

**SURGICAL
CONTRACEPTION AND
THE NEW ERA STRATEGY
OF BKKBN**

Assessment Team Report

September 2001

**The STARH Program in collaboration with
Badan Koordinasi Keluarga Berencana Nasional
(BKKBN)
Ministry of Health (Depkes)
Yayasan Kusuma Buana (YKB)**

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ACRONYMS

ADB	Asia Development Bank
AIDS	Acquired immune deficiency syndrome
AVSC	Association for Voluntary Surgical Contraception
BKKBN	<i>Badan Koordinasi Keluarga Berencana Nasional</i> (National Family Planning Coordination Board)
CPR	Contraceptive prevalence rate
DepKes	Department of Health
DinKes	<i>Dinas Kesehatan</i> (Health Division of local government)
FP	Family planning
GP	General Practitioner
HIV	Human immunodeficiency virus
IDHS	Indonesian Demographic and Health Survey
IEC	Information, education and communication
IFLS	Indonesian Family Life Survey
IP	Infection prevention
JAMSOSTEK	<i>Jaminan Sosial Tenaga Kerja</i> (a social insurance scheme for the private sector mandated by the 1992 Social Security Act)
JHPIEGO	Johns Hopkins Program for International Education and Training in Reproductive Health
JHU-CCP	Center for Communication Programs, Johns Hopkins University
JPKM	<i>Jaminan Pemeliharaan Kesehatan Masyarakat</i> (managed care)
KONTAP	<i>Kontrasepsi mantap</i> (“secure contraception,” i.e. surgical contraception)
MMR	Maternal mortality ratio
NCTN	National Clinical Training Network
Ob-gyn	Obstetrics and gynecology
PKMI	<i>Perkumpulan Kontrasepsi Mantap Indonesia</i> (Indonesian Association for Secure Contraception)
PLKB	<i>Petugas lapangan keluarga berencana</i> (family planning field worker)
POGI	<i>Perkumpulan Obstetri dan Ginekologi Indonesia</i> (Indonesian Association of Obstetrics and Gynecology)
PPKBD	<i>Pembantu petugas keluarga berencana desa</i>
PSFP	Private Sector Family Planning Project
PTC	Provincial Training Center (at Provincial-level Hospital)
RSUD	<i>Rumah Sakit Umum Daerah</i> (District Hospital)
RH	Reproductive health
SDES	Service Delivery Expansion Support Project
SDP	Service delivery point
SRI	Survey Research Indonesia
STARH Program	Sustaining Technical Achievements in Reproductive Health Program
TA	Technical assistance
TFR	Total fertility rate
UI	University of Indonesia
UNFPA	United Nations Population Fund
URC	University Research Corporation
VS	Voluntary sterilization
VSC	Voluntary surgical contraception
YKB	<i>Yayasan Kusuma Buana</i>

EXECUTIVE SUMMARY

USAID and other donors have provided support for voluntary sterilization (VS) in Indonesia for 20 years, yet it is not fully integrated into the national family planning program and use of the method remains quite low by international standards. In 1997 less than 4 per cent of married women (15-49) reported relying on VS (female or male) as their method of contraception, and the total number of VS operations performed each year actually declined during the 1990s (from around 150,000 in 1990 to 105,000 in 2000). USAID has requested STARH to make an assessment of current policies and other constraints on the use of VS, as a basis for deciding whether support for VS should continue under the STARH Program, and if so, the form this support should take. In collaboration with YKB, STARH appointed an Assessment Team, with supporting members representing key stakeholders.

The Assessment Team focused on three aspects of VS:

- the policy environment;
- access to services;
- the quality of these services.

The team finds that the current policy environment is not conducive to increasing the prevalence of VS in Indonesia, nor even to providing quality VS services on a limited basis. Government policy is to support VS using national family planning program resources without promoting it actively as an official program method. This policy was introduced in the 1970s, when BKKBN was still in its formative period and it was feared opposition to VS from religious groups could threaten the entire program. The Indonesian Association for Voluntary Sterilization (PKMI) was established and given the responsibility to organize and manage the delivery of VS services (with funding from USAID and technical assistance from AVSC). During the 1980s PKMI, working with DepKes and BKKBN, set in place all the components needed for a successful VS program, including a system for reimbursement, training, clinical counseling, and quality assurance. District hospitals and other sites were refurbished and equipped so they could perform VS, and an in-country equipment repair and maintenance facility was established.

This arrangement with PKMI was never intended to be permanent, and in the 1990s USAID urged BKKBN to institutionalize the VS program on a sustainable basis. For various reasons the institutionalization process within the Government was never completed successfully: some components were fully institutionalized (e.g., the reimbursement process and training), while others (notably clinical counseling and quality assurance) were not. As a result the current policy environment for VS is confused and unsupportive. Although VS is *de facto* part of the national family planning program, with DIP funds routinely allocated for VS activities, Government regulations stating that VS cannot be an official program method have not been rescinded, and PKMI

still appears *de jure* responsible for providing VS services and training and for the quality of those activities. BKKBN regularly requests PKMI to provide services and training, and appears to assume that in meeting their request PKMI will ensure all appropriate quality standards are met. PKMI for their part consider quality assurance and medical counseling as supplementary activities requiring additional funds, and they only provide the core VS services that have been explicitly asked to do. The majority of the BKKBN province programs do not allocate funds for quality assurance and medical counseling, and without funds PKMI can no longer perform these activities.

Access to services is still somewhat limited, especially in the more remote parts of the country. This is not the only, nor even the main, factor determining low use of the method, however. Low demand for VS is also important, due to lack of awareness and erroneous beliefs about the method. Moreover in the mid-1990s the Norplant[®] implant became widely available and was strongly promoted by BKKBN as a preferred long-term method. Low demand for VS is not surprising given that the method has not been consistently and actively promoted.

The team found a large number of serious shortcomings in the quality of current VS services, at least at the dozen or so hospitals and clinics visited across four provinces. We have no way of assessing how representative our observations are of VS services as a whole, but there is no reason to believe the sites visited are atypical. Among the various shortcomings observed at different sites were the following:

- medical personnel did not verify informed consent at the SDP;
- no counseling was done by medical personnel at the SDP;
- no effort was made to build rapport between client and provider;
- medical personnel did not screen clients receiving VS at the SDP;
- medical personnel did not provide any post-operative care or monitoring of vital signs;
- standard infection prevention practices were widely ignored or implemented in ways which reduce their effectiveness;
- caseloads were too high or the supply of equipment inadequate to allow sufficient time for proper disinfection of equipment;
- general anesthesia was commonly used (with no vital sign monitoring), despite the greater risk to the client;
- doctors and sites were inadequately prepared to deal with emergencies or complications.

Different sites shared many of these shortcomings in common although the exact combination exhibited varied from site to site, suggesting a pervasive general breakdown in compliance to quality standards. (Of course, many similar shortcomings may be equally serious for other surgical procedures carried at the SDPs, but the focus of this report is on VS.) Further quality problems emerged from discussions with providers and trainers. The team could not investigate the reasons for these shortcomings in detail, but an underlying cause appears to be the partial and incomplete manner in which VS services and related activities have been institutionalized.

The team argues that any mature FP program should provide safe and effective VS services for those couples requiring a long-term method. The report includes recommendations for STARH regarding ways the program might explore supporting VS in the future, and the conditions under which it might want to provide such support. The recommendations fall under four main points.

First, there is an urgent need to take immediate action to ensure the safety of clients and providers of surgical contraception services. The team recommends, *inter alia*:

- VS in *puskesmas* should be discontinued until minimum quality standards can be met;
- district level facilities should be discouraged from doing VS until minimum quality standards can be met;
- facilities that have done less than 12 tubectomies in the last 12 months should be prohibited from offering the procedure (until further notice);
- instructions should be issued to discontinue the use of general anesthetic in tubectomies.

Second, the team recommends completing the institutionalization process of VS begun in the early 1990s. This requires, *inter alia*:

- giving VS equal status with other official program methods in the national program;
- institutionalizing an adequate quality assurance (QA) system, including supervision and monitoring, possibly using some components previously designed by PKMI and modifying them where needed;
- re-establishing counseling at SDPs by medical personnel; and
- selecting and strengthening better SDPs.

Third, rationalize the VS program components already institutionalized. In particular, this requires:

- rationalizing the reimbursement system;
- strengthening the training system (including the selection of trainees, and subsequent follow-up); and
- selecting and strengthening better training sites.

Fourth, consider further consolidation and expansion of services. The report emphasizes, however, that efforts to expand access to VS services should *only* be undertaken when quality of services can be assured, and where there is a demonstrable unmet need for the services. VS does not require a high-profile IEC campaign, but potential clients do need more information about the method. A suitable strategy may be an IEC campaign targeted at FP and RH service providers, to increase their awareness and provide them with updated information, and to encourage them to promote the method (along with other methods) to potential clients who are already seeking FP services. There is also a need to involve the private sector more, especially through insurance schemes and health maintenance organizations.

The Assessment Team believes that if such recommendations are pursued successfully then more couples who already know they want no more children will choose voluntary sterilization as their preferred method of contraception, and that in this way the family planning program will contribute even more to the happiness and welfare of Indonesian families.

The report also recommends that in future the term “surgical contraception” rather than “voluntary sterilization” be used in English-language documents in Indonesia, since for many the word “sterilization” carries negative connotations.

RINGKASAN EKSEKUTIF

USAID dan lembaga-lembaga donor lain telah memberikan dukungan bagi sterilisasi sukarela (VS, voluntary sterilization) di Indonesia selama 20 tahun terakhir, namun sampai saat ini belum terintegrasi secara penuh dalam program KB nasional karena masih merupakan metode kontrasepsi dengan tingkatan pemakaian yang tergolong rendah berdasar standar internasional. Dalam tahun 1997 dilaporkan bahwa kurang dari 4 % pasangan usia subur (15-49 th) memakai VS (wanita atau pria) sebagai metode kontrasepsi yang dipakai. Selain itu jumlah prosedur VS yang dilakukan per tahun menurun sejak tahun 1990-an dari 150.000 pada tahun 1990 menjadi 105.000 pada tahun 2000. USAID telah meminta STARH untuk melakukan asesmen tentang kebijakan yang berlaku mengenai VS dan hambatan-hambatannya, agar dapat dijadikan dasar untuk menentukan apakah dukungan bagi VS perlu dilanjutkan melalui Program STARH, serta apa bentuk dukungan yang diberikan bila hal itu memang dibutuhkan. Melalui kerjasama dengan YKB, STARH telah menyusun suatu Tim Asesmen yang turut melibatkan perwakilan stakeholder utama sebagai anggota.

Tim Asesmen ini memusatkan perhatian pada tiga aspek VS sbb.:

- Situasi Kebijakan
- Akses terhadap Pelayanan
- Kualitas Pelayanan

Temuan Tim menunjukkan bahwa situasi kebijakan saat ini kurang kondusif untuk terjadinya peningkatan prevalensi VS di Indonesia, sekalipun bila pelayanan berkualitas dilakukan secara terbatas. Kebijakan pemerintah yang berlaku adalah untuk mendukung VS dengan memakai sumberdaya program KB nasional tanpa mempromosikannya secara aktif sebagai metode resmi. Kebijakan ini diperkenalkan sejak tahun 1970-an pada masa awal pembentukan BKKBN dimana ada kekhawatiran bahwa tentangan terhadap program VS dari kelompok agama dapat menjadi ancaman terhadap program secara keseluruhan. Didirikanlah Perhimpunan Sterilisasi Sukarela Indonesia (kemudian menjadi PKMI) yang diberi tanggung jawab untuk mengorganisasi dan mengelola pemberian pelayanan VS (dengan dukungan dana USAID dan bantuan teknis AVSC). Selama tahun 1980-an PKMI, bekerjasama dengan Depkes dan BKKBN, telah mengadakan semua komponen yang diperlukan sampai dapat terselenggara program VS yang berhasil, termasuk didalamnya sistim reimbursemen, pelatihan, konseling klinis, dan jaminan mutu. Rumah Sakit Kabupaten dan fasilitas pelayanan lain direnovasi dan dilengkapi dengan peralatan memadai untuk dapat melakukan pelayanan VS. Selain itu fasilitas untuk reparasi dan pemeliharaan telah didirikan.

Pengaturan semacam ini dengan PKMI tidak pernah dimaksudkan untuk menjadikannya permanen, tetapi pada tahun 1990-an USAID mendorong BKKBN untuk melembagakan program VS agar menjadi “sustainable”. Karena berbagai sebab, tidak pernah tercapai pelembagaan secara penuh: beberapa komponen dapat dilembagakan (seperti proses “reimbursement” dan pelatihan), sedangkan pada yang lainnya (khususnya konseling

klinis dan jaminan mutu) tidak terwujud. Sebagai akibatnya situasi kebijakan VS saat ini menjadi tidak jelas dan tidak mendukung. Sekalipun VS secara *de facto* menjadi bagian dari program KB nasional, dimana kegiatan VS secara rutin dialokasikan dalam DIP, masih belum dicabut ketentuan pemerintah yang menyatakan bahwa VS tidak dapat menjadi program resmi, karenanya PKMI masih secara *de jure* bertanggung jawab untuk penyelenggaraan pelayanan VS, pelatihan, dan mutu bagi kegiatan-kegiatan tersebut. BKKBN masih meminta PKMI untuk menyediakan pelayanan dan pelatihan, sambil mengandalkan bahwa PKMI yang akan memastikan bahwa standar kualitas akan dipenuhi. PKMI, disisi lain, menganggap jaminan mutu dan konseling medis merupakan kegiatan tambahan yang membutuhkan dukungan dana tambahan, mereka hanya menyelenggarakan kegiatan inti pelayanan VS saja seperti yang diminta. Sebagian besar program BKKBN propinsi tidak mengalokasikan dana untuk jaminan mutu dan konseling medis, tanpa adanya dana PKMI tidak dapat menyelenggarakan kegiatan-kegiatan tersebut.

Akses akan pelayanan masih terbatas, khususnya di daerah terpencil. Namun hal ini tidaklah merupakan satu-satunya faktor (bahkan bukan faktor utama) yang menyebabkan rendahnya pemakaian metode ini. Permintaan masyarakat yang rendah akan VS juga merupakan faktor penting, karena kurang-tahuan dan kepercayaan keliru tentang metode ini. Selain itu pada pertengahan 1990-an alat KB Norplant[®] tersedia secara meluas dan mendapat promosi yang kuat oleh BKKBN sebagai metode kontrasepsi jangka panjang yang dianjurkan. Rendahnya permintaan masyarakat akan VS ini tidaklah mengherankan mengingat bahwa metode ini tidak dipromosikan secara konsisten dan aktif selama ini.

Tim Asesmen menemukan sejumlah besar kekurangan yang serius mengenai kualitas pelayanan VS saat ini, yang dijumpai pada setidaknya belasan rumah sakit dan klinik di empat propinsi yang dikunjungi. Kami tidak mempunyai cukup informasi untuk menentukan tingkat representasi hasil pengamatan kami mengenai pelayanan VS secara keseluruhan, namun cukuplah alasan untuk yakin bahwa kondisi fasilitas-fasilitas yang dikunjungi ini adalah kondisi yang umum dijumpai. Beberapa contoh kekurangan yang diamati pada berbagai fasilitas adalah sbb.:

- provider medis tidak mem-verifikasi “informed consent” pada fasilitas pelayanan;
- konseling tidak dilakukan oleh provider medis pada fasilitas pelayanan;
- tidak ada upaya untuk membuat catatan lengkap antar klien dan provider;
- provider medis tidak menyaring klien yang mendapatkan VS pada fasilitas pelayanan;
- provider medis tidak melakukan asuhan pasca operasi atau me-monitor tanda-tanda vital;
- pencegahan infeksi yang standar diabaikan, atau dilakukan sedemikian rupa dengan cara yang mengurangi efektifitasnya;
- jumlah kasus terlalu banyak atau persediaan alat-alat tidak cukup agar ada kesempatan cukup untuk desinfeksi alat yang memadai;
- anestesi umum sering dipakai (tanpa monitoring tanda-tanda vital), sekalipun ini meningkatkan risiko bagi klien;

- dokter dan fasilitas pelayanan tidak dipersiapkan secara memadai untuk mengatasi kedaruratan atau komplikasi.

Kekurangan-kekurangan ini dijumpai secara umum pada berbagai fasilitas dengan kombinasi yang berbeda dari satu tempat ke tempat yang lain, ini mengindikasikan adanya kecenderungan umum tidak dipatuhinya standar kualitas. (Beberapa kekurangan tersebut dapat mempunyai efek serius bagi pelayanan bedah lainnya pada fasilitas pelayanan bersangkutan, tetapi fokus laporan ini adalah mengenai VS) Masalah kualitas lainnya terungkap saat diskusi antara provider dan pelatih. Tim tidak sempat melakukan investigasi mengenai penyebab kekurangan ini secara rinci, tetapi tampaknya yang menjadi dasar penyebab adalah karena proses pelembagaan VS, dan kegiatan terkait, tidak dilakukan dengan lengkap dan menyeluruh.

Tim berpendapat bahwa suatu program KB yang dewasa selayaknya menyediakan pelayanan VS yang aman dan efektif bagi pasangan yang membutuhkan metode jangka panjang. Laporan ini memuat rekomendasi bagi STARH mengenai hal-hal yang dapat dijajagi oleh program (STARH) untuk mendukung VS dimasa yang akan datang, serta kondisi-kondisi apa yang perlu ada supaya dukungan itu dapat diberikan. Rekomendasi-rekomendasi ini mencakup empat butir utama.

Pertama, adanya kebutuhan mendesak untuk melakukan tindakan segera agar dapat dicapai kepastian keamanan pelayanan kontrasepsi dengan pembedahan bagi klien dan provider. Tim merekomendasikan, antara lain:

- VS di Puskesmas perlu dihentikan sampai dapat dicapainya standar kualitas minimum;
- fasilitas pelayanan (RS) di tingkat kabupaten dianjurkan untuk tidak melayani VS sampai dapat dicapainya standar kualitas minimum;
- fasilitas dengan jumlah pelayanan tubektomi dibawah 12 dalam 12 bulan terakhir perlu menghentikan pelayanan (sampai ada pemberitahuan lebih lanjut);
- perlu dikeluarkan instruksi untuk menghentikan penggunaan anestesi umum pada tubektomi.

Kedua, tim merekomendasikan untuk melanjutkan proses pelembagaan VS yang telah dimulai pada awal 1990. Hal ini akan membutuhkan, antara lain:

- menempatkan VS dalam status sama dengan metode resmi lainnya dalam program nasional;
- pelembagaan sistim jaminan mutu yang memadai, termasuk supervisi dan monitoring, bisa dengan menggunakan beberapa komponen yang telah dikembangkan oleh PKMI sebelumnya dengan memodifikasi bila diperlukan;
- mengadakan kembali pelayanan konseling pada fasilitas pelayanan oleh provider medis; dan
- memilih dan memperkuat fasilitas pelayanan yang lebih baik.

Ketiga, melakukan rasio nalisasi komponen-komponen program VS yang telah dilembagakan. Khususnya, hal ini memerlukan:

- rasionalisasi sistim reimbursement;
- memperkuat sistim pelatihan (termasuk pemilihan peserta latih, dan kegiatan tindak lanjutnya); dan
- memilih dan memperkuat tempat pelatihan yang lebih baik.
- Keempat, pertimbangkan konsolidasi dan perluasan pelayanan lebih lanjut. Laporan ini menekankan, bahwa upaya untuk memperluas akses terhadap pelayanan VS sebaiknya dilakukan hanya bila kualitas pelayanan dapat dipastikan, serta adanya unmet need yang nyata. VS tidaklah membutuhkan kampanye KIE besar-besaran, tetapi klien-klien potensial membutuhkan informasi lebih lengkap mengenai metode ini. Strategi yang cocok dapat berupa kampanye KIE yang diarahkan bagi provider pelayanan KB dan KR, untuk meningkatkan pemahaman mengenai informasi mutakhir, dan mendorong mereka untuk mempromosikan metode ini (bersama dengan metode lainnya) pada klien-klien potensial yang telah mencari pelayanan KB. Dibutuhkan pula keterlibatan sektor swasta yang lebih besar, khususnya melalui program asuransi dan JPKM.

Tim Asesmen yakin bahwa bila rekomendasi-rekomendasi tersebut dapat dilaksanakan dengan baik maka akan lebih banyak pasangan yang telah tidak ingin punya anak lagi akan memakai VS sebagai metode pilihan yang disukai, serta dengan cara ini maka program KB akan dapat memberi kontribusi lebih besar pada tercapainya kebahagiaan dan kesejahteraan para keluarga masyarakat Indonesia.

Laporan ini juga merekomendasikan agar dimasa yang akan datang dipakai istilah “surgical contraception” dan bukannya “voluntary sterilization” dalam dokumen dengan bahasa Inggris di Indonesia, karena istilah “sterilization” memiliki konotasi negatif.

SURGICAL CONTRACEPTION AND THE NEW ERA STRATEGY OF BKKBN

Surgical Contraception Assessment Team¹

“The aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods.”

ICPD, Cairo (UN 1994: para 7.12).

I. THE AIM OF THE ASSESSMENT

I.1 Objectives

Surgical contraception² is not widely used as a method of contraception in Indonesia. A number of earlier studies have discussed this issue (e.g. Reynolds and Vogel 1992; Ross and Lubis 1994). The present report has been commissioned by the STARH Program to give an updated assessment of the situation in the context of democratization and decentralization, and bearing in mind the current interests and concerns of the National Family Planning Coordinating Board (BKKBN), the United States Agency for International Development (USAID), and other stakeholders. The report will provide a principal basis for decision making regarding future support for surgical contraception under the STARH Program. Specific objectives are:

- to review the current situation regarding surgical contraception in Indonesia;
- to assess whether surgical contraception services should be changed or expanded, and, if so, to make some preliminary strategy recommendations regarding how, and under what conditions.

The report focuses on three aspects of surgical contraception:

- access to surgical contraception services and the barriers to clients receiving them;
- the quality of existing services and compliance to clinical standards;

¹ The composition of the Assessment Team is given in the Acknowledgements.

² Also known as voluntary sterilization (VS) or voluntary surgical contraception (VSC); these alternative terms can be used interchangeably and are sometimes used in this report, especially in contexts where the alternative terms are more common. We prefer “surgical contraception” because it avoids the negative connotations associated in some people’s minds with the term “sterilization.” Strictly speaking the term “surgical contraception” should also include implants, but in this report it applies only to voluntary sterilization (for contraceptive purposes). In Indonesia surgical contraception is usually referred to as *kontrasepsi mantap (KM)*, or “secure contraception.”

- the policy environment of surgical contraception and the socio-cultural factors affecting use and expansion of services.

The Government of Indonesia is committed to the principles stated in the *Programme of Action* adopted at the 1994 International Conference on Population and Development (ICPD) in Cairo. Reproductive rights are regarded as resting on “the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health” (UN 1994 para 7.3). BKKBN’s New Era Strategy builds on this foundation and extends it (Knowles 2000; Parawansa 2001a). The perspective adopted in the present report is informed by the shift in focus in the national program towards a client-oriented approach grounded in reproductive rights.

I.2 Methodology

The STARH Program is mandated to make an assessment of surgical contraception in Indonesia: “Voluntary sterilization remains an important, but very limited option for women and men. The USAID program has provided years of inputs to the VS [voluntary sterilization] program in Indonesia. Before future program inputs can be considered, (in the event that VS remains an element supported under this program), there should be an assessment of the current policy, operational and financial constraints to VS. Depending on the outcome of this assessment, a future program might provide technical guidance to facilitate policy reform efforts on voluntary sterilization, and limited resources for training and service delivery. Support to PKMI will also have to be reviewed” (USAID 2000: 41-42).

To this end STARH contracted the Kusuma Buana Foundation (*Yayasan Kusuma Buana*, or YKB) to form an Assessment Team to produce a report reviewing the current situation regarding surgical contraception, both male and female, in Indonesia. YKB was asked to include the following stakeholders: PKMI, PKBI, the STARH Reproductive Health Advisor, and the STARH Policy Advisor; and to collaborate with a STARH Consultant, hired to help with the preparation and drafting of the report. The report was to be based on (i) a literature review; (ii) interviews with key informants; and (iii) field visits to observe procedures and facilities. The main activities coordinated by YKB took place during 12 February – 30 April 2001.

The composition of the Assessment Team is described in the Acknowledgements. The team was organized as three sub-teams: one focusing on issues of quality, another on access, and a third on policy. Some members of the quality and access sub-teams observed services and interviewed key informants in North and South Sumatra, while others went to Central and East Java. The policy sub-team interviewed key informants in Jakarta. Each sub-team produced a sub-report, and these were subsequently incorporated in a more comprehensive draft report, *The Place of Voluntary Sterilization in the Context of the New Era Strategy*, drafted by the Team Leader (Firman Lubis) and the STARH

Consultant (John Ross on loan from The Futures Group). The team's findings and recommendations were presented to BKKBN, USAID, Department of Health, PKMI and other stakeholders at BKKBN on 27 April. The Draft Report was then revised, taking into account feedback from the 27 April meeting, and formally submitted by YKB to the STARH Program on 1 May (Lubis and Ross 2001).

I.3 Organization of the Report

The present Assessment Team Report is based on the earlier Draft Report submitted by YKB (Lubis and Ross 2001) but has been considerably revised, rewritten and expanded. These revisions were made to make the report more user-friendly for a wider audience of stakeholders.³ Despite the extensive revisions (and a new title) the present report, *Surgical Contraception and the New Era Strategy of BKKBN*, remains true to the main findings and recommendations of the earlier draft and reflects the work of the Assessment Team as a whole.⁴

Chapter II summarizes background information on the benefits and risks of surgical contraception for couples and its public health and demographic consequences; and gives a brief historical account of the policy regarding, and use of, surgical contraception in Indonesia.

Chapter III presents the Policy Sub-team's report. This chapter advocates fully integrating surgical contraception into the national family program and making surgical contraception an official program method. It argues that BKKBN's commitment to the client-oriented approach described in the Cairo statement and in BKKBN's New Era Strategy effectively requires this. Moreover it appears the current "step-child" status of surgical contraception has contributed indirectly to the current low quality of services (as discussed in Chapter V).

Chapter IV comprises the report of the Access Sub-team. Although access is somewhat limited, it is *not* the determining factor in low use of surgical contraception in Indonesia today.

Chapter V is the report prepared by the Quality Sub-team. The sub-team found serious shortcomings and deficiencies in the quality of surgical contraception services being offered at the sites visited. Without further research we cannot assess the extent to which these shortcomings are typical of all service delivery points (SDPs), nor can we quantify the impact of these shortcomings on the health of clients. Nonetheless the Assessment Team as a whole concurs with the sub-team's assessment that addressing these quality issues should be treated as a matter of urgency, and given priority before considering further the future of surgical contraception in the national family planning program.

³ Ricky Lu took the lead on revising Chapter V and Adrian Hayes other parts of the report, with major inputs from other team members, and with many suggestions from STARH colleagues, especially Gary Lewis, Anne Pfitzer and Russ Vogel.

⁴ Although not every team member would necessarily agree with every detail.

Chapter VI presents the Assessment Team's recommendations regarding initiatives STARH can explore with BKKBN and its partners for surgical contraception. They are grouped under four main points: First, take urgent action to ensure the quality of services and protect the reproductive rights of clients. Second, complete the institutionalization process commenced in the mid-1990s, so surgical contraception is integrated in BKKBN's "cafeteria approach" and fully institutionalized within the national program. Third, rationalize components already institutionalized, especially the system of reimbursement and the VS training system. Fourth, help service providers promote surgical contraception (alongside other methods in the program) to family planning clients, and support surgical contraception in other ways respecting religious and cultural sensitivities. The chapter emphasizes that service delivery should be expanded *only if* quality can be guaranteed and the demand for services grows.

II. BACKGROUND

In this chapter we briefly summarize the known advantages and disadvantages of surgical contraception, both from the point of view of family planning clients and from the perspective of broader population and development goals. Any policy change regarding surgical contraception must be informed by a common understanding of the known benefits and risks. We then give a brief overview of surgical contraception policy and program in Indonesia during the past 25 years to provide a context for the present assessment.

II.1 Benefits and Risks of Surgical Contraception for Clients

Surgical contraception for women (tubectomy) involves mechanically blocking the fallopian tubes to prevent the sperm and egg from uniting, while for men (vasectomy) it involves a similar operation blocking the *vasa deferentia* to prevent sperm entering into the ejaculated seminal fluid. Surgical contraception, as a method of contraception, has some significant characteristics, benefits and risks from the point of view of couples who wish to have no more children (Stewart and Carignan 1998; Hatcher *et al.* 2001). The main characteristic is permanence, which is normally seen as an advantage for those who know they want no more children, but if for any reason they change their mind this benefit becomes a disadvantage. (Although reversal by surgery is often possible this surgery is major surgery, much more difficult than the original procedure; it is expensive and the success rate is not high.)

Among the benefits and advantages are:

- high effectiveness;
- cost effectiveness (in most cases);
- lack of significant long-term side effects;
- nothing subsequently to buy or remember; and

- no need to interrupt sexual intercourse.

Sterilization for contraceptive purposes also has some disadvantages and risks:

- all surgical procedures and the use of anesthesia carry *some* risk for the patient; and
- significant expense at the time of procedure; and
- female surgical contraception is initially painful immediately following the procedure, but the pain starts to go away after a day or two; and
- male, compared to female, surgical contraception requires less complicated surgery, is associated with lower risk of complications, and is less expensive but it also less popular.

Nonetheless both methods, when performed by trained providers under appropriate conditions, are extremely safe and effective. Many couples in developed societies choose surgical contraception, male or female, as their preferred method of contraception when they are sure they want no more children. For these couples it effectively eliminates the risk of contraceptive failure (and pills, for example, are not recommended for many women over 35).

II.2 Demographic and Public Health Consequences of Surgical Contraception

From a programmatic perspective, surgical contraception has certain advantages and disadvantages relative to other methods of contraception. If the public health system cannot assure minimum standards of quality of care the disadvantages to clients and program can readily outweigh the advantages. Potential advantages from providing surgical contraception in the public sector include:

- the method provides many years of almost perfect protection for each client resulting from a single, one-time procedure;
- continuation rate is close to 100 per cent.

Possible disadvantages and limitations include:

- it requires service providers with more advanced clinical training than is true for most other methods;
- appropriately equipped and functioning aseptic operating sites are needed;
- program costs are relatively high, at least in the short-term. More detailed studies often show that over the long-term surgical contraception is highly competitive in terms of cost, and vasectomy often proves to be the most cost-effective method of all; such studies generally assume minimum standards of quality of care are met, and if they are not then the additional numbers of infections (including the possibility of Hepatitis and HIV/AIDS) and other complications which result will significantly add to the cost, both to couples and to the public health system;
- medical risks associated with surgery increase dramatically if minimum quality of care standards are not maintained, putting at risk both clients and providers;

- medical risks also bring with them risks of litigation, and risks to the reputation of the entire RH/FP program.

If use of surgical contraception is increased in Indonesia and quality is assured, then we can expect, based on experience in other countries, this will make a positive contribution to a number of demographic and health goals, including (i) reducing maternal mortality; (ii) reducing unmet need for long-term contraception; and (iii) reaching replacement-level fertility.

Maternal mortality Maternal mortality is still very high in Indonesia. As with any method of contraception, increasing the use of surgical contraception will tend to lower the number of pregnancies, and hence the number of women at risk of maternal mortality. Increasing the use of surgical contraception also tends to lower the maternal mortality ratio (i.e. the number of maternal deaths per 1,000 live births), since statistically surgical contraception tends disproportionately to provide protection among older and high-parity women who otherwise would be at risk of becoming high-risk pregnancies. In other words, surgical contraception statistically tends not only to contribute to lowering maternal mortality by putting fewer women at risk (like any other method of contraception), it also tends to reduce (more than other methods) the more risky pregnancies among older and higher-parity women.

The Government of Indonesia has set a goal of reducing the maternal mortality ratio from an estimated 350 deaths per 100,000 live births today to 125 deaths per 100,000 live births by 2010. This goal can more readily be attained if more couples adopt surgical contraception.

Unmet need A priority of the Cairo *Programme* and BKKBN's New Era Strategy is to reduce unmet need by providing these couples with quality family planning services (UN 1994: para 7.12). According to the 1997 IDHS the total unmet need for family planning services is 9.2 per cent (of which about 4% was unmet need for spacing and 5% for limiting⁵) (BPS 1998: 99). An increase in the acceptance of surgical contraception will by definition lower unmet need if these couples were not previously using a method; but even if they are simply changing from other methods adopters of surgical contraception still tend to lower unmet need over time yet more (i.e. than would be the case if they had stayed with their previous methods) because surgical contraception has such an extremely low discontinuation (drop-out) rate.

Replacement-level fertility The small-family norm is now widely institutionalized in Indonesia, and 49.7 per cent of couples with two children say they want no more (BPS 1998). To reach replacement-level fertility the contraceptive prevalence rate needs to reach about 75 per cent (corresponding to about 4.6 million additional users). Experience in other countries suggests it is difficult to reach replacement-level fertility without surgical contraception making a significant contribution to the total contraceptive prevalence rate. The 1997 IDHS gives an estimated TFR of 2.6 (based on own children

⁵ In 1991 and 1994 total unmet need was 13 per cent and 11 per cent, respectively, again more or less evenly split between the unmet need for spacing and for limiting.

method). The Government's target (according to PROPENAS) is to reduce the TFR to 2.4 by 2004 (GOI 2000: VIII-23).

Unwanted pregnancies Contraception reduces unwanted pregnancies, and helps reduce maternal deaths and morbidity due to unsafe abortion. Surgical contraception is especially effective in this respect because of its low failure rate.⁶

Male participation Providing and promoting vasectomy is one of the main ways of attaining more male participation in a program's family planning efforts. Increasing male participation is an important objective in the national FP program (GOI 2000: VIII-23).

II.3 Surgical Contraception in Indonesia

Relatively low use Given that the benefits of surgical contraception are well-known among family planning experts it is important to understand why it remains a "very limited option for women and men" in Indonesia (USAID 2000: 41). According to the latest Demographic and Health Survey only 3.4 per cent of currently married women aged 15-49 in Indonesia are relying on surgical contraception as a method of contraception (3.0% with tubectomy and 0.4% with husbands with vasectomy) (BPS 1998: 75). About 100,000 couples adopt surgical contraception nationwide each year, a not insubstantial figure but small in relation to the total pool of potential acceptors.⁷ Indonesia's surgical contraceptive prevalence rate is much lower than in China (45.0% in 1992), India (30.7% in 1992), Thailand (24.0% in 1996), Sri Lanka (27.2% in 1993), Nepal (17.5% in 1996), Iran (12.3% in 1994), the Philippines (10.3% in 1998), Bangladesh (8.6% in 1996) and Malaysia (7.7% in 1984) (Ross *et al.* 1999: A.2). It is particularly notable that Indonesia has a lower surgical contraception prevalence rate than a number of countries which have lower total (all methods) contraceptive prevalence rates, such as India, Nepal, the Philippines, Bangladesh and Malaysia.

The Assessment Team was not mandated to undertake a detailed scientific study of the causes of low use, but a review of what we know about these factors is clearly relevant to any assessment of current constraints on voluntary sterilization. Both demand and supply factors appear to play a role. Ten years ago Reynolds and Vogel, drawing together information from a number of sources, argued convincingly that the main reason for low surgical contraception prevalence in Indonesia is lack of *demand* more than lack of supply (where the latter is taken to include facilities, access, trained personnel, quality of care, and cost):

“Although there can be improvements in all aspects of the supply side, it seems clear that this is not the fundamental reason for the lack of acceptance of VS.

⁶ The failure rate of other methods which are not so effective accumulates with time: for example, a method that lowers the monthly risk of conception to one per cent will still result in one or more failures among 70 per cent of women over a 10-year period (Lubis and Ross 2001: 3).

⁷ Further statistics on patterns and trends in surgical contraception use in Indonesia are given in Appendix II.

Services are widely available through hospitals and health centers throughout the country. Clearly, more could be done to extend these services to remote areas, but the majority of Indonesian couples have ready access to VS services. PKMI has done a superb job in training providers, and in upgrading the quality of training, supervision, and reporting. Important initiatives are underway now to improve provider quality even more. The PSFP project, AVSC, JHPIEGO and URC's Quality Assurance Project are all working with PKMI toward that end. Service quality is a strength of the VS program, and should improve as providers become more concerned with quality. The cost of VS does not seem to be a significant obstacle for most people. It is still offered free to those who cannot afford to pay (some 20%), and at a nominal price for the majority of people interested in VS (another 40%). Those who pay high prices for VS are probably better off, prefer private providers, or have the operation in conjunction with another medical procedures" (Reynolds and Vogel 1992: 6).

Why then the lack of demand? Commentators often identified ignorance and fear among the population as important contributing factors. "Although there is a significant pool of couples who should consider VSC, very few do. This appears to have less to do with awareness of VSC than with gaps in factual knowledge about the method (especially about the operation and potential side effects) and motivation to use it" (Reynolds and Vogel 1992: 7). One study (SRI 1992) for example, albeit a non-probability sample, found 77 per cent of respondents had a significant fear about VS: fear it would make them weak, fear it would inhibit their sex life, fear it could cause "pregnancy outside the womb," fear it might encourage their spouse to "go astray," etc. An earlier study (Basuki 1986) also lists fear of the operation and of anesthesia, fear of husband's disagreement, fear of religious proscription, and fear that the operation would fail.⁸

Supply factors are clearly also significant, although there is no comprehensive study which allows a systematic weighing of the relative contributions of demand for and supply of services in determining the low usage of surgical contraception. Anecdotal evidence from service providers suggests that in many areas there is a significant unmet demand for surgical contraception services. Many of the fears and concerns listed in the studies cited above are similar to those associated with other methods of contraception *before* those methods were successfully promoted through IEC campaigns and other means by BKKBN and its partners. Surgical contraception has had a special status in the work of BKKBN, however, and for sound cultural and political reasons has not been actively promoted like other methods. International experience suggests that when quality surgical contraception services are evident and known to be safe and reliable clients invariably present themselves

Surgical contraception and Islamic opinion When voluntary surgical contraception was first widely promoted in developing countries by the international family planning movement during the 1960s and 70s opinions differed among Islamic theologians as to whether sterilization as a means of contraception was legal in terms of Islamic law or not (Omran 1992: 187-190). While all agreed there was no text of prohibition either in the Qur'an or the *Sunnah* (the tradition of the Prophet), many were opposed on the grounds it

⁸ A number of studies of VSC and other long-term methods are summarized in Reynolds (1996: 115-159).

seemed to contradict more general principles, as for example when the *Shari'ah* specifies “procreation” as one of five areas of life which should be “preserved” (the others being self, religion, mind and property). Thus the famous *fatwas* of Sheikh Jadel Haq Ali Jadel Haq, the Grand Imam of Al-Azhar, published in 1983 and widely cited in support of family planning, contain the views:

“... Hence temporary methods like contraceptive pills or the coil (IUDs) or other methods are permitted as long as there is no permanent impairment of fertility. Actually the modern methods are better than *al-azl* [withdrawal] because they allow normal and complete marital relations. ...

“Other than for pressing health reasons, sterilization through surgery or through drugs is not permissible if it causes permanent loss of fertility. Sterilization may be used when it is established that a hereditary disease may pass to children or causes pain. In that case sterilization becomes mandatory, based on the juristic principle of permitting an injury to avoid a greater injury. This is conditional on the disease being incurable and must take into consideration advances in medical technology” (reprinted in Omran 1992: 7-8).

In Indonesia the first major Muslim organization to proclaim publicly its support for family planning was Muhammadiyah in the Decision of its Legal Affairs Committee in 1968⁹; Nahdlatul Ulama (NU) followed with a similar Decision of its Executive Board for Legislative Affairs in 1969. Neither decision sanctioned sterilization, however, which was still generally regarded as *haram* by Muslim leaders Indonesia. The Decision of the National Congress of Ulama on Population, Health and Development Affairs in 1983 contains:

“Islam teaching permits family planning in order to maintain mothers’ and children’s health, and to propagate healthy, intelligent and well-behaved children.

“Family planning includes communication, information, and education, and should be based on consideration of religious and cultural factors, and the voluntary application of humane methods.

⁹ The Decision of the Legal Affairs Committee is in fact a highly nuanced document. On the one hand it declares, “Prevention of pregnancy is contrary to Islamic teaching, as is family planning which is done by prevention of pregnancy,” while on the other, “In emergencies it is permitted, on condition that husband and wife agree, and that it will not cause disadvantage to either body or spirit” (English translation taken from BKKBN 1993: 195-199). In the “Explanations” section of the document the Committee describes “emergency” as “an individual matter, which does not permit publication of a regulation.” Thus the Decision, despite its assertion that “prevention of pregnancy” is “contrary to Islamic teaching,” opened the way for further legitimation of family planning by sanctioning its use for medical (health) or other “emergency” reasons (BKKBN 1993: 24). The Explanations effectively proscribe sterilization in the following point: “Prevention of pregnancy is considered to be contrary to Islamic teaching if the attitude and behavior of the married couple reflect unwillingness to have children, or if it involves damaging or changing the relevant organ.”

“Vasectomy and tubectomy are contrary to Islamic law, except in urgent situations, i.e., avoiding hereditary diseases, or when the mother’s life is threatened if she becomes pregnant or gives birth” (BKKBN 1993: 217).¹⁰

When BKKBN and the Department of Health were first establishing a national family planning program in Indonesia during the early 1970s it was decided the time was not right to promote voluntary sterilization as an “official method” of the program, since opposition from religious leaders could inflict serious damage to the program as a whole.¹¹ The instructions of the Minister of Health/Chair of BKKBN¹² in 1980 stated, “Sterilization is not to be used in connection with the national family planning program” (Surjaningrat 1980).

Early beginnings of a national VS program BKKBN has, nonetheless, given substantial support indirectly to surgical contraception services over the years, notably by paying for the training of providers, for equipment and supplies, and for reimbursement of actual procedure costs. Much of the funding for this was initially provided by USAID.¹³ The Department of Health has also contributed personnel and facilities, and covered some of the costs of procedures. The vast majority of surgical contraception procedures in Indonesia take place in government hospitals. Instead of promoting surgical contraception as an official “program method,” however, a special arrangement was put in place between BKKBN, the Department of Health and the Indonesian Association for Secure Contraception (PKMI),¹⁴ whereby responsibility for the management of surgical contraception services was effectively delegated to PKMI.¹⁵

¹⁰ The Indonesian Council of Ulama (MUI) was founded in 1977 as a national consultative body representing all the major Islamic organizations in the country. It sponsored the 1983 Conference and the Conference Decision can be interpreted as an MUI Decision on family planning. As such it has not been updated and remains in force today (see section III.2).

¹¹ Voluntary sterilization was field tested by BKKBN in pilot studies in Java and Sumatra in the mid-70s (Hull *et al.* 1977: 20).

¹² The Minister of Health held the position of Chair of BKKBN at that time.

¹³ By the mid-1990s ADB, the World Bank and UNFPA were also contributing to surgical contraceptive services.

¹⁴ A PKMI (1994: 2) publication succinctly describes the organization’s *raison d’être*: “It is unfortunate that due to the still existing social and religious constraints, VSC can not yet be included officially in the national family planning program. The policy regarding VSC followed by the government is to place the issue of VSC in the hands of the community members themselves. If the community feels it needs VSC services, then it is up to the community to organize it. In that case, the role of government is to both supervise the service quality and to assist the community that need the service as much as possible. Thus, in accordance with such a policy, on the initiative of several community leaders, in 1974 the PKMI organization was established, with the goal to specifically focus its activities on supporting VSC in Indonesia.” In the early years the Association was known by the acronym PUSSI.

¹⁵ This arrangement finds formal expression in a Ministerial *edaran* (circular) of 1991: “*Pelayanan teknis medis kontrasepsi dengan metoda operasi (tubektomi untuk wanita dan vasektomi untuk pria) tetap harus dilakukan atas indikasi yang jelas dan pelaksanaannya agar disesuaikan dengan pedoman/panduan yang telah disusun oleh para ahli dari profesi (PKMI)*” (Adhyatma 1991). (“Medical services providing permanent contraception in the form of tubectomy (for women) and vasectomy (for men) must be carried out base on the clear [medical] indications, and the implementation should be in accordance with the standards and guidelines, already compiled by the professional experts (PKMI).”) See also PKMI (1994).

This arrangement has led some to describe surgical contraception as a “step-child” of the national family planning program.

Serious efforts to establish a national surgical contraception program in Indonesia began in 1978 with a USAID-supported visit of senior Indonesian family planning officials to AVSC headquarters in the USA. A strategic plan was devised for the step-wise development of surgical contraception in Indonesia. It included setting up five surgical contraception training centers, supporting a repair and maintenance center for surgical contraception equipment, establishing and resourcing PKMI, and encouraging a strong AVSC presence in Indonesia (which the USAID Mission had earlier opposed). That same year AVSC sent a team to Indonesia to help PKMI get established, set up the training centers, and develop a working relationship between AVSC and the USAID Mission, BKKBN and PKMI. The strategy was, first, to establish the necessary components of a national surgical contraception program and then, when the government was ready and the time right, to turn over these components to the government, so the program could be “institutionalized” and self-sustaining.¹⁶ The Association for Voluntary Surgical Contraception (AVSC) worked with PKMI on the first phase of this process for about five years. The surgical contraception training network grew from five centers to over ten, and USAID funds were also used to reimburse some surgical contraception service provision on a per case basis. Already at this time the vast majority of cases were performed at government hospitals.

A second phase of the process started in 1982 with the addition of a quality assurance system, a counseling program, and the systematic upgrading of district service delivery points (i.e., hospitals for tubectomies and vasectomies, and health centers for vasectomies). The training network grew to 17 centers, and the surgical contraception per case reimbursement system, funded by USAID through AVSC, was made more systematic and national in scope. A third phase began in the late 1980s, consolidating the program by building awareness and generating demand for the services. The first steps towards institutionalizing the program as a government responsibility began around this time.

Institutionalizing surgical contraception activities In the early 1990's the Government was under pressure to institutionalize more of the surgical contraception program. After 15 years of funding surgical contraception through AVSC and PKMI, USAID was eager to see this activity institutionalized by BKKBN, especially since the agency was planning to phase out its health and family planning work in Indonesia by the end of the decade. BKKBN would then take responsibility for the costs of the surgical contraception program, even if services and related activities were still managed by PKMI.¹⁷

¹⁶ The expectation that the surgical contraception program would someday become a government responsibility was always clearly articulated and agreed to by all parties. It was also clearly understood that PKMI would not be able to exist as the main surgical contraception operational agency if and when that happened, and would therefore have to “re-invent” itself.

¹⁷ This was a difficult challenge: Anyone familiar with governance in Indonesia knows it is very hard for large amounts of government funds to be given to professional or NGO organizations.

The first component of the surgical contraception program to be institutionalized was the per case reimbursement activity, which became a direct government expenditure already during the 1980's. In this instance the government got around the difficulty of providing government funds to PKMI (an NGO) by providing the per case reimbursement directly to the facilities (typically provincial and district hospitals, or *puskesmas* in the case of vasectomies).¹⁸ The second component slated for institutionalization was the laparoscopy repair and maintenance activity. USAID decided to phase out its support when they believed the government should take it over, and after much discussion BKKBN agreed. This component was not successfully institutionalized, and there are now no national facilities for the repair and maintenance of laparoscopy equipment in the country.

With the start of the USAID-funded SDES Project (1995-2000), BKKBN took more control of the VSC program budget. A major objective of SDES was to increase the availability and use of long-term methods, but when Norplant[®] implant arrived in Indonesia (in the mid-1990s) the Chair of BKKBN decided to commit more of the organization's resources to this long-term method than to surgical contraception. Suggestions that surgical contraception be now made an official program method were rejected, on the grounds that the risk of religious opposition still made such a policy change inadvisable. The special arrangement with PKMI was no longer fully implemented, with the result that key components of the surgical contraception program were left to atrophy from lack of funding. Before 1995, PKMI had designed and implemented a surgical contraception counseling program, and had trained medical staff (typically midwives and nurses) at most service delivery points where services were provided to counsel surgical contraception clients. PKMI had also established an elaborate quality assurance system, including systematic supervision and monitoring. These activities were funded by USAID, through AVSC. After 1995, PKMI no longer received funds for these activities.

After 1995, when USAID awarded all its funding for surgical contraception activities to BKKBN through the SDES Project (in the hope these activities would then become institutionalized in a more sustainable way), BKKBN neither institutionalized the full range of existing surgical contraception program components, nor did it fund PKMI to continue its work developing and implementing certain components. The exceptions were training and per case reimbursement. BKKBN contracted PKMI (using its USAID funds) to provide training in surgical contraception; and the reimbursement by BKKBN for VSC cases, paid direct to the facility (by now using the Government's own funds), continued as before. Other key components, notably providing training in surgical contraception counseling to clinical staff at service delivery points and (most crucially) the quality assurance system, were not funded by BKKBN. Any hopes of soon rectifying this situation – whereby some components of the surgical contraception program (training, reimbursement) were effectively supported by BKKBN while other key

¹⁸ This expenditure for surgical contraception reimbursement kept growing, of course, because the cost for the services kept increasing: The first per case surgical contraception payments in the 80's were around Rp 5,000; the current per case reimbursement is Rp 200,000.

component (quality assurance, specialized counseling) were not – were dashed by the onset of the financial crisis in 1997.

III. POLICY ENVIRONMENT

III.1 Current Policies

The current policy of the Government is to support surgical contraception using national family planning program resources (e.g. providing equipment, covering training costs, and providing reimbursement for the cost of surgical contraception services) without promoting it actively as an official program method. As described in section II.3, this policy was introduced in the 1970s, when BKKBN was still in its formative period and it was feared opposition to surgical contraception from religious groups could threaten the entire program. The Indonesian Association for Secure Contraception (PKMI) was established and given the responsibility to organize and manage the delivery of surgical contraception services, including setting appropriate clinical standards, with technical assistance from AVSC and funding from USAID (Adhyatma 1991; PKMI 1994). During the 1980s PKMI, working with DepKes and BKKBN, set in place all the components needed for a successful surgical contraception program, including a system for reimbursement, training, clinical counseling, and quality assurance. District hospitals and other sites were refurbished and equipped so they could perform surgical contraception, and an equipment repair and maintenance facility was established.

This arrangement with PKMI was never intended to be permanent, and in the 1990s USAID urged BKKBN to institutionalize the surgical contraception program on a sustainable basis. Starting in 1995 all USAID funds for surgical contraception were given to BKKBN (through SDES), and AVSC withdrew from the surgical contraception scene (and focused on general FP quality issues). The institutionalization process was completed only partially, however: As noted earlier, some components were fully institutionalized, like the reimbursement process and training, while others, notably clinical counseling and quality assurance, were not. As a result the current policy environment for surgical contraception is confused and unsupportive. Surgical contraception is *de facto* part of the national family planning program, with Government funds routinely allocated for surgical contraception activities. Government regulations stating specifically that sterilization cannot be included as an official method of the program (Surjaningrat 1980) have not been rescinded, however, and PKMI is still *de jure* responsible for providing surgical contraception services and training at acceptable levels of quality. BKKBN regularly requests PKMI to provide services and training, and appears to assume that in meeting their request PKMI will ensure all appropriate quality standards are met. PKMI for their part consider quality assurance and medical counseling at the service delivery point as supplementary activities; they see their responsibility as providing the core surgical contraception services that have been asked explicitly to do and for which they receive payment. BKKBN (in most provinces)

allocates no funds for quality assurance and medical counseling, and PKMI cannot perform these activities without a budget. The quality of services inevitably suffers, as described in Chapter V.

Informed consent is required for all surgical procedures, but consent for sterilization is usually given without the benefit of consultation with medically-trained providers (again, see Chapter V). Another relevant policy issue is that reimbursement by BKKBN does not cover *all* the associated costs at all SDPs, and this could contribute to low compliance with standards (and hence low quality) at some sites. Furthermore the rather marginal role surgical contraception currently plays in the national program means training and supply of equipment for surgical contraception is often provided on an ad hoc basis, making quality assurance (or any deliberate planning to expand services) a low priority and difficult.

A recent Ministerial Decree (Sujudi 2000) concerning surgical contraception (*pelayanan medis kontrasepsi metode operatif*) reaffirms the importance of informed consent, and clarifies what kinds of SDPs can offer the procedures, allowing for the first time *puskesmas* with overnight beds to offer tubectomies. The decree asserts it replaces the 1991 *surat edaran* in respect to those items explicitly covered, but otherwise the 1991 decisions regarding PKMI appear still to be valid.¹⁹ The latter are not updated to reflect changes in the way surgical contraception services are institutionalized since 1991, and consequently ambiguities in the precise allocation of responsibility for the quality of services in particular remain.

The present policy environment is not conducive to providing quality surgical contraception services to clients, even on a limited basis. Nonetheless the 2000 Ministerial Decree effectively increases the number of sites at which services can be provided.

Impact of decentralization It is not clear yet what will be the impact of decentralization on surgical contraception policy at the province or district levels. BKKBN will retain its centralized structure for 2 or 3 more years while DepKes and most other sectors have decentralized and merged with local government (Hull 1999; World Bank 2000). The implications of this for BKKBN staff (in terms of future job security and social benefits, for example) or for specific FP programs (such as whether local governments will be prepared to allocate funds to subsidize surgical contraception) are not clear. A major concern is that decentralization could lead to even less compliance with standards, leading to further deterioration in quality of services. Decentralization may make quality assurance even more difficult than it already is. On the other hand some districts could prove to be super-achievers in health and social welfare.

¹⁹ “Dengan ditetapkannya Keputusan Menteri Kesehatan RI ini, Surat Edaran Menteri Kesehatan R.I. Nomor 185/Men.Kes/III/1991 tanggal 23 Maret 1991 tentang Pengendalian Pelayanan Teknis Medis Kontrasepsi Dengan Metode Operatif, dinyatakan tidak berlaku lagi” (Sujudi 2000).

III.2 Potential Obstacles to Expanding Services

Religious obstacles Most government and NGO officials interviewed believe religious obstacles are no longer a major issue yet cannot be totally discounted. Anecdotal evidence presented to support this view includes the broadcasting of TV spots promoting surgical contraception in East Java (sponsored by BKKBN) with no opposition or complaints recorded. At the same time they usually argue for a low-key IEC campaign (aimed at service providers, who can then inform FP clients of the surgical contraception option as appropriate) to accompany surgical contraception services and stimulate demand rather than a pro-active advocacy campaign (aimed at opinion leaders, parents and the community) in order to minimize the risk of any religious groups being offended and adopting an oppositional stance.

Internationally, opinions have differed among Muslim theologians regarding whether sterilization is permissible as a contraceptive method (Omran 1992: especially pp. 187-190). Theologians in all traditions generally agree that when they examine the Qur'an or the *Sunnah* they find, in the words of Sheikh Jadel Haq, "no text prohibiting sterilization, i.e. rendering a man or a woman unable to procreate totally and permanently by surgery or chemical or other means" (cited in Omran 1992: 188). Theologians have no objection to sterilization performed for medical reasons, because the operation is then seen as a "method of treatment" and the legitimacy of treatment is well-established in Islamic law. Sterilization for contraceptive purposes is often opposed, however, on the grounds it is forbidden to alter irreversibly "the natural capacity to procreate" unless necessary to do so for some higher purpose, and in the case of contraception taking such irreversible action cannot easily be seen as "necessary" if reversible non-surgical methods of contraception are available. Even so, Islamic thought on family planning is still evolving. Ten years ago Omran (1992: 192) noted there are important reasons for Islamic theologians to re-examine the legality of sterilization, but at that time concluded, "Until then, the majority opinion supervenes, namely, that permanent irreversible sterilization with no excuse is not allowed."

In Indonesia the largest Muslim groups, NU and Muhammadiyah, both support surgical contraception in their own hospitals and clinics. NU, in its 1995 Congress in Yogyakarta, endorsed surgical contraception as an acceptable method of family planning for its members (see Sugiati 2001). Muhammadiyah, on the other hand, has not officially revised its *fatwah* of 1968, finding voluntary sterilization for family planning purposes to be "contrary to Islamic law" (see section II.3). Without Muhammadiyah revising its opinion it is not possible for the Indonesian Council of Ulama (MUI) to proclaim a more favorable decision on surgical contraception than that proclaimed in 1993: "Vasectomy and tubectomy are contrary to Islamic law, except in urgent situations."

The matter has not been definitively settled, and there is interest among Muhammadiyah leaders in seeing a more positive decision on surgical contraception proclaimed for all Indonesian Muslims. With possible religious objections in mind it is important to point out, first, that modern sterilization techniques are increasingly seen as "reversible";

second, that surgical contraception arguably results in fewer and more circumscribed physiological changes than the use of hormonal methods of contraception, so there are definite medical and health reasons for preferring it as a method of contraception for certain women, especially older women and/or those with high parity; and third, with the institutionalization of the small-family norm in Indonesia and the aging of the population there is a growing number of couples who are fertile and already have the number of children they want, and consequently there is a pressing need for a growing number of couples for a safe and effective long-term contraceptive method.

Cultural obstacles As with any novel technology that impinges on vital processes, false beliefs and misconceived worries abound. Some people appear to confuse male sterilization with castration, while others worry that if their spouse is sterilized it will make clandestine affairs easier (Reynolds and Vogel 1992). There is also widespread fear – with much justification – of operations and hospitals. Such concerns can be addressed rationally through better public education, greater attention to combating misinformation, and improving the quality of the services.

Political obstacles Political leaders and program managers in the past did not want to risk a backlash among religious groups and therefore played it safe by letting NGOs and the private sector take the lead in promoting the method. The political context today is quite different. The risk of religious opposition appears to be reduced. The current political situation is unstable, however, making leaders reluctant to take unnecessary risks. It is possible some opposition groups could attempt to embarrass the Government by resurrecting old religious arguments if surgical contraception were promoted too aggressively.

Economic obstacles The cost of a surgical contraception procedure is relatively high, but it is a one-time cost. When calculated on a “years of protection” basis the costs are not prohibitive, and surgical contraception can prove more cost-effective than other methods. In general cost has not been a “significant deterrent to acceptance of VS” (Reynolds and Vogel 1992: 6). However the costs to clients and to the public health system could be considerably increased if poor quality infection prevention leads to clients contracting Hepatitis B or C or HIV/AIDS.

III.3 Policy Options

Logically, one can imagine a number of possible scenarios:

Option 1 Continue with present policies. No net gain will come this way. Use of surgical contraception will probably remain at about 3-4 per cent of couples. Many couples will continue to use inappropriate and/or inefficient methods for many years after they know they want no more children; also it will remain difficult to increase contraceptive use enough to reach replacement fertility. Furthermore the Quality Sub-team found that surgical contraception procedures are not up to acceptable quality standards. The risks of infection and other complications observed are particularly

disturbing since surgical contraception is essentially a matter of elective surgery and that the women and men who present for the surgery are usually healthy *before* the procedure. The present policies and their implementation are unsafe for clients and clearly not adequate. To recommend absolutely no change would be unconscionable. There is also a significant political risk to BKKBN if policies remain unchanged and no action is taken, since it is BKKBN which is funding the services putting healthy women and men at risk of morbidity or even death.

Option 2 First improve the quality and then expand the use of surgical contraception, but without changing the overall structure under which these services are currently institutionalized; i.e. keeping the special arrangement with PKMI in place, without further integrating surgical contraception into the national program or explicitly making it an official program method. The advantage of this option is that it minimizes the political risk of opposition. A disadvantage is that access to quality services will likely remain very uneven. The most serious disadvantage is that it is likely to be very difficult to improve quality and maintain good quality on a sustainable basis without some significant structural change in the way surgical contraception services are currently managed. Improving quality on a sustainable basis requires institutionalizing and advancing support systems such as pre-service and in-service training, refresher courses, infrastructure, equipment, site preparation involving the whole team, supervision, etc. It is likely to prove extremely difficult – although not necessarily impossible – to institutionalize these systems on an adequate scale without making surgical contraception an official program method.

Option 3 Change the policy regarding surgical contraception: Expand the method mix (cafeteria approach) in the context of a client-oriented approach, make surgical contraception an official program method like the others, and support it in both public and private sectors. This can certainly be done quietly, without a public promotion campaign. It does require a changed subculture within the program, with the promulgation of new guidelines and regulations for service providers. It requires a Ministerial Decree to supercede the 1980, 1991 and 2000 decisions. It requires a review of the arrangement between BKKBN, DepKes and PKMI. It requires putting in place effective quality assurance systems, making sure they are adequately resourced, that responsibility for all aspects of quality and safety are clearly assigned, and that there is a clear path to long-term sustainability of services.

Option 4 Discontinue or significantly reduce program support for surgical contraception. Given the poor quality of existing services, the fact that healthy clients are put at unnecessary risk of morbidity and even mortality, and the potential damage to the entire FP/RH program if these shortcomings become exploited politically, an argument could be made to restrict surgical contraception services to just a few selected SDPs where quality can be guaranteed.

In Chapter VI the Assessment Team builds on Option 3 in making its recommendations.

IV. ACCESS TO SERVICES

Only a few additional comments are needed regarding access issues, based on observations from the field visits. Metaphorically speaking, the access glass can be seen as half full or half empty:

Knowledge access A few figures sum up the essence of the knowledge problem: in the 1997 IDHS, 40 per cent of married women did not know of female sterilization and 64 per cent did not know of vasectomy. The 1991 and 1994 surveys gave very similar percentages, so knowledge of the method has not been significantly improving.

Physical access The 1997 IDHS showed very little difference in contraceptive prevalence between rural and urban respondents, regardless of whether this was in Java, Outer Islands I, or Outer Islands II. Indonesia has an extensive network of SDPs for family planning. Nevertheless physical distance from a service varies by method, being on average greatest for sterilization and the implant. Distance barriers are probably least serious in Java compared to parts of the Outer Islands.

Cost access Cost is a barrier for some poor clients. Hospital charges vary but can be considerable. In the 1997 survey 32 per cent of female sterilization clients received surgical contraception free, but the rest paid an average of Rp. 223,000 in government facilities and Rp.425,000 in private facilities.

Interpersonal access at the facilities There is little or no counseling for surgical contraception at the service sites at the district level, according to the Quality Sub-team's observations. Some counseling is supposed to occur prior to the service visit, by the PLKB and *kaders*, but the team was not able to check this. Physician attitudes are often quite impersonal toward surgical contraception adopters, most of whom are of lower income and educational groups. In general the team felt that the service atmosphere is unsympathetic at best.

V. FINDINGS: QUALITY OF CARE

A client-oriented reproductive rights approach to family planning sees improving the quality of care as an essential step towards the full realization of those rights (UN 1994: para 7.23). The Quality Sub-team was tasked with making a quick assessment of the quality of surgical contraception services. This assessment was not intended to be comprehensive or representative, but rather to make an exploratory foray into the subject and see whether a small sample of observations suggest quality meets relevant Indonesian standards, or whether there are significant quality issues which need to be addressed.

V.1 Introduction

The Quality Sub-team divided into two groups and visited SDPs in four provinces: North and South Sumatra, and Central and East Java. Data collection (see Table 1) included:

- Observing laparoscopic procedures performed by obstetrician-gynecologist (Ob-gyn) and trained general practitioners (GP) at four District Hospitals;
- Observing minilap procedures performed by trained GPs at one District Hospital and one Private Hospital;
- Observing vasectomies performed by GPs in an NGO clinic and at a *puskesmas*;
- Conducting round-table discussions with provincial as well as district level staff from BKKBN and *Dinas Kesehatan* (DinKes);
- Observing minilap clinical skills training.

The observed practices were assessed in terms of Indonesian standards, or international standards where appropriate. The team used clinical checklists based on the current training standards of PKMI for minilaparotomy and no-scalpel vasectomy. For laparoscopic tubectomy, the sub-team drew on an internationally accepted clinical checklist developed by JHPIEGO.²⁰

Government officials, as well as clinicians, PLKBs, *kader*, and clients, were included in the interviews. The only clinical skills training that the team directly observed was on minilaparotomy under local anesthesia. The team was able to interview some advanced and master trainers in minilap as well as laparoscopic tubectomy.

V.2 Interpersonal Communication and Counseling Practices

Sterilization services are organized through the local BKKBN network. The *kaders* (family planning volunteers) and PLKBs (family planning field workers) provide the essential link between potential clients and the health care system, and it is the local BKKBN staff who arrange the schedule with clinical providers at the appropriate service delivery point (SDP). The SDP may be at the nearest district hospital, the *puskesmas*, or at a private hospital. The determining factors in this selection are the availability of a team of clinical providers and their location. For example, in a locality where there are several providers, BKKBN may select a general practitioner at a private hospital if this option is more accessible to the clients or convenient in other ways.

²⁰ During the preparatory phase of this assessment, the medically-trained members of the team met to review current and past learning packages in tubectomy and vasectomy developed by PKMI. The most recent version of the T-Mal under local anesthesia and an older no-scalpel vasectomy manual were available for review, but no manual for laparoscopic tubectomy was available. The team agreed to use the clinical checklists based upon current training standards of PKMI for minilaparotomy and no-scalpel vasectomy; for laparoscopic tubectomy the team drew on the internationally accepted clinical checklist developed by JHPIEGO for its country programs.

Regardless of the service site, the responsibility for counseling and securing informed consent from the client appears to rest on the *kaders* and PLKBs. Clinical counseling by medically-trained providers, including verification of informed consent, was not observed to take place at any of the surgical sites visited. When queried, the clinic providers as well as the organizers replied that the *kaders* and PLKBs usually perform this function at the village level. The team did not have an opportunity to observe the quality of this counseling (or the extent to which it ensured informed choice). The team did observe that the interpersonal communication between the clinical provider and their clients was typically limited to routine inquiries such as name and address, as well as orders to get onto the operating table. There was little attention given to building any rapport between client and provider, and the resulting impression was that of a rather uncaring and impersonal service being provided by a technician.

This is in contrast to common international practices where clinical staff provide more focused clinical counseling of clients or couples prior to their signing the consent forms. The clinicians can provide specific information about the operative procedure, respond to questions about the operation and the management of pain, describe post-operative care and follow-up, and reassure the client. The surgeon is, or designated medical personnel are, expected to verify that the client fully understands the surgical procedure and has voluntarily consented. The surgeon is expected to review the medical screening criteria or confirm that adequate screening has been completed to ensure that the client is an appropriate candidate for a permanent surgical method. The counseling and informed consent verification steps are seen as opportunities for establishing client-provider rapport that is critical to the overall client satisfaction with the selected method. These practices do not seem to be common for surgical contraception in Indonesia, at least at the sites visited.

The team observed that most of the time the surgeons do not have any contact with the client until after the client is lying on the table. In most instances, the client is already heavily sedated so the opportunity for even limited client-provider interaction is largely lost. When sedation is not used and the client is fully awake, as in the minilap cases observed at one of the surgical sites, the interaction happened only when clients were reacting to pain. In several instances instead of providing verbal reassurances, as well as reassessing need for additional pain management, the provider verbally intimidated the clients into keeping quiet. Verbal anesthesia or “verbocaine” is a recognized clinical practice that supplements the medical benefits of local anesthesia. However, its effectiveness rests on establishing and maintaining rapport between provider and client. The surgeon is responsible for the health and well being of his/her clients. Most of the observed providers seemed to focus only on completing the clinical procedure rather than the overall provision of care to the client.

The argument that clinical providers are busy and do not have the time to counsel has no standing in high quality healthcare services today. At the very least, the surgeon should verify that the client has made an informed and voluntary choice. Provider time constraints can be addressed by better case-load and operating-time management, so that elective surgery is not squeezed into too limited time slots at the facility, thus allowing

providers more time to counsel and interact with clients. Providers too must be prepared to put time into counseling their clients and to see this as an integral part of their professional responsibilities. Current trends in clinical care emphasize combining professional standards with a personal and sincere caring attitude.

V.3 Client Assessment

International and Indonesian standards of medical practice require adequate medical screening before any surgery is carried out. The screening processes in the surgical contraception cases observed by the Quality Sub-team were not satisfactory. While it is not impossible to train a non-clinician to perform basic client screening using a checklist, it should nevertheless be routine for clinicians to review the checklist and conduct a more thorough physical and verbal examination as needed. A pelvic examination is considered mandatory for female sterilization, especially if pregnancy is thought to be a possibility. If another provider performed the screening pelvic examination, the surgeon is expected to repeat it prior to the procedure to check the position of the uterus. A preoperative screening of male acceptors of vasectomy is also the norm. However, the Quality Sub-team did not observe any of these basic prerequisite steps happening at the surgical sites for vasectomy and tubectomy. Instead the process is as follows: (i) *kaders* and PLKBs screen the client prior to scheduling the procedure; (ii) upon arrival at the SDP the client is sent directly to the operating theater to wait for their turn when called; (iii) in tubectomy procedures, uterine manipulators are inserted without first checking for the position of the uterus, with the result that the effectiveness of the uterine elevator as a lever is lost and the risk of uterine perforation is increased.

The absence of pre-surgical screening at the clinical site also leads to inappropriate waiting times for clients. In one of the district hospitals the team visited, a client with obviously severe upper back deformity (kyposcolioni) had to wait until all eight or so cases listed before her had been completed before learning that she was not clinically eligible for laparoscopic tubectomy at that center. (It is not known whether she was offered counseling on alternative methods.) A waiting time of about 4 hours, only to learn one is not eligible for the service chosen, is not acceptable by any standards of quality care.

V.4 Infection Prevention Practices

The most basic concepts of asepsis and antisepsis and of the transmission cycle of diseases appeared not to be well understood by the service providers at the sites visited, from the Ob-gyns performing the surgery down to the cleaners and other support staff. Departure from accepted basic infection prevention practices exposes healthy clients to the risk of blood-borne infections, including HIV/AIDs and Hepatitis B and C. Most of the breaks in what should be standard practice involve deficiencies in instrument processing, dangerous use of contaminated gloves and other surgical items, and ineffective hand washing.

The service providers who were observed, including cleaners, circulating and assisting paramedical staff (nurses and midwives), and physicians (both specialists and GPs), are currently exposing both their clients and themselves to inordinate risks of infection. In a number of instances surgical assistants in laparoscopic and minilaparotomy procedures did not routinely change gloves and wash their hands after each procedure. The team observed surgical assistants using the same pair of gloves in case after case with only a perfunctory rinsing with sterile water or spirits in between. At one site the practice was to change gloves only after every third case. Supply of gloves is often cited as a reason but at several of the sites where this was observed new pairs of gloves were readily available. Poor provider attitude is certainly a contributing factor as providers strive to complete the procedures as quickly as possible.

The surgeon is equally deficient by omission and commission. They generally fail to insist that everyone comply with IP practices, including gloving and hand washing. Excepting one physician (who changed gloves after every 3 cases), all surgeons generally changed to a new pair of gloves after each case. However, the surgeons failed to rescrub (after every 5 cases as is the norm) or use an alcohol rub (60-70% alcohol and glycerin solution) after every case in between scrubbing.

Another questionable practice is the utilization of unused, or minimally used, items from one patient to the next. Practices observed by the team in some surgical sites include the reuse of items such as antiseptics in a common bowl; and the reuse of surgical instruments such as “minimally used” scissors and forceps coming from one completed case, in which case providers would only wipe the instruments with an antiseptic or disinfectant. These practices contravene basic IP standards and increase the risk of cross contamination among clients – a risk no healthy client should be exposed to during an elective procedure.

Instrument processing is another deficient area. For example, the time to adequately complete the processing cycle for laparoscopic equipment is about 45 minutes:

- 10 mins. for decontamination;
- 10 mins. for disassembling the Veress needle, trocar and laproscator systems prior to cleaning and washing with soap and water;
- 20 mins. for high level chemical disinfection of the cleaned instruments in a correctly prepared disinfectant (either 0.1% chlorine, or 2.5% glutaraldehyde or Cidex); and
- 5 mins. for rinsing of laproscator and needle in cooled boiled water prior to reassembly.

45 mins. total time required to sterilize a laparoscope by international standards.

At the two sites the team visited, the entire cycle took 5-10 minutes to complete. The shortcuts involved both time and process. The laproscator was not disassembled prior to

cleaning it; and the disinfectant solution was diluted down to as little as 1:50 concentration (or 0.05%) at one site (the manufacturer's recommended concentration is 2.5% activated glutaraldehyde). Both the surgeon and the instrument processor are under the impression that their processing practices are generally adequate. The "assembly line" method of providing surgical contraception services is particularly prone to dangerous "cutting of corners." This is evident at SDPs where surgical contraception is routinely performed (as with vasectomy at a *puskesmas*, or laparoscopic tubectomy in a district hospital), and at sites where the surgical facility is only a space to perform the procedure (as in minilap tubectomy in a private hospital). In all these situations the providers are often under considerable pressure to complete a large number of cases scheduled for the day. This pressure derives from a variety of sources, including the hospital only scheduling a limited amount of operating room time for elective surgery.

All of the providers reported that postoperative infection was the least of their problems. Excepting occasional surgical site infections that were considered minor, they could not recall any cases that needed admission for treatment. This is not surprising considering that the acute bacterial infection process is dependent on a number of factors, including exposure time, load of bacterial inocula, tissue handling, and the integrity of the host immune system. Tubectomy and vasectomy, in the hands of an experienced provider, are minor surgical procedures when applied to a generally healthy individual. The routine use of postoperative antibiotics in therapeutic doses (ampicillin 500 mg TID 5 days) possibly precludes postoperative bacterial infections, thereby making current IP practices appear less problematic than they really are. The excess use of antibiotics to counter poor IP practices increases the cost of the procedure, and may contribute to the reduced effectiveness of antibiotics.

Viral infections like Hepatitis and HIV, however, can only be prevented by strict compliance to effective IP practices. In Indonesia, the high Hepatitis B and C prevalence rates are a particular cause for concern. Current HIV/AIDS prevalence in Indonesia is low, but is potentially a significant threat to the well being of clients in high-risk areas. The cause and effect relation between surgical contraception practices and these viral infections is not immediately evident because of the delayed manifestation of these infections. The time lag does not create an awareness of urgency and importance to infection prevention practices either for the protection of the clients or for providers. Protection of the providers themselves is also minimal: most of them have not been screened for HBV, nor is it routine to vaccinate providers who are at high-risk for needle stick injuries, such as surgical staff and instrument processors.

IP quality also suffers from a failure of the system to provide adequate IP equipment. For example, one relatively highly supported *puskesmas* depends on a recently acquired dish dryer (advertised for home and hospital sterilization) for final processing and storage of its minilap instruments. No one at the site is aware that the operating specifications of the equipment (125 degrees Celsius on non-programmable automatic shut-off) is not adequate for dry heat sterilization (170 degrees Celsius for 2 hours), much less high level disinfection. At another *puskesmas* offering vasectomy, provisions for instrument processing were not factored into the financial support provided to build a new

vasectomy operating room. The *puskesmas* continues to rely on an autoclave unit the volumetric capacity of which is less than 1 liter, and a 2-3 liter boiling pan.

V.5 Pain management: Analgesia and Anesthesia

Local anesthesia using 1% lidocaine is the standard for vasectomy procedures. At two sites where no-scalpel vasectomies were observed, the pain management during and after the operation appeared to be adequate. The provider at one site effectively used infiltration techniques to deliver 1% lidocaine along the surgical field. At another site, pehacaine with adrenaline was used. There is no valid reason to use adrenaline in vasectomy as the surgical technique itself precludes bleeding and the operative duration from skin to skin is less than the 40 minutes of therapeutic effect expected from most local anesthetics. Paracetamol was provided for 3-5 days postoperatively.

Choices for pain management in tubectomies range from local anesthesia alone to general anesthesia. International and local experience have documented the effectiveness and safety of local anesthesia, especially when supported by verbal reassurances from the surgeon (“verbocaine”). The use of general anesthesia and heavy sedation in tubectomy has been associated with increased risk of anesthetic morbidities and mortalities. The team observed that the norm for analgesia and anesthesia in laparoscopic and minilap tubectomy is facility dependent. With the exception of one site, most of the clients are heavily sedated using different combinations of diazepam and pethidine, or diazepam and ketamine, or ketamine alone, on top of using lidocaine (1 or 2%) for local anesthesia. Atropine sulfate (a preoperative drug) was given in all cases for vasovagal reflex prevention. Because clients are heavily sedated the client-provider interactions are minimal and verbocaine is not universally practiced. At the exceptional site, clients were not sedated and local anesthesia using 2% lidocaine (the standard is 1%) was practiced. Most of the clients were comfortable during the short procedure. However, the provider’s response to failed or inadequate local anesthesia was to intimidate the client rather than reassure her and make a reassessment for additional pain management.

There is much to be said about sedation needed for tubectomy. Most of the reported tubectomy mortalities in the literature point to general anesthesia and its complications. Pethidine and diazepam can depress respiratory functions while ketamine must be used with caution in hypertensive clients. Currently, atropine sulfate is not used in most VS programs outside of Indonesia, even when the client is lightly sedated. In the hands of a skilled provider, the procedure is quick and uncomplicated so the benefits of atropine sulfate are not cost-effective. The providers interviewed agree there are risks in analgesia and anesthesia but argue that their track record testifies to good practice since there have been no reported mortalities, or morbidities. However, it is not justifiable to put a healthy, walking, conscious woman to avoidable risk for an elective surgical procedure. Correctly used, local anesthesia together with good client preparation and verbal reassurance is effective in managing pain during the procedure.

In all instances observed baseline and periodic vital signs monitoring intraoperatively was irregular. Postoperative vital signs monitoring was not generally practiced. If there was a problem case it is unlikely to be identified by the surgical team until already advanced.

V.6 Surgical Approach and Postoperative Instructions

The Quality Sub-team observed the no-scalpel vasectomy procedure. The standard steps of the procedure were followed by providers, with some minor variations. These variations, such as the technique for throwing a knot, are personal preferences developed through experience. However, in most cases the technique of dissecting away varicoceles or clumps of small blood vessels and closing of the scrotal incision needs to be strengthened.

The providers for minilap currently represent two extreme ends of the training cycle. At one site in a private hospital the GP was trained more than 10 years ago and has never had a refresher, while another GP in a *puskesmas* received his training less than 2 years ago. The private physician does not use the uterine elevator but effectively uses the tubal hook to catch the tube. His techniques for tubal ligation include ligating and cutting the fimbria (fimbriectomy) for higher parity and older women, and legating and cutting the middle part of the tube (ampullectomy) for younger and lower parity clients, a decision he personally makes. As in the older school of practice, the abdominal incision is closed layer-by-layer, including the peritoneum. There was only one case observed at the *puskesmas*, but based on an interview with the GP, after sedating the client he inserts a uterine elevator. The tube is manipulated under the incision and ligated using simple Pomeroy technique. The peritoneum is left as it is during abdominal closure. The GP at the *puskesmas* follows the current, updated PKMI and international standards under which most new providers are trained in Indonesia.

The minilap procedure at two other sites were observed to utilize two different techniques for picking up the tubes: one with a uterine elevator and one without it (the “Rebate” or blind-finger technique). At a provincial training center, the site of minilap training, minilap was done by a proficient Ob-gyn, using a uterine elevator and general anesthesia. The approach to the fallopian tube and tubal ligation was performed smoothly. The minilap procedure without the uterine elevator (the “R” technique) was performed by a resident in training at another provincial teaching hospital and under local anesthesia and sedation with diazepam. This technique was also observed in one of the district hospitals connected with this provincial teaching hospital. It seems that the “rebat” or finger technique makes it much more difficult to find the tube compared to the procedure using a uterine elevator.

Laparoscopic tubal ligation predates the use of minilap techniques. Introduced first in the mid-70s, laparoscopic tubectomy was performed under conscious sedation, usually with a combination of diazepam (10 mg) and pethidine (50-75 mg) with or without the atropine sulfate. The surgical steps included bimanual examination prior to uterine elevator

insertion, infiltrative local anesthesia, insufflation with carbon dioxide using a Veress needle, trocar insertion, inspection with a laproscator, falope ring loading and application, and finally closure of skin incision.

At two laparoscopic sites visited, most of the basic steps were followed. However, some deficiencies were observed that can significantly affect the quality of the service. The operator relies on an assistant to insert the elevator, but the nurse or midwife does not have the pelvic examination skills to check the uterine position. Consequently the elevator is inserted blindly, placing the client at risk for uterine perforation. The elastic integrity of the Falope or Yoon ring is the basis for its effectiveness. The rings are loaded way ahead of time and remain dilated for more than the 5 minutes maximum recommended by the manufacturer. Consequently the silastic material can lose its tightness and may slip off the tube after application

The state of the laparoscopic equipment at these two sites is symptomatic of a lack of clear guidelines on the role of laparoscopy in the surgical contraception program. In one district hospital, the remaining laproscator is five years old and the light and insufflation units are salvaged from older broken sets of equipment. At another district hospital, the provider is sometimes forced to use an optically defective unit in addition to another old but working laproscator in order to complete the scheduled tubectomies. In both instances, there is no provision for repair and maintenance.

In yet another district hospital the surgical approach for laparoscopic procedures appeared to follow standard technique. The team could only observe the extra-abdominal steps of the procedure, including the insertion of the trocar and the laproscator. No teaching scope or extension monitor was available to monitor the intraabdominal portion of the procedure.

In all of the clinical sites visited by the team for either tubectomy or vasectomy, the responsibility for providing postoperative instructions are relegated to the PLKBs and/or *kaders*. Prepackaged “prophylactic antibiotics” (Ampicillin 500 mg 3 times per day for 5 days) and analgesic (paracetamol 500 mg 3 times per day for 3-5 days) are handed out to clients or their relatives. The *kaders* or PLKBs provide instructions for wound care and follow-up. The team was not able to check the quality of these postoperative instructions, but one observation involving a postvasectomy case could be indicative. Following the usual routine, the client was given a pack of condoms without checking if he knew how to use them or offering to explain their use. In fact the client had never used a condom before. Furthermore clinical providers appear not to give advice regarding signs and symptoms of complications to watch out for during the recovery period.

There is generally no need for routine prophylactic antibiotics if surgical contraception is performed according to accepted standards. It is arguable that the current practice is really prophylactic in the true sense of the terminology. In practice, the dosing and schedule represent more of a therapeutic dose to deter an incipient bacterial infection resulting from poor IP practices.

V.7 Emergency Preparedness and Complication Management

Essential emergency drugs such as epinephrine or adrenaline, atropine sulfate, and dopamine, are generally available at larger centers such as the district and private hospitals. This is not as evident in the *puskesmas*. Parenteral lines and fluids were present in all of the sites visited, and all sites were equipped with means for transporting patients to the nearest next level of care.

Although the available physical facilities and human resources to deal with urgent, life-threatening complications are different at various levels of the health care system, those service delivery sites that offer surgical procedures must be prepared to deal with emergencies and complications. At its most basic, the provider should be able to identify a complication, stabilize a case, and make a decision to manage further or refer out. There are some doubts whether the GPs and their VS surgical teams have been adequately trained to deal with these events. At the same time, since there is little evidence of routine vital signs monitoring any complication is likely to go undetected until it becomes an emergency.

V.8 General Physical Status of Facilities

Surgical contraception services are conducted on an ad hoc basis at some surgical sites. There is no place for the doctor who will perform the procedure to review the client screening form or conduct a pelvic examination. The client-flow is such that clients must wait in the recovery room or dressing room or any unused space in the operating suite. The surgical team depends on non-medical PLKBs and *kaders* to watch the clients postoperatively.

Instrument sets are too few for the caseload normally scheduled, since enough sets are needed to allow for instrument processing time. Also, most of the surgical instruments are old and need to be replaced. Emergency resuscitation sets such as ambu bags, facemasks, nasal cannula, and airway tubing need refurbishment. Equipment for instrument processing is sometimes inadequate. In a *puskesmas* serving as a vasectomy site, funding to set up an extension for minor surgery did not include equipment for instrument and linen processing. The only autoclave on site was an old, small unit for sterilizing syringes and needles. A kerosene stove and a short rectangular pan for boiling are the only other alternative for high-level disinfections. At the other end of the spectrum, a team visited two *puskesmas* both with adequate surgical facilities, i.e. operating theatre, scrub room, and recovery room; and both having adequate surgical instruments and other equipment required for minor surgery. In these cases the facilities are under-utilized, and minilap procedures have never been performed due to lack of a trained provider.

V.9 Training

One part of the Quality Sub-team observed clinical skills training for minilap tubectomy under local anesthesia. This training was organized by the PKMI training center, with funding from BKKBN's ADB project. The 6-day training was for two teams of health center providers. Observations of Day 1, Day 3 and Day 4 training activities indicated that the training followed the standard training course (revised guidelines September 2000) including contents of the essential knowledge and training approach. The demonstrations with models and clients were performed using the standard surgical procedure. Day 5 and Day 6 were allocated to "solo" practice by the participants. However, due to low caseload it is doubtful that the participants had sufficient clinical practice to reach a level of competence to be able to perform the procedure safely and confidently in health centers. It is not clear whether the trainers have plans for post-training follow-up, or whether BKKBN is funding a post-training follow-up visit. Lack of follow-up supervision and the consequent inability to perform post-training practice will almost certainly result in skills loss in less than a year.

This training of the health center providers was done at the provincial hospital or another training site but without the involvement of the district hospital which has the responsibility for supervision clinical services at those health centers. This situation usually results in lack of surgical contraception supervision and monitoring at the health centers from their respective district hospitals.

There were no on-going training for tubectomy and vasectomy to observe at the other training site visited by the team. The team interviewed trainers from the site, and the major performance issues appeared to be:

- Poor selection of new service sites and providers;
- Ad hoc training sites;
- Lack of clinical skills standardization among the clinical trainers;
- Insufficient support for immediate follow-up and subsequent supervision;
- Insufficient planning and coordination between sponsoring institutions and the training system.

There is currently no well-established cycle of training and refresher training courses to ensure that the knowledge and skills of all service providers are in accordance with current standards. One of the general practitioners providing minilap tubectomy was trained more than 10 years ago, and has never had any subsequent refresher training. He continues to use 2% Lidocaine for local anesthesia (while the current standard is 1% Lidocaine for infiltrative local anesthesia). Some of the trainers themselves have not updated their clinical skills according to current clinical standards, yet continue to be called upon to conduct training. The emphasis on competency-based training lacks full implementation. Full implementation requires modeling of standards of care not only by the trainer but also in the clinical practice sites as well. It also requires strong coaching, and a feedback mechanism which still operates after training when trainees have returned

to their health centers. Apparently, supervision and follow-up activities continue to play only a minor role in the planning of service delivery expansion.

V.10 Summary

The Quality Sub-team found a large number of serious shortcomings in the quality of current surgical contraception services, at least at the dozen or so hospitals and clinics visited across four provinces. We have no way of knowing how representative our observations are of surgical contraception services as a whole, but there is no reason to believe the sites visited are atypical. The shortcomings presumably signal more widespread deficiencies in the health care system, not just in the case of surgical contraception. Among the various shortcomings observed at different sites were the following:

- medical personnel did not verify informed consent at the SDP;
- no counseling was done by medical personnel at the SDP;
- no effort was made to build rapport between client and provider;
- medical personnel did not screen clients receiving surgical contraception at the SDP;
- medical personnel did not provide any post-operative care or monitoring of vital signs;
- a doctor verbally abused a client;
- pain management (for minilap) was ineffective, due to a lack of concern or the use of inappropriate procedures;
- standard infection prevention practices were widely ignored or implemented in ways which reduce their effectiveness;
- caseloads were too high or the supply of equipment inadequate to allow time for proper disinfection of equipment;
- facilities lacked equipment and funding for supplies for high-level disinfection supplies;
- general anesthesia was commonly used (with no vital sign monitoring), despite the greater risk to the client;
- doctors were inadequately prepared to deal with emergencies or complications;
- emergency resuscitation equipment had not been examined or updated to ensure readiness to deal with problems;
- the laparoscopic procedures are still being performed in preference to minilap.

Different sites exhibited different combinations of specific shortcomings, suggesting a pervasive general breakdown in compliance to quality standards. Further quality problems emerged from discussions with providers and trainers:

- equipment was misallocated, so a facility might be well-equipped even though the site has no trained provider;

- doctors in surgical contraception training are receiving inadequate supervised practice (because of low caseload) to be able to claim competency; and often have too low caseloads subsequently to maintain competency;
- there is no follow-up or post-training skills assessment;
- poor selection of new sites and providers;
- ad hoc training sites;
- lack of follow-up;
- lack of standardized skills; and
- lack of coordination between the training program and the clinical service providers.

The team could not investigate the reasons for these shortcomings in detail, but the underlying cause appears to be the partial and incomplete manner in which VS services and related activities have been institutionalized to date.

VI. RECOMMENDATIONS

VI.1 Introduction

The hallmarks of a mature client-oriented family planning program grounded in reproductive rights are that it “make[s] available a full range of safe and effective methods,” it follows the “principle of informed free choice,” and it works to “ensure a continuing improvement in the quality of services” (UN 1994: para 7.12 and para 7.17). International experience shows that surgical contraception is an appropriate method, and indeed the preferred method of choice, for many couples who are certain they want no more children. Any mature FP program should offer safe and effective surgical contraception services for couples requiring a long-term method.

Since the findings of this assessment will provide a basis for decisions regarding any further support of surgical contraception using USAID funds, the Assessment Team was asked to attempt to formulate recommendations where appropriate. Our recommendations focus on areas involving surgical contraception where we believe improvement will make a significant contribution to quality and choice in the program. The recommendations are directed at issues in the program, and are not specific to STARH. Nonetheless STARH can initiate discussions with BKKBN, DepKes, PKMI, and other partners, regarding these issues; and explore with them how these issues can be resolved, and how STARH support, primarily TA, can be used effectively to this end.

The recommendations fall under four main points. First, there is an urgent need to take immediate action to ensure the safety of clients and providers of surgical contraception services. Second, the team recommends completing the institutionalization process of surgical contraception begun in the early 1990s. Third, rationalize the surgical contraception program components already institutionalized. Fourth, consider ways to

further consolidate and expand services. Service delivery should be expanded only if quality can be assured and the demand for services grows.

We want to stress that these are the recommendations of the Assessment Team, and do not necessarily reflect the views of other organizations involved with FP services in Indonesia. Moreover they have been formulated without any systematic consideration given to cost.

VI.2 Urgent Action Needed to Ensure Quality

Recommendation 1: Convene a task force to design immediate interventions to protect the safety of clients and providers of surgical contraception services.

The quality of services for those couples who do elect for surgical contraception is at present far from satisfactory. Lack of full compliance to clinical standards and other shortcomings are putting the health and safety of clients and providers alike at risk, and while there are no recent documented cases of mortality or serious morbidity resulting from surgical contraception, the unanimous opinion of the medical members of the team is that at the sites visited the risks (to both clients and providers) are unnecessarily and unacceptably high, and are inconsistent with a reproductive rights approach to the provision of services. The poor quality of surgical contraception services is putting the entire family planning program at risk, and is undoubtedly contributing to keeping the demand for these services relatively low.

Immediate intervention is needed to ensure the safety of clients and providers. This intervention will likely be implemented on a “stop-gap” basis, before a more comprehensive and sustainable quality assurance system can be designed and put in place. Surgical contraception services should only be available at SDPs which meet minimum quality standards. This intervention therefore may require a short-term restriction of services; district hospitals should only be allowed to provide surgical contraception when compliance with acceptable standards has been verified. Implementation of the recent ruling that permits female sterilization in *puskesmas* with beds should perhaps be cancelled until an appropriate certification or quality assurance system is institutionalized.

VI.3 Complete the Institutionalization Process

Recommendation 2: Rationalize the current policy concerning surgical contraception and give it equal status with the other “official program methods” (removing its “step-child”), so as to fully integrate and institutionalize surgical contraception within the national program.

In the 1980s and early 90s PKMI was authorized by the GOI to establish all the components needed for a quality surgical contraception program. PKMI did this, with

support from USAID and with TA from AVSC. The arrangement GOI had with PKMI was a temporary measure, not intended to be permanent. An attempt to integrate the surgical contraception program into the national family planning program began in the early 1990s. For various reasons this attempt at institutionalizing surgical contraception was abandoned before all the needed components were in place. Reimbursement on a per case basis, and training, are among the components institutionalized; quality assurance, and counseling at the SDP by medically-trained providers, are among those that are not. The result is a poorly organized system which provides “incomplete” surgical contraception services, and which is unable therefore to guarantee the quality of those services or protect the safety of the client.

Revising the current policy whereby surgical contraception has an ambiguous status in the national program and fully integrating it into the program as an official program method is essential to institutionalizing the method on a long-term sustainable basis. Certainly the ambiguity of its current status is contributing to lack of clear lines of responsibility regarding the quality of services provided.

Sub-recommendation 2a: Consider holding a national conference or workshop to generate consensus around the policy issue of fully institutionalizing surgical contraception; and to consider policy options regarding the balance between the public and private sectors in providing surgical contraception services.

This conference could be sponsored by PKMI, BKKBN, DepKes, Department of Religious Affairs, and STARH; invited participants would include representatives from districts and provinces, and from all concerned ministries, religious groups, NGOs, and donors. The conference should be preceded by a small technical meeting, to set objectives and agenda.

BKKBN’s current policy of, in principle, providing services free needs to be revised in the light of new economic realities. BKKBN’s New Era strategy calls for focusing on demand functions and shedding the provision of services and commodities, except perhaps in the case of for the poor. The Assessment Team did not consider in depth policy options regarding the role of subsidies for surgical contraception services, or the relative balance between the public and private sectors in providing these services. The small technical meeting should perhaps make an initial foray into this area, and put it on the agenda for the national conference or workshop. Institutionalizing surgical contraception as an official program method of equal status with other methods should not be taken to mean that any client can then expect this service on demand free of charge. It is a relatively expensive method, and policies need to be established regarding the extent of subsidies and cost recovery for those who receive it in the public sector.

Sub-recommendation 2b: Consider supporting a Study Tour for a small number of religious/political leaders to selected Islamic countries to study how surgical contraception is institutionalized and reconciled with Islamic law in other settings.

The aim of such a study tour is not so much to try and change anyone's opinion on whether surgical contraception is contrary or not to Islamic law, but rather to collect the tested arguments of respected ulama so the family planning program in Indonesia can advance in ways appropriately respectful of religious thought and practice. UNFPA, we are told, is already considering supporting such a tour. An alternative activity would be to invite one or two religious leaders to Indonesia.

Recommendation 3: Institutionalize an adequate quality assurance (QA) system, including clearly specified lines of authority and responsibility for all QA functions (supervision, monitoring and evaluation, etc.), possibly using some components previously designed by PKMI and modifying them where needed.

At present there is no national surgical contraception QA system in operation, making it difficult to improve and maintain high standards. All the major providers seem to think QA is someone else's responsibility: BKKBN invokes the argument that clinical standards are in general the responsibility of DepKes, and, in the specific case of surgical contraception, of PKMI; DepKes argues BKKBN and PKMI share responsibility for surgical contraception; PKMI says that under the "new arrangement" that came in with SDES they are only responsible for the service components they are funded by BKKBN to implement. There is an urgent need to re-establish a comprehensive national QA system for surgical contraception, covering both providers and SDPs. The QA system should clearly specify standards and guidelines, should clearly specify lines of authority and responsibility for all quality functions, and clearly specify sanctions and procedures in the event of non-compliance to standards.

Recommendation 3a: Consider introducing an accreditation system for sites where surgical contraception services meet appropriate quality standards.

PKMI, working with DepKes and BKKBN, could help establish appropriate site standards, and provide experts to sit on accreditation boards and teams. Sites where laparoscopy is provided need to have a system in place for repairing and maintaining equipment properly.

Recommendation 4: Revisit the medical counseling system designed and used by PKMI until the mid-1990s, institutionalize it (with revisions or adjustments made where necessary), and integrate with non-medical counseling already supported by BKKBN.

Standard international practice requires that for surgical procedures, no matter how extensive the counseling by lay persons prior to the surgery, some counseling at the site should be provided by medically-trained personnel. Again, PKMI designed such a system in the 1980s and implemented it at SDPs where they managed services until responsibility for all components was given to BKKBN in the mid-90s. At this point BKKBN chose to rely solely on its own pre-existing counseling system (where counseling is provided by non-medical personnel) and the system was no longer used.

VI.4 Rationalize Components Already Institutionalized

Recommendation 5: Rationalize the reimbursement system.

Reimbursement by BKKBN for surgical contraception procedures on a per case basis has been institutionalized for over 20 years, and for the last decade has been paid for entirely from GOI's own funds. Periodically the amount reimbursed has been increased to take account for increasing costs and inflation. The amount for tubectomy was raised from Rp 80,000 to Rp 90,000 per case in 2000, and Bappenas has agreed (pending final approval) to a figure of Rp 120,000 for 2001. Actual costs vary in fact by district and by SDP. Local funds are sometimes used to supplement the amount reimbursed. It is generally agreed that the actual total costs of surgical contraception to hospitals almost always exceeds the amount reimbursed, and this encourages staff to "cut corners." A more adequate reimbursement system would lessen the burden on hospitals and help sustain high quality of services. Reimbursement should only be made to facilities which meet specified quality standards. A revised reimbursement system will also have to take into account the exigencies of decentralization.

Recommendation 6: Strengthen the current surgical contraception training system, and introduce a quality improvement process which targets provider performance.

The training system developed by PKMI was better-integrated with other components of the VS program than appears to be the case today, and included more attention to selection of trainees, the equipment and facilities available at their place of work, and included a follow-up monitoring visit to observe their application *in situ* of what they had learned during training. Training needs to be linked to a performance and quality improvement process including:

- Defining a clear trainer and provider development process;
- Defining current standards of care for minilap, laparoscopy and vasectomy. The clinical practice standards have already been developed for both minilap and vasectomy, but the dissemination of these clinical standards has been limited to training activities. So far it has not been extended to include the surgical facilities themselves, or specific offices in BKKBN or regional health departments (DinKes). If the Government plans to support current laparoscopy sites as well as expand to new sites, there is a need to disseminate updated information for that procedure;
- Integrating clinical skills training for surgical contraception into a broader set of interventions for providing quality surgical contraception services (as mentioned in recommendation 3²¹). Traditionally, clinical skills training covers only "provider skills," which are only one aspect of quality services. The training should at least be integrated into training of other hospital staff responsible for maintaining the surgical facility and equipment. IP practices should be

²¹ Historically PKMI developed the quality assurance system out of, and in close relationship with, the training system.

established at the site prior to the training of the provider. Competency-based training introduced more than 5 years ago should be reinforced, and should include immediate post-training follow-up to make sure participants have reached competency level at their respective SDPs.

Recommendation 7: Review, upgrade, and strengthen clinical training sites.

Regionalization of the training system is needed, so core advanced trainers from a recognized Provincial Training Center can be called on to develop additional trainers as well as assist in the training of providers at the district level. The same core group, together with provincial trainers, can coordinate to provide initial follow-up and supervision, as well as assist in setting up an onsite quality improvement mechanism. The clinical training site should:

- Model a practical service delivery point;
- Train support staff;
- Have sufficient case load for the number of participants in a course.

VI.5 Further Consolidation and Expansion of Services

Recommendation 8: Launch a systematic IEC awareness campaign targeted at hospital staff, providers and program staff from DepKes and BKKBN to give all health providers enhanced awareness and updated information about surgical contraception.

There is no need for a high-profile public awareness campaign regarding surgical contraception. However awareness of the method is limited in the population and misconceptions and misplaced fears abound. To overcome this, the team recommend improving awareness and information among family planning and reproductive health service providers, and allowing them to promote surgical contraception alongside other methods to clients already “in the system.” Moreover the campaign should also target personnel who provide surgical contraception or work at such SDPs, and include information regarding maintaining client safety, stressing that the client be seen as a healthy person who should not be exposed to unnecessary risks of complications. Finally the campaign should also increase awareness about the standards for key components of surgical contraception services, including counseling, client assessment, and clinical management of clients. These activities could be phased in, starting with SDPs which already provide the best quality of surgical contraception services, and working out.

Recommendation 8a: Explain the option of vasectomy for couples who know they want no more children in all family planning promotion aimed at increasing the participation of men.

Recommendation 9: Encourage more participation by the private sector, especially through insurance schemes and health maintenance organizations.

In the past, both ASKES (JAMSOSTEK) and ASTEK have been seen as relevant to sterilization provision, but ASKES in practice does not cover this. It is also undergoing administrative changes that may reduce its scope, related to the spin off of voluntary participants as per Regulation 73 of the Ministry of Finance, and the pressures for all state enterprises to be scaled down. However, JAMSOSTEK does cover sterilization, and has a membership of some 2.7 million participants. Inquiries should be made to learn its detailed provisions, and the approximate numbers of its family planning clients including sterilizations of both genders. Adjustments in regulations, procedures, or policies may be possible to enlarge its role.

Health maintenance organizations (JPKM) may emerge as a large force in the private medical sector, and they are quite free to include all family planning services. They now cover perhaps a million participants. Information should be obtained on their experience, with tracking to watch their growth and their actual provisions.

Recommendation 10: Sponsor research where sound policy information and programming are hindered by a lack of knowledge.

Arrange for key studies that will clarify action steps. More information is needed concerning minilap vs. laparoscopy preferences and actions by providers in Indonesia; and while there is a substantial literature about other relevant issues such as interval vs. postpartum, general vs. local anesthesia, specialist vs. GP work, the relevance of this literature for Indonesia has not always been adequately determined yet. Another example, also neglected, is cost/benefit calculations for private insurance plans. More of them, and more companies, would offer family planning methods if the relative gains to the balance sheet were made clear.

Recommendation 11: Expand accessibility to services only when quality can be assured and where there is a demonstrable unmet need.

The taskforce mentioned in Recommendation 1 could begin the job of establishing the standards and conditions which must be satisfied before an SDP can offer surgical contraception services.

VI.6 Summary List of Recommendations

A. Urgent Action Needed to Ensure Quality

Recommendation 1: Convene a task force to design immediate interventions to protect the safety of clients and providers of surgical contraception services.

B. Complete the Institutionalization Process

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Sub-recommendation 2a: Consider holding a national conference or workshop to generate consensus around the policy issue of fully institutionalizing surgical contraception; and to consider policy options regarding the balance between the public and private sectors in providing surgical contraception services.

Sub-recommendation 2b: Consider supporting a Study Tour for a small number of religious/political leaders to selected Islamic countries to study how surgical contraception is institutionalized and reconciled with Islamic law in other settings.

Recommendation 3: Institutionalize an adequate quality assurance (QA) system, including clearly specified lines of authority and responsibility for all QA functions (supervision, monitoring and evaluation, etc.), possibly using some components previously designed by PKMI and modifying them where needed.

Recommendation 3a: Consider introducing an accreditation system for sites where surgical contraception services meet appropriate quality standards.

Recommendation 4: Revisit the medical counseling system designed and used by PKMI until the mid-1990s, institutionalize it (with revisions or adjustments made where necessary), and integrate with non-medical counseling already supported by BKKBN.

C. Rationalize Components Already Institutionalized

Recommendation 5: Rationalize the reimbursement system.

Recommendation 6: Strengthen the current surgical contraception training system, and introduce a quality improvement process which targets provider performance.

Recommendation 7: Review, upgrade, and strengthen clinical training sites.

D. Further Consolidation and Expansion of Services

Recommendation 8: Launch a systematic IEC awareness campaign targeted at hospital staff, providers and program staff from DepKesSos and BKKBN to give all health providers enhanced awareness and updated information about surgical contraception.

Recommendation 8a: Explain the option of vasectomy for couples who know they want no more children in all family planning promotion aimed at increasing the participation of men.

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Recommendation 10: Sponsor research where sound policy information and programming are hindered by a lack of knowledge.

Recommendation 11: Expand accessibility to services only when quality can be assured and where there is a demonstrable unmet need.

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Appendix I

ACTIVITIES OBSERVED BY QUALITY SUB-TEAM BY TYPE OF FACILITY

CLINICAL SITE CATEGORY	ACTIVITIES OBSERVED		PROVINCE	TUBECTOMY		VASECTOMY
	Training	Service		Mini- lap	Laparoscopy	
NGO Clinic			C. Java			
Private Hospital			C. Java			
RSUD ¹			C. Java			
Puskesmas w/ Bed			C. Java			
PTC/ RH Clinic ²			E. Java			
Puskesmas w/ Bed			E. Java			
RSUD			E. Java			
NGO Clinic + Non government Hospital ³			N. Sumatra			
RSUD			N. Sumatra			
Puskesmas w/ Bed ⁴			N. Sumatra			
RSUD			N. Sumatra			
PTC ⁵			S. Su matra			
Private Hospital			S. Sumatra			
RSUD			S. Sumatra			
RSUD			S. Sumatra			

¹ The training observed here was for an Ob—Gyn Resident, 3rd year level, rotating at the RSUD (district hospital)

² No actual training was observed at this PTC (provincial hospital) but met with the training team to discuss training and supervision issues.

³ Classroom activities and clinical practice at the NGO Clinic and VS clinic at the non—government owned hospital.

⁴ Services not observed despite clinical site was provided with equipment and 2 providers (one was subsequently transferred to another facility and the remaining PTT doctor was not confident in performing the procedure) were trained but never followed up.

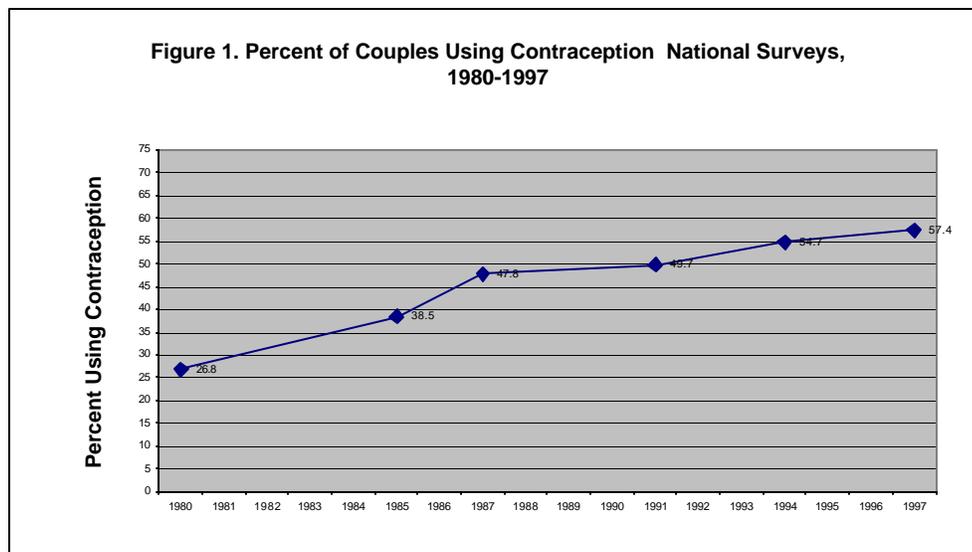
⁵ Training observed here included Ob—Gyn residents providing VS services.

Appendix II

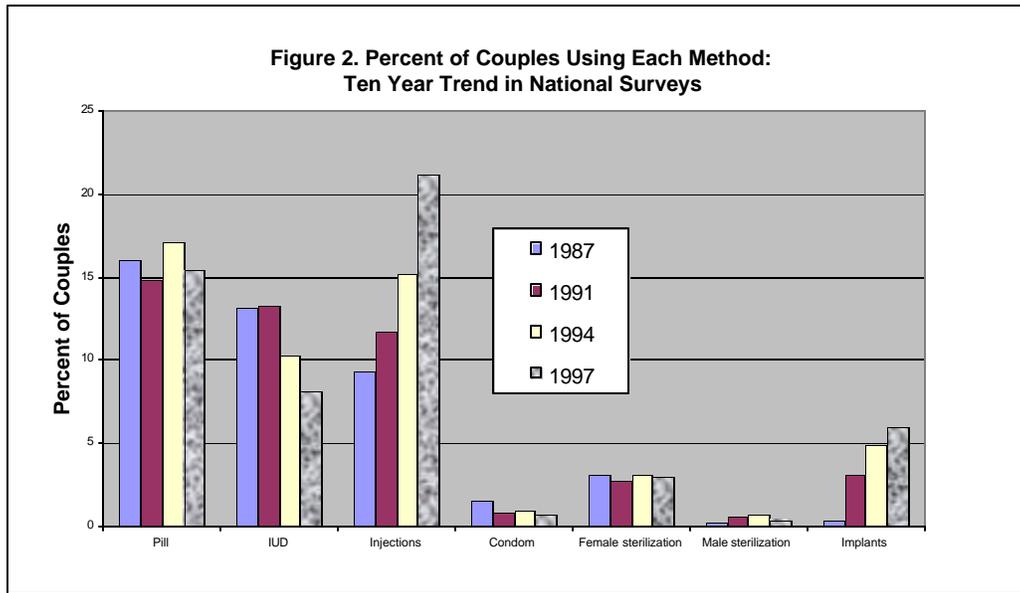
STATISTICAL BACKGROUND: TRENDS IN SURGICAL CONTRACEPTIVE USE IN RELATION TO OTHER METHODS

A brief statistical overview (taken from Lubis and Ross 2001) is provided in this appendix, to show overall levels of surgical contraception use (referred to as voluntary sterilization, or VS, in the figures), together with provincial differences and future burdens upon services. Each point is accompanied by a numbered figure with relevant data.

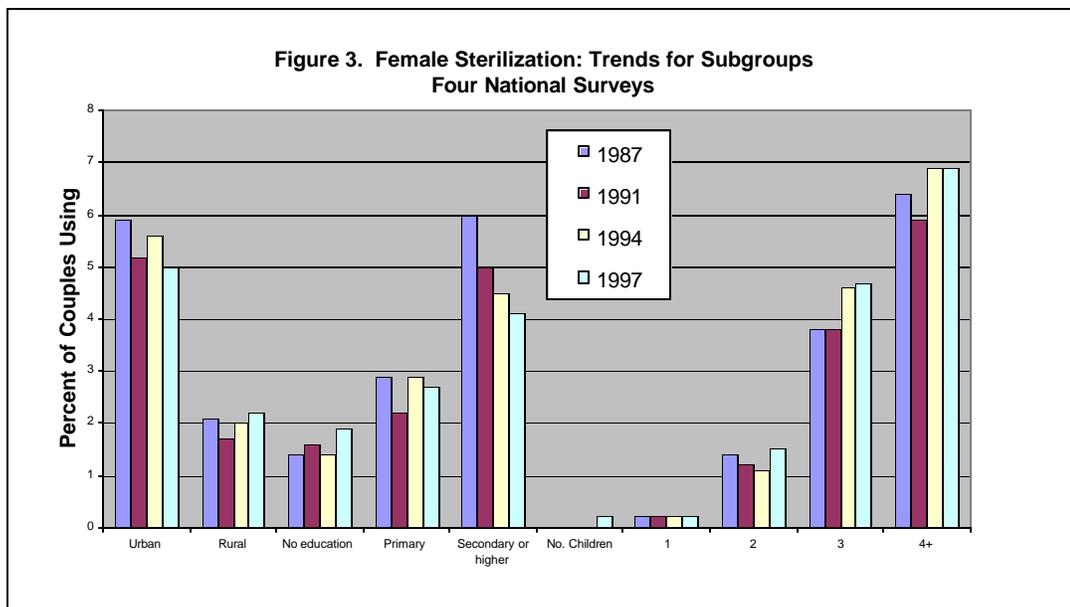
1. The use of all contraceptive methods in Indonesia grew rapidly from 1980 to 1987 but only gradually thereafter. On average, prevalence of use grew by only 1 per cent annually over the 10 years from 1987 to 1997. International comparisons suggest that one reason is the small contribution of surgical contraception, since very few countries attain a high level of prevalence without a substantial VS contribution.



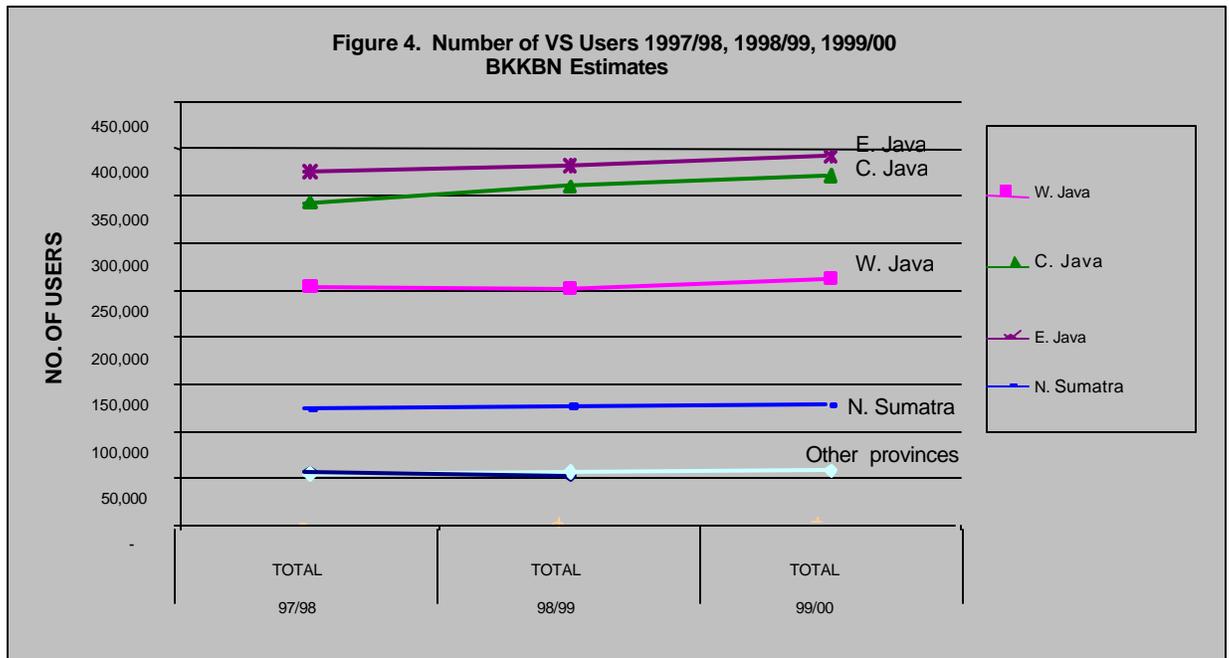
2. The ten-year history of the method mix shows the popularity of the pill, and the rapid growth of the injectable. Meanwhile IUD use has declined, while implant use has risen (though only to about 6% of couples). The condom and male and female sterilization have remained at very low levels.



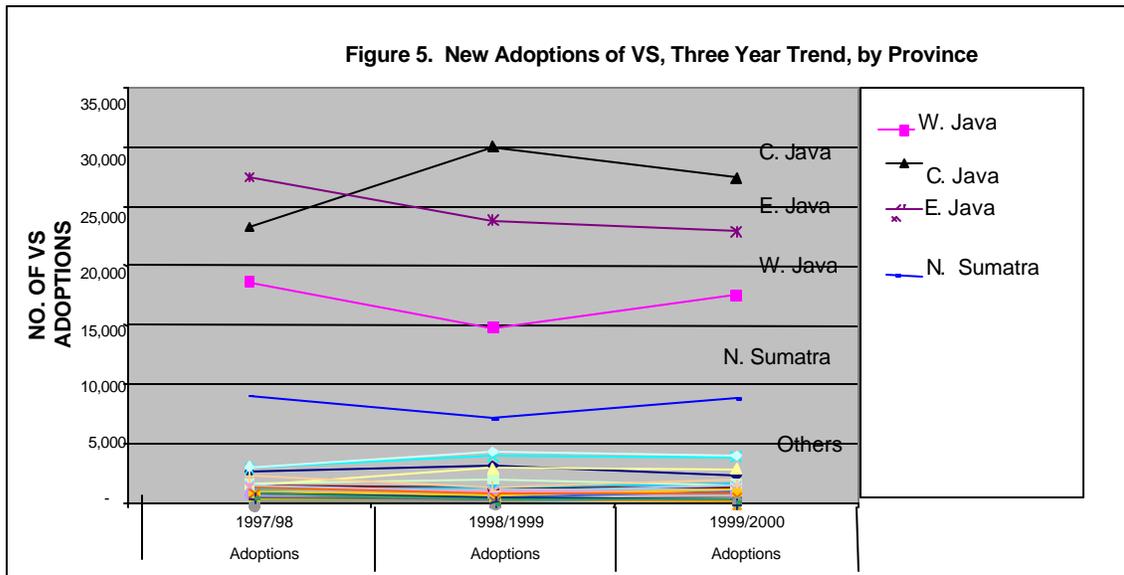
- Reliance upon surgical contraception varies from one subgroup to another: more in urban areas, and more in the higher primary and secondary education groups (the decline in the secondary group may reflect a preference for the IUD and injectable, apparent in the 1997 DHS survey). The sharpest gradient follows family size: VS use rises from about 1 per cent at two children to about 7 per cent at four or more children.



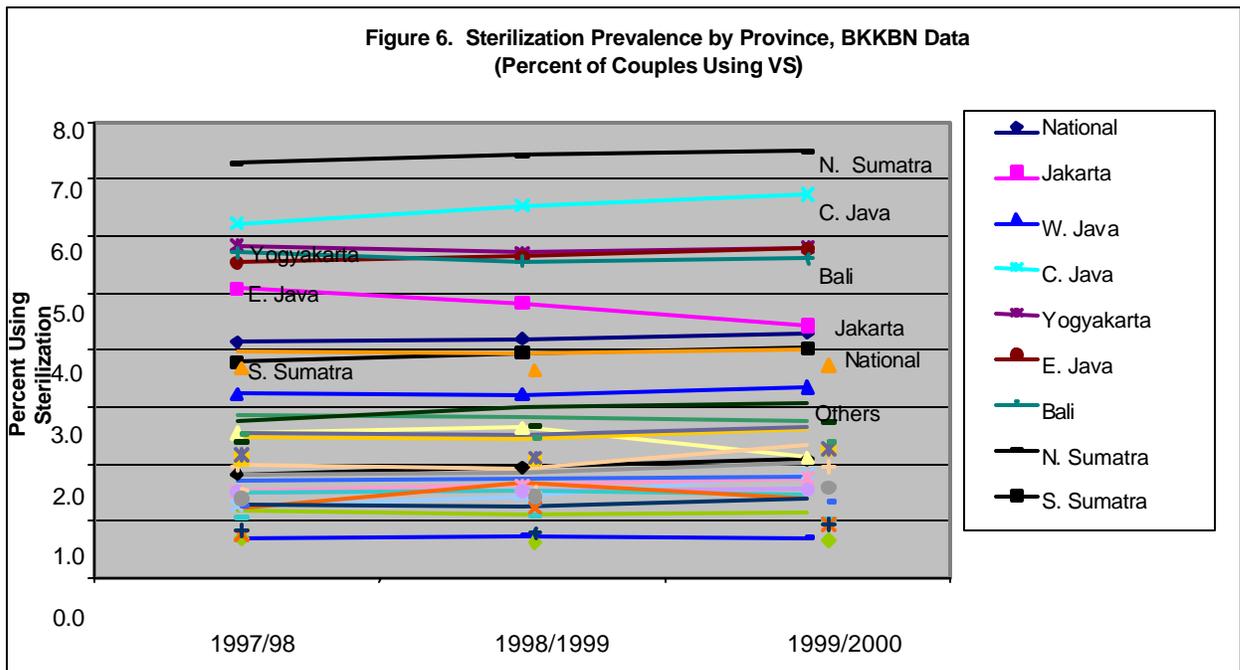
- According to BKKBN data, the number of VS users in the country has remained approximately level in the recent 3-year period. Small gains appear in East, Central, and West Java, but none in North Sumatra; elsewhere most patterns are level and low.



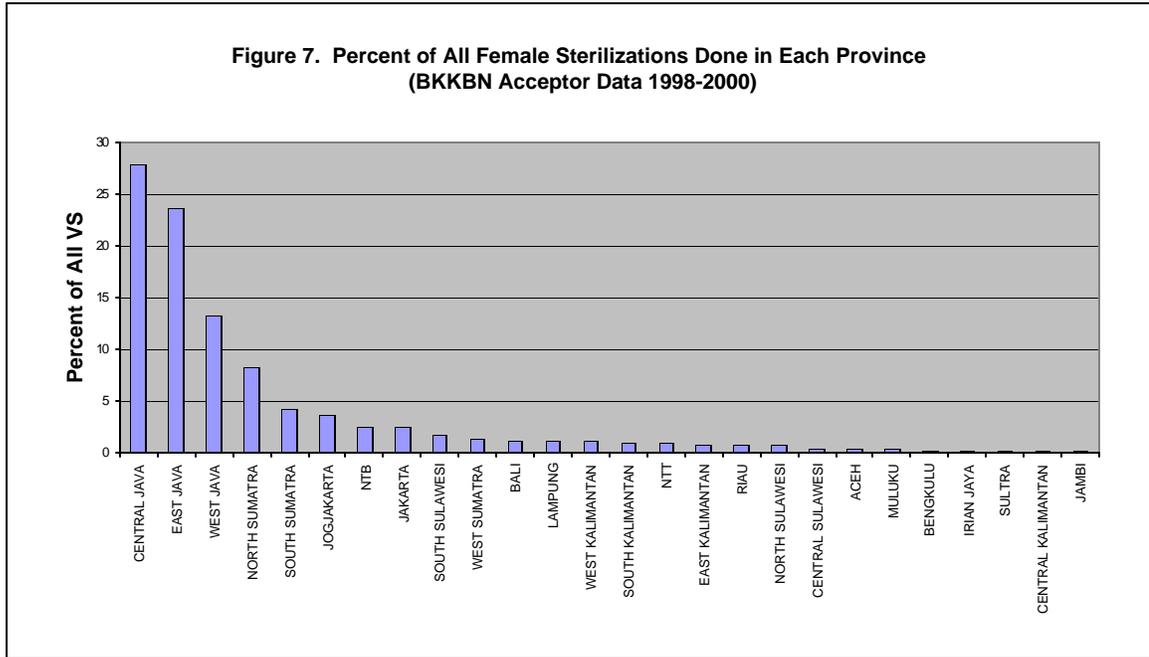
- New adoptions of surgical contraception also show little gain. The same four provinces dominate the picture as for current users, and there is no clear sign of increase. The smaller provinces contribute only a few thousand new adoptions annually.



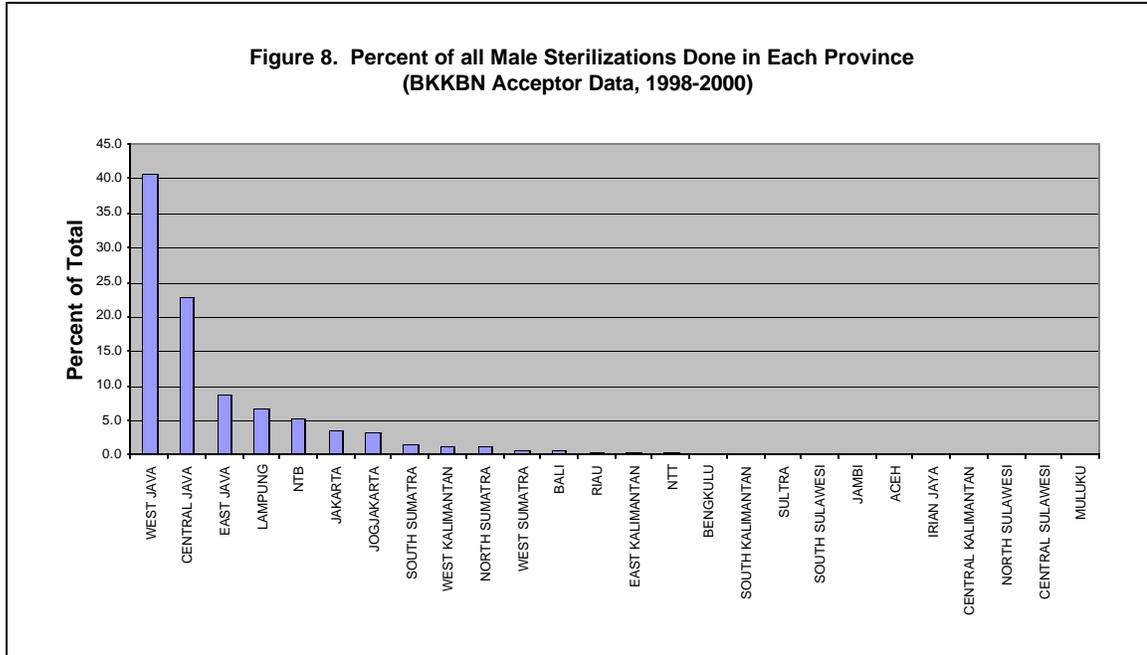
6. The provincial ordering is different for the *percentage* of couples using VS, rather than the numbers doing so. North Sumatra now ranks first, and Yogyakarta, Bali, and Jakarta rank much higher than before. However Central and East Java are still prominent. West Java is lower, with only about 3 per cent of couples using the method according to the BKKBN data.



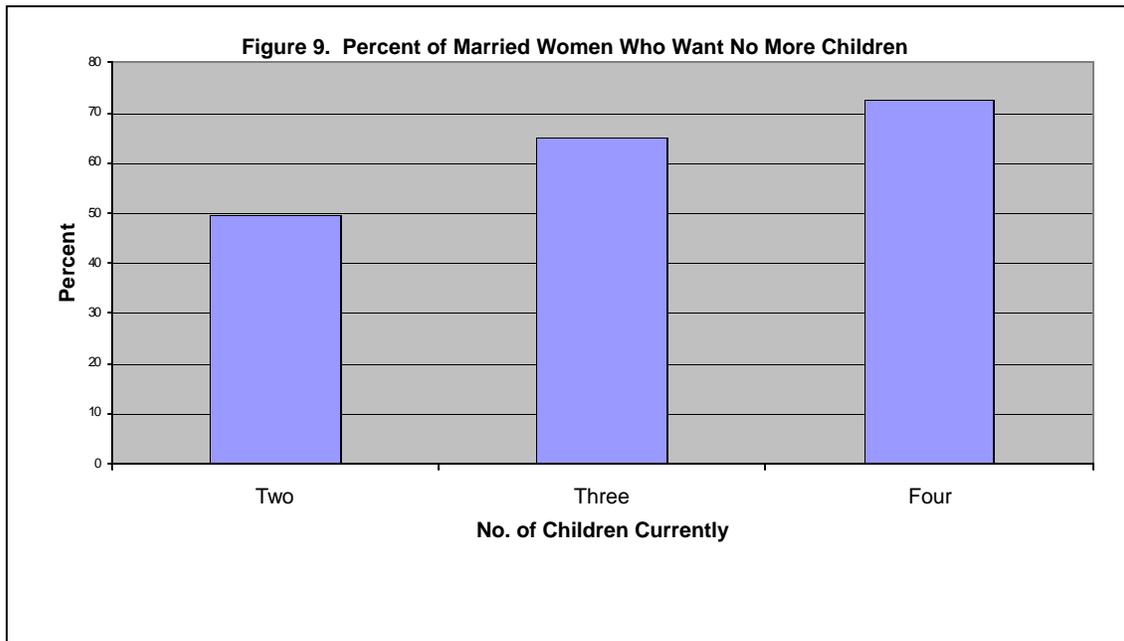
- The total volume of female VS adoptions is highly concentrated in four provinces: Central, East, and West Java and North Sumatra. The first two have half and the four have nearly three-fourths of all VS procedures, respectively. The other 22 provinces have the rest. (This suggests one strategy to address the neglect of VS is to focus on the areas – *kabupaten* as well as provinces – where it is already known and services are active, and build on the lessons learned in these areas.)



- As with female VS adoptions, male adoptions are also very concentrated. West Java alone has about 40 per cent of the total, Central Java has another 22 per cent, and East Java has about 8 per cent, totaling over two thirds of the total. Note that the adoption *rate* is rather low everywhere; this pertains only to the geographic distribution of the procedures done.

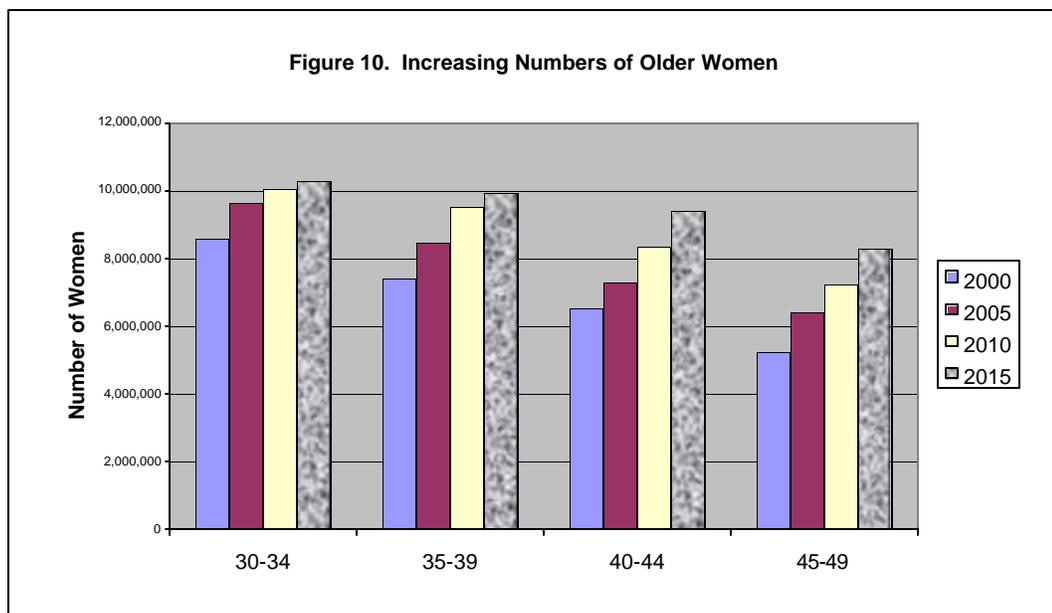


9. The need for a long-acting method is notable in the context of many couples wanting to cease childbearing. Half of married women with only two children want no more. Two-thirds of married women with three children wish to stop, 70 per cent of those with three children, and even more at higher parities (not shown). Many women with two or three children are still young, and need a method with automatic, long-term continuation.



10. That reality is posed against the growing burdens for services to come. The rise in the numbers of women over the next fifteen years will be very substantial. At ages above 30 many women have finished their childbearing and still face some 15 years of needed protection from unwanted pregnancies.

- i. The age group 30-34 will grow by one-fifth (19%), adding about 1.5 million women.
- ii. The age group 35-39 will grow by one-third (34%), adding about 2.6 million women.
- iii. The age groups at 40-44 and 45-49 will grow by 45 per cent and 59 per cent respectively, adding over 6 million together.



11. The public share of services needs to decline, considering these large populations and the increasing proportions who will be using some contraceptive method. In fact the public share has declined for the resupply methods – the pill and injectable, and for the condom (rather little use). However the public sector continues to carry the main load for all long-acting methods, at about 70 per cent of users. The implant (not shown) was also at 71 per cent in 1997. Any efforts to increase the use of surgical contraception should note the double reality of reliance on the public sector and rising numbers, while also trying to encourage greater private sector participation.

Figure 11. Changing Public Share of Contraceptive Supply Over 6 Years

