win-win story for quality of care.

### Previous issues of Communication Impact!



### COMMUNICATION Impact!

Summarizes key research and programmatic findings of the Population Communication Services (PCS) project of Johns Hopkins University, Center for Communication Programs (JHU/CCP).

#### Johns Hopkins University

#### Center for Communication Programs

Phyllis Tilton Piotrow, Professor and Director  
Jose G. Rimon II, Deputy Director

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**Communication Makes the Difference.**

## Attachment C



# COMMUNICATION

August 2000 Number 10

*Impact!*



Street theater presentations were part of the community campaign for Brazil's PROQUALI project.



**“Going to the PROQUALI health center is like going to a private clinic.”**

**To learn more about the PROQUALI Project contact:**

Robert Ainslie, Program Officer  
Alice Payne Merritt, Associate Director,  
JHU/CCP, 111 Market Place, Suite 310,  
Baltimore, Maryland 21202, USA  
Tel.: (410) 659-6300; Fax: (410) 659-6266  
Website: <http://www.jhuccp.org>  
E-mail: [orders@jhuccp.org](mailto:orders@jhuccp.org)

OR

Rosa Valéria A. Said, Country Representative  
Johns Hopkins University  
Centro para Programas de Comunicación  
Centro Comercial Casablanca  
Av. Santos Dumont, 3060  
Sala 406 - 4o. Andar  
Fortaleza, Ceará  
CEP 60150-161  
BRASIL  
Tel/Fax: (55-85) 224-3923  
E-mail: [rvasaid@uol.com.br](mailto:rvasaid@uol.com.br)

## PROQUALI Improves Health Services in Brazil

“Your future is in your hands,” predicts the fortuneteller from a tarot card that has a picture of an IUD on it along with a short explanation. The fortuneteller mingles with dancers, musicians, and actors among a joyful crowd of people gathered in the central plaza of Redenção, in Ceará, Brazil. “The best place to get correct reproductive health information is from the professional providers at the health clinic,” proclaims the fortuneteller as she distributes her tarot cards among the crowd, which also includes dignitaries, TV crews and press photographers.

This festive community-wide event is being held to honor the director and staff of the Redenção health center for achieving accreditation as one of the selected centers for the PROQUALI Project. Initiated in late 1996, the PROQUALI Project is a collaborative effort among Johns Hopkins University/Center for Communication Programs, JHPIEGO, Management Sciences for Health, and the State Secretariats of Health of Bahia and Ceará to improve the quality of reproductive health services in the public sector of these two states.

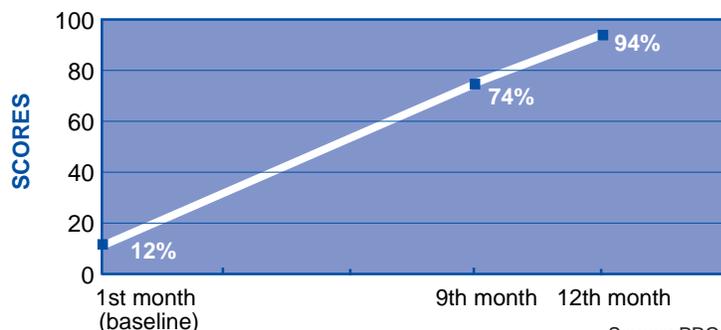
PROQUALI, meaning to pursue quality, moves beyond the traditional model of focusing solely on clinical changes for improvement in the quality of health services to a new, client-oriented model based on the principle of supply and demand. The process actively involves the clients and providers in identifying problems and solutions in delivering health services in a

decentralized system by providing tools to implement, measure, and evaluate improvement.

The PROQUALI strategy uses an accreditation model to improve and verify the delivery of reproductive health services and a communication strategy to promote those services. The communication strategy focuses on two phases of the campaign. First, the clinic campaign is designed to raise expectations and stimulate interest among clients while motivating providers who participate in the improvement process. After accreditation, the community campaign promotes awareness of the improved reproductive health services, supports ongoing client demand for the new level of quality service delivery, and publicizes providers as caring professionals who provide quality services.

In the initial phase of the PROQUALI Project, five health clinics in two states were chosen to participate in the accreditation process, three in Ceará and two in Bahia, of which the Redenção health clinic is one. Using client input and tools of the PROQUALI model, such as job descriptions, self-assessment checklists, and team-building techniques, the health clinic staff is able to identify, correct, and improve weaknesses within their service delivery system. When a clinic has made its improvements, a Quality Improvement Team visits the site and, using an external assessment checklist (another PROQUALI tool), determines the accreditation status.

**Figure 1. Accreditation Scores for Five Clinics**



Source: PROQUALI, 1999

A site achieves accreditation, within 12 months on average, when it meets 90% of 61 criteria in five core areas: 1) clinical services; 2) client counseling, orientation, and information; 3) infection prevention; 4) management systems; and 5) facilities and supplies. Upon accreditation, a ceremony, like the one described for the Redenção health clinic, is held to honor the providers of the clinic whereupon they are presented with a “quality symbol” plaque (shown on the front page).

For all of the health centers participating in the PROQUALI Project, the slogan developed for the clinic campaign was “Health for you, satisfaction for us,” which was emblazoned on banners and printed on T-shirts, hats and buttons that were worn by providers. Some of the materials produced in the community campaign for the clinics included: five 5-minute radio dramas, street theater presentations, client-painted murals on clinic walls, cue cards for providers, referral cards for health agents, clinic posters and signs, family planning tarot cards, and informed choice materials.

## IMPACT

Quantitative data demonstrate that the PROQUALI Project has had a positive impact on actual clinic and provider performance as shown by accreditation results (Figure 1) and on increased demand for services depicted by increased numbers of family planning visits (Figure 2). Qualitative research demonstrates similar results with clients perceiving services as being improved.

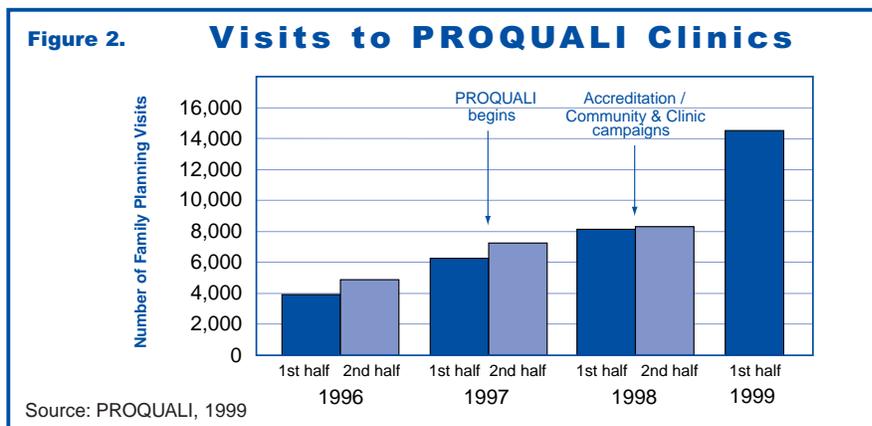
Figure 1 shows the results of the total accreditation assessments for the five initial clinics. The 61 quality criteria were observed and rated during each of the five clinic’s accreditation process. Only 12% of the criteria had been achieved at baseline, whereas after 12 months of participation in the PROQUALI Project, the average percentage of service quality criteria achieved was 94%. This represents a 700% increase. At that 12-month point, four of the five initial clinics had achieved accreditation.

Project activities began in the second half of 1997. As shown in Figure 2, the number of clients visiting the first five health centers combined was already steadily increasing prior to project initiation. The increase was maintained during the first year of project activities (1997-1998) and

leveled off in the second half of 1998. By mid-1999 following accreditation and community campaigns, the total number of clients visiting the clinics increased by 74%, compared to the end of 1998.

and to other states using the Internet and a PROQUALI CD-ROM.

The PROQUALI Project has proven that public sector clinics can offer quality reproductive health services, while inspiring



Qualitative research was accomplished through focus group discussions with clients before and after accreditation of the health clinics. Clients were asked what they saw and perceived as service improvements. “Better attention given to women” was mentioned as an improvement. This included better communication between providers and clients, more information about services, and an increased number of methods consistently available.

An important finding of the qualitative data was that as the quality of the services improved and as clients’ earlier needs were met, clients’ expectation of quality became more specific. For example, as waiting times decreased, being treated “well” changed to “calming ones fears, clarifying doubts and conversing with clients”; “fixing” the bathroom lock became wanting “separate” bathrooms.

With the completion of the initial phase, the current expansion phase of the PROQUALI Project has an additional 25 to 30 health clinics throughout Brazil that should be accredited within the next year. The PROQUALI methodology – its accreditation process and its tools – is being institutionalized across the country. In Ceará, the Secretariat of Health has institutionalized the PROQUALI model as its quality improvement approach in providing primary health care to children and adults. The State Secretariat of Health in Bahia has designated a facility to serve as the Reproductive Health Reference Center from which the PROQUALI model will expand in Bahia

all those involved. During the project, the three cooperating agencies advanced in partnership and technical innovation. The role of the Secretariats of Health in Ceará and Bahia in delivering improved services was strengthened. The participating service providers were empowered to solve health center weaknesses and take pride in their work. Municipal leaders were able to mobilize scarce health care resources, while gaining political support in the community – “Cliente Satisfeito, Prefeito Re-eleito” (satisfied client, mayor re-elected). Most importantly, the women and communities in Bahia and Ceará states were encouraged to make informed choices and actively participate in their own health care, ultimately sustaining quality reproductive health services.

## COMMUNICATION *Impact*

Summarizes key research and programmatic findings of the Population Communication Services (PCS) project of the Johns Hopkins University Center for Communication Programs (JHU/CCP).

### Johns Hopkins University Center for Communication Programs

Phyllis Tilson Piotrow, Director  
Jose G. Rimón II, Deputy Director

### Center Publications

Nancy B. Smith, Associate Editor  
Rita C. Meyer, Materials Development Manager

### Population Communication Services and the Population Information Program

are funded by the United States Agency for International Development.



**Communication Makes the Difference!**

## **Attachment D**

### **Illustrative Programmatic Indicators for the *Quality Family* Communication and Advocacy Campaign**

- Number of facilities with informed choice (Tiahart) poster displayed
- Percentage of providers aware of *Quality Family* campaign messages
- Percentage of providers following informed choice guidelines
- Percentage of providers assessed by a technical supervisor in the past year
- Percentage of providers using IEC materials for counseling
- Percentage of facilities certified under new QIQ certification program
- Percentage of facilities with established mechanisms for clients and community feedback on performance
- Number of favorable media references to *Quality Family* campaign
- Number of favorable policy makers references to *Quality Family* campaign
- Percentage of district, provincial and central budget allocated and distributed for RH/FP programs
- Percentage of clients served through private-sector sources
- Percentage of adolescents receiving accurate RH/FP information
- Percentage of clients who would recommend providers to others
- Percentage of new clients expressing method preference during counseling
- Percentage of clients reporting satisfaction with amount and type of information received
- Percentage of non-users fearing side-effects
- Percentage of couples reporting discussion on RH/FP
- Percentage of non-using women intending to adopt FP
- Percentage of clients advocating RH/FP services to others
- Percentage of men and women aware of health benefits of FP
- Percentage of men and women using specific FP methods (both short and long term)
- Percentage of public and clients with positive attitudes towards VS
- Percentage change in method mix towards long term methods
- Percentage of husbands who approve FP use by wife
- Percentage of increase in male method use
- Percentage of public understand how to protect themselves from HIV/AIDS
- NRD strengthened, disseminated and positively referenced regarding men as partners
- Percentage of RH/FP service facilities for IDPs
- Number of NGO linkages to promote *Quality Family* campaign
- Increase in NGO budgets, staff, activities in advocating for *Quality Family*
- Number of non-RH/FP NGOs advocating for RH/FP
- Number of special local advocacy events organized to promote *Quality Family*
- Percentage of NGOs providing RH/FP services actively adopting sustainability plan
- Percentage of community members, particularly women, participate in *Quality Family* community based activity
- Number of district action plans created in support of the *Quality Family* campaign

## REFERENCES

Boulay, Marc, J. Douglas Storey, and Suruchi Sood. In review. "Indirect Exposure to Family Planning Mass Media Campaign in Nepal." Submitted to the *Journal of Health Communication*.

Demographic Institute, Faculty of Economics. 1999. "Baseline Survey of Young Adult Reproductive Welfare in Indonesia 1998/1999: Executive Summary and Recommendations Program."

Kak, Neeraj. 1999. "Key Findings: Service Delivery Expansion Support Project Evaluation."

Knowles, James. 2000. "New Era Strategic Analysis for the National Family Planning Coordinating Board (BKKBN) 2000-2015." The Futures Group.

Macro International, Inc., 1997. "Indonesian Demographic and Health Survey."

Measure *Evaluation* Project and the Monitoring and Evaluation Subcommittee of the Maximizing Access and Quality (MAQ) Initiative. 2001 "Quick Inventory of Quality (QIQ)."

Pariani, Siti, David M. Heer and Maurice D. Van Arsdol, Jr.. 1991. "Does Choice Make a Difference to Contraceptive Use? Evidence from East Java." *Studies in Family Planning* 22, 6:384-390.

Situmorang, Augustina. Adolescent Reproductive Health and Premarital Sex in Medan, April 2001. Dissertation submitted for the Doctor of Philosophy, Demography Program, The Australian University.