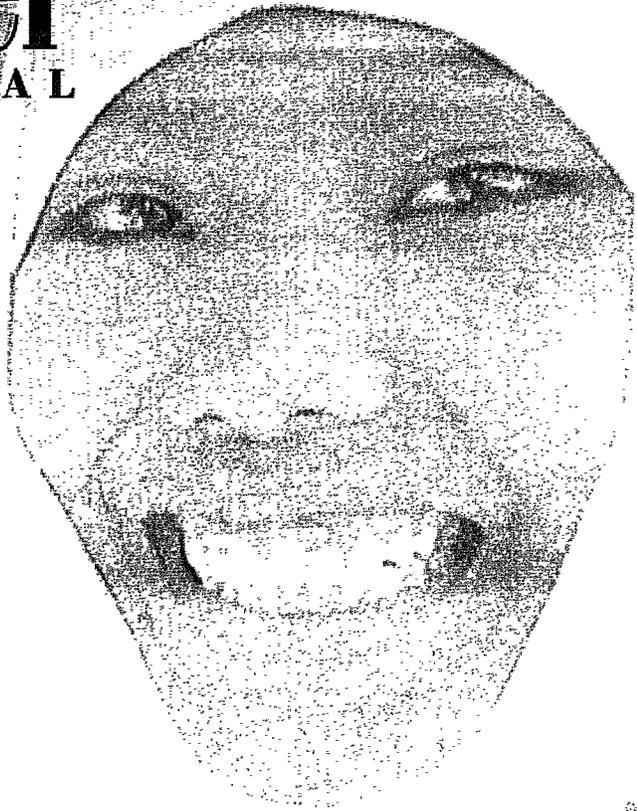
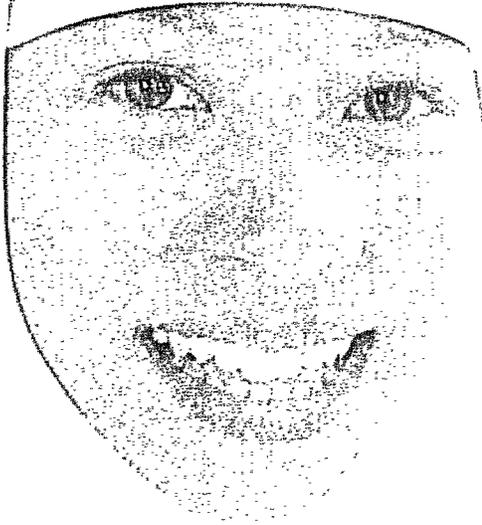


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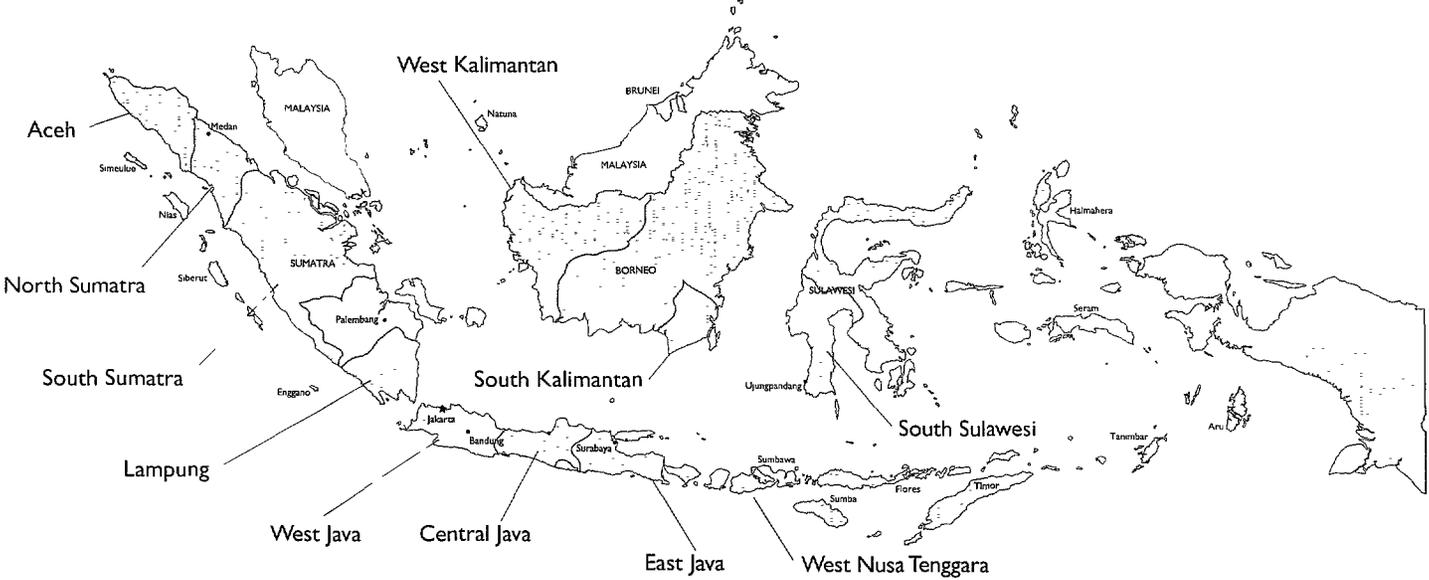
# Service Delivery Expansion Support (SDES) Project:

## Expanding Family Planning Services in Indonesia

Report of Achievements  
1994-1997

AUTHORS:  
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# Indonesia SDES Provinces



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# PREFACE

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This report documents the success of SDES in working from the ground up to build support for family planning in Indonesia with community and religious leaders and women's groups, to increase access to family planning services in hard-to-reach areas, to improve the quality of services, and to strengthen the institutional capacity of the government and NGO sectors to respond to the country's contraceptive needs.

As the use of modern contraception steadily increased in Indonesia over the past three decades, family size concurrently declined. To illustrate this significant shift, in 1994 the total fertility rate dropped to 2.8 per family from 5.6 just 20 years previously. Yet, beneath these national statistics, there exist major provincial variations, vast urban and rural discrepancies, and changing method preferences. SDES initially targeted seven provinces (later adding four more) with low contraceptive use, especially long-term methods, and limited access to services. In particular, SDES focuses on underserved and hard-to-reach communities due to geographic, social, or economic exclusion.

The goal of SDES is to increase the overall use of contraceptives in these provinces by improving service availability at the local level through the following strategies:

- Building community awareness and acceptance of contraceptive use, especially long-term methods;
- Strengthening community health posts and distribution systems;
- Improving provider knowledge and skills; and
- Increasing the capability of private sector organizations and practitioners to provide quality family planning.

At the midterm point of the project, SDES has fostered a culture of innovation at the local level by targeting hard-to-reach communities with specific programs and by working closely with provincial BKKBN officials. Community-based and women's associations and local volunteers, for example, played a key role in building acceptability of family planning services among hard-to-reach populations. In rural areas, in particular, the training of midwives in both the public and private sector paid off in an increased availability and acceptance of a wider range of contraceptive methods. In addition, increasing the service delivery capacity of both mature and emergent NGOs and improving the coordination between public and private sector providers have been key components in improving access to hard-to-reach communities.

Increasing use of long-term methods has been a particular challenge for SDES. The obstacles are complex, including limited access and availability, prevailing attitudes or beliefs, religious opposition, lack of or inconsistent political support, sociocultural stigma associated with certain methods, and poor-quality services.

Additional areas for improvement include developing long-term strategies to strengthen the participation of the private and NGO sectors, generating a wider commitment to improving quality, expanding the understanding of client rights within BKKBN, and integrating essential health services at the village level.

The midterm review indicates that SDES has expanded support to the private sector, increased access to services, improved coordination between the public and private sectors, and created a demand for high-quality services. With the further expansion of SDES in years three and four, the impact and sustainability of a community-based strategy can be more thoroughly evaluated.

# ACKNOWLEDGMENTS

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This report was developed using a collaborative process between Pathfinder International and USAID to highlight the impact of the Service Delivery Expansion Support (SDES) Project in Indonesia. USAID played a key role in the conceptualization of SDES and has provided technical guidance and support to Pathfinder and BKKBN throughout the project. The authors in particular wish to thank Leslie B. Curtin, Chief, Office of Population, Health and Nutrition, USAID/Jakarta, who has overseen the project since its inception, and Lana Dakan, Technical Advisor for FP and RH, USAID/Jakarta.

This document reports on a large and multifaceted project. The authors thank the SDES grantees in Indonesia, including BKKBN and local NGOs, for providing much of the information and data that made this assessment possible. They are the implementors of SDES on the ground and deserve much credit for the work they are doing to improve the quality of family planning services and the lives of women and couples in Indonesia. In particular, the authors would like to recognize the project directors and staff from BKKBN South Sulawesi, the Indonesian Midwives Association (IBI), and the Indonesian Planned Parenthood Association (PKBI), for their contributions to this report, and to the communities that so graciously hosted our visits.

In addition, the authors thank the USAID Cooperating Agencies working in Indonesia, including JHPIEGO, JHU/PCS, AVSC International, The Population Council, and the University Research Corporation, all of which have contributed to the SDES project in various ways. The collaborative work accomplished under SDES has been critical to the project's success. Thanks also goes to Pathfinder headquarters and country office staff for their time and input into this document. In particular the authors would like to acknowledge Dr. Does Sampoerno, Sumengen Sutomo, Penelope Riseborough, Tom Fenn, Douglas Huber, Wendy Swirnoff, Leah Gay, and Stacy Schwandt.

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Elizabeth Fabel, MPH, and Lynette Johnson, MA

# ACRONYMS & TERMS

<b>BKKBN</b>	<i>Badan Koordinasi Keluarga Berencana Nasional</i> National Family Planning Coordination Board
<b>Baruga</b>	<i>Balai Keluarga</i> , family center
<b>Bidan</b>	midwife
<b>Bidan di Desa</b>	village midwife (public sector)
<b>CBD</b>	community based distribution
<b>DHS</b>	Demographic and Health Survey
<b>DTC</b>	District Training Center
<b>IAKMI</b>	Indonesian Public Health Association
<b>IBI</b>	Indonesian Midwives Association
<b>IDI</b>	Indonesian Doctors Association
<b>IEC</b>	information, education, and communication
<b>IPADI</b>	Indonesian Demographers Association
<b>IPC/C</b>	interpersonal communication/counseling
<b>IPPA</b>	Indonesian Planned Parenthood Association
<b>ISI</b>	Indonesian Sociologists Association
<b>ISFI</b>	Indonesian Pharmacists Association
<b>IUD</b>	intrauterine device
<b>JHU/CCP</b>	Johns Hopkins University/Center for Communication Programs
<b>JSI</b>	John Snow, Inc.
<b>KB Mandiri</b>	self-reliant family planning
<b>KS</b>	<i>Keluarga Sejahtera</i> , family welfare
<b>Kabupaten</b>	district
<b>Kecamatan</b>	sub-district
<b>LTM</b>	long-term method (VS, IUD, and implant)
<b>MOH</b>	Ministry of Health
<b>MWRA</b>	married women of reproductive age
<b>NCTN</b>	National Clinical Training Network
<b>NGO</b>	non-governmental organization
<b>NRC</b>	National Resource Center
<b>PAKBD</b>	<i>Pos Alat KB di Desa</i> , village contraceptive distribution post

<b>PKMI</b>	Indonesian Association for Secure Contraception
<b>PLKB</b>	<i>Petugas Lapangan Keluarga Berencana</i> , family planning field worker (employed by BKKBN)
<b>POD</b>	<i>Pos Obat Desa</i> , village medicine post
<b>POGI</b>	<i>Perkumpulan Obstriki dan Gynokologi Indonesia</i> Indonesian Obstetrics/Gynecology Association
<b>PPKBD</b>	<i>Petugas Pembantu Keluarga Berencana di Desa</i> , volunteer family planning field worker at the village level
<b>PTC</b>	Provincial Training Center
<b>Pesantren</b>	religious boarding schools
<b>Polindes</b>	<i>Pos Bersalinan di Desa</i> , village birthing post
<b>Posyandu</b>	village integrated health post
<b>Puskesmas</b>	<i>Pusat Kesehatan Masyarakat</i> , public health center, district level
<b>TBA</b>	traditional birth attendant
<b>SDES</b>	Service Delivery Expansion Support
<b>SDP</b>	service delivery point
<b>URC</b>	University Research Corporation
<b>USAID</b>	United States Agency for International Development
<b>VS</b>	voluntary sterilization

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# INTRODUCTION AND BACKGROUND

Indonesia, the fourth most populous country in the world with more than 200 million people, faces a great challenge. Since the early 1970s, the Government of Indonesia has supported a national family planning program that combines national-scale organization with community participation to promote contraception for a two-child norm. This program has been credited with achieving a remarkable reduction in Indonesia's total fertility rate from 5.6 children per woman in 1967-70, 2.8 in 1994, to 2.7 in 1997.<sup>1</sup> Sustaining this success as 34 percent of the population enter their childbearing years requires expanding the program to reach all Indonesian couples with family planning information and services, especially in remote regions, and improving the quality and choice of services available to all.

Following the 1994 International Conference on Population and Development in Cairo, Indonesia expanded its family planning policy to embrace a broader concern for the reproductive health of women and couples. Despite successes in family planning, Indonesia's maternal mortality rate remained high, with national estimates ranging from 390<sup>2</sup> to 650 maternal deaths per 100,000 live births.<sup>3</sup> This situation called for wider access to reproductive health and safe motherhood services along with family planning to achieve Indonesia's goals for improved family welfare.

In order to attain the Government of Indonesia's goal of bringing the country's total fertility rate down to 2.1 children per couple by the year 2005, its program is challenged to identify and serve areas of unmet need for family planning and reproductive health services. In this archipelago of more than 17,000 islands—covering 1.9 million square kilometers and inhabited by myriad ethnic, religious, and linguistic communities—achieving equitable access to health services is no small task. It requires strong coordination between the public and the private sectors, fair distribution of resources, and leadership and political support from the national level to provinces, districts, and communities.

In response, the United States Agency for International Development (USAID) launched the Service Delivery Expansion Support (SDES) Project in 1994. As a funding mechanism, SDES was designed to support the efforts of the Government of Indonesia to augment the reach and quality of public sector family planning services and to increase the role of the private and non-governmental sectors in the National Family Planning Program. The five-year project is implemented by Pathfinder International in 11 provinces through the Indonesian National Family

**S**DES was designed to support the efforts of the Government of Indonesia to augment the reach and quality of public sector family planning services and to increase the role of the private and non-governmental sectors in the National Family Planning Program.



Planning Coordination Board (BKKBN). SDES was introduced in seven provinces in 1994 and expanded to four additional provinces in 1996.

SDES was designed to enhance the role and sustainability of BKKBN and the private sector by increasing service delivery capacity, improving program quality, and promoting public-private sector collaboration. SDES builds on Pathfinder's historical role in Indonesia to pilot and expand programs to improve the access and quality of family planning, while simultaneously strengthening BKKBN's ability to link community education and outreach with public and private health services.

This document presents third-year midterm achievements in the seven provinces where the SDES program was initiated in 1994. Data are drawn from the 1994 and 1997 Indonesia Demographic and Health Surveys and BKKBN and Pathfinder International service statistics as of June 1997.<sup>4</sup> The purpose of the document is to assess the effectiveness of SDES at its third year midpoint, and to guide future directions of the program. Understanding the contribution of SDES to reducing fertility can also help to identify the ingredients for success and replication of the SDES strategy in other countries with mature family planning programs.

The document presents a brief history of family planning in Indonesia, provides an overview of the objectives and strategies of the SDES program, and reports third-year midterm achievements toward the four program objectives. The final section reviews the trends in fertility and contraceptive use from the 1994 and 1997 Indonesia DHS, highlights the lessons that can be learned from the program's first three years, and suggests future directions.

## Family Planning in Indonesia

The public sector is the primary provider of family planning and reproductive health services in Indonesia. In 1970, the Government launched a National Family Planning Program in response to growing concern about rapid population growth. BKKBN was established to coordinate family planning service delivery through both governmental and non-governmental agencies.

Indicator	1971	1980	1990	1995	1997
Population (in thousands)	119,210	147,490	179,380	194,750	201,400
Growth Rate <sup>1</sup>	not available	2.32	1.98	1.66	1.57
% urban population <sup>1</sup>	17.4	22.3	30.9	35.9	36
% under age 15 <sup>1</sup>	44	40.9	36.5	33.9	33.5
% of women marrying under age 16 <sup>1</sup>	not available	31.2	24.9	21.5	15.9
Life expectancy at birth <sup>2</sup>	45.7	52.2	59.8	64.4	64.7
Infant Mortality Rate/1000 live births <sup>3</sup>	145	109	74.2	66.4	52.2
Maternal Mortality Rate/100,000 births <sup>3</sup>	not available	not available	404	390	not available
Contraceptive Prevalence Rate <sup>4</sup>	< 10	26	49.7	54.7	57.4
Total Fertility Rate <sup>5</sup>	5.6	4.7	3	2.86	2.76

**Table I**  
Demographic  
Profile of Indonesia  
1971-1997

### **National Family Planning Coordination Board (BKKBN)**

BKKBN is the primary governmental organization responsible for coordinating the National Family Planning Program, including the distribution of contraceptives. Its 33,000 field workers (PLKBs) and an even larger cadre of volunteer field workers (PPKBDs) serve the important function of providing information, education, and outreach in close coordination with the government health facilities, run by the Ministry of Health. Under BKKBN, Indonesia developed a model of village-based family planning to serve its primarily rural population. Several early innovations remain central to Indonesia's family planning program in the 1990s. These include the creation of midwife delivery posts at the village level, called *polindes*; village contraceptive distribution posts or *PAKBDS*; family planning information posts managed by community volunteer cadres; and village integrated health posts, called *posyandu*, run by women community leaders.

BKKBN's mandate has expanded considerably since its inception. In recent years, BKKBN has embarked on a "family welfare" movement (*Keluarga Sejahtera* or *KS*) which includes family health education, income generation activities, and micro savings and credit programs to increase the self-reliance of Indonesia's poorest communities. Over the years, the BKKBN program has evolved from a centrally-managed government program to one that encourages innovation by provincial BKKBN offices and depends on the participation of local communities and the private sector.

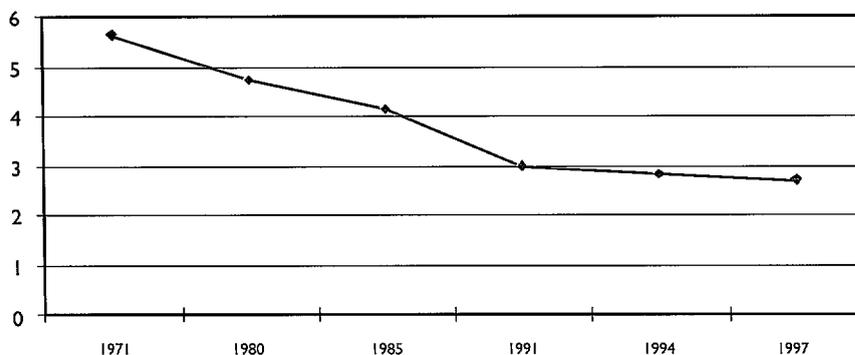
As community demand and capacity to pay for contraceptives increased, the Indonesian program sought to foster a complementary relationship between public and private services. The private sector—including pharmacists, midwives and doctors, and NGOs—is playing an increasingly significant role in service delivery. At the outset of SDES in 1994, the percentage of clients receiving services through the private sector had grown to 28 percent, up from 11 percent in 1987.

### **Population and health trends**

The positive impact of the National Family Planning Program on contraceptive use and fertility rates is undisputed. Analyses of the Indonesian program attribute much of its success at reducing fertility to strong political support, well-developed and decentralized service delivery infrastructure and systems, and community participation based on a traditional system of mutual self-help.<sup>5</sup> Social marketing and community and religious leader endorsement of important messages helped to

**T**he BKKBN program evolved from a centrally-managed government program to one that encourages innovation by provinces and depends on the participation of local communities and the private sector.

**Figure 1**  
**Total Fertility**  
**Rate, Indonesia**  
**1971-1997**



Over the past three decades, modern contraceptive use by Indonesian couples has steadily increased, which has been matched by declines in family size.

increase popular demand for and build acceptance of family planning. The Government of Indonesia's strong emphasis on primary education, as well as socioeconomic development, also contributed to positive attitudes toward family planning. By 1994, Indonesian women were staying in school longer, joining the formal labor force in growing numbers, and marrying and bearing children later in life. In 1994, women between the ages of 45-49 married at a median age of 17.2, while women aged 25-29 married at a median age of 19.2.<sup>6</sup>

Over the past three decades, modern contraceptive use by Indonesian couples has steadily increased, which has been matched by declines in family size. In 1994, the year that SDES was initiated, the total fertility rate (TFR) had declined to 2.8 children per family, compared to 5.6 in 1971. Fertility declined for all age groups, with an accelerated decline among younger women, shifting the peak age of childbearing from women aged 20-24 to women aged 25-29. The use of modern contraception—less than ten percent in 1971—stood at nearly 55 percent in 1994.<sup>7</sup>

Underlying these broad national trends, however, were provincial variations, wide urban and rural differentials, and shifting method preferences. 1994 DHS figures reflected the gaps still to be addressed by the National Family Planning Program:

- There was a large differential in fertility between provinces, from a total fertility rate (TFR) of 2.14 in Bali to 3.88 in North Sumatra, one of the seven original SDES provinces.
- Urban women were closer to the national two-child ideal, with an average of 2.3 children, while rural women had an average of 3.2 children.
- Urban women married two years later than rural women and women who had attended secondary school married more than five years later than women with some primary education.
- The proportion of current users who used long-term methods remained steady at approximately 34 percent since 1990 and counts of new users of long-term methods, such as implants, IUDs, and voluntary sterilization (VS) plateaued or only marginally increased in some provinces.

### **Meeting Indonesia's needs**

Throughout Indonesia, there is significant need for a range of family planning methods that offer long- and short-term contraception. In 1994, 91 percent of married women of reproductive age (MWRA) expressed a need for family planning. Of these, 48 percent indicated that they wanted no more children and 43 percent wanted to wait to have more children (14 percent within 2 years, 25 percent after 2 years, and 4 percent unsure about the timing). At the same time, only 54.7 percent of MWRA were using contraception, of which only 34.7 percent used a long-term method.<sup>8</sup> These numbers reflected substantial unmet need, reported to be at 11 percent in 1994, with equivalent needs for limiting and spacing methods.<sup>9</sup>

Despite a well-developed health system and infrastructure, the majority of births in Indonesia are performed at home with the help of traditional birth attendants (TBAs), and only rarely with the assistance of professionally-trained midwives. Midwives are increasingly becoming the largest providers of family planning in both the public and private sector, and have the potential to provide both long- and short-term family planning methods. In addition, they can provide an essential point of contact for postpartum women with family planning needs. Yet low utilization suggests that midwife services are not available to all, and where available, may be underutilized for both births and family planning services.

The SDES project was introduced to support BKKBN efforts to expand and strengthen its service delivery systems to meet the needs of Indonesian couples for family planning. At the outset of SDES, BKKBN faced substantial challenges in achieving increased contraceptive use among hard-to-reach populations; reducing the high percentage of unmet need for long-term family planning among women over 25; and improving the quality and availability of all contraceptive methods. Worldwide experience indicates that the goal of reaching an average two-child family size by the year 2005 would require an increase in contraceptive use to a national average of 70 percent. To achieve this, the National Family Planning Program would have to serve an estimated additional 5-6 million new family planning users each year for the next 10 years and maintain the 22-24 million current users per year.<sup>10</sup> With contraceptive use already high at 54.7 percent, BKKBN recognized the need to improve the quality, choice, and availability of contraceptives in order to increase acceptance further and reduce drop-out rates. It also realized that improving the sustainability of the national program, and the contributions of the private sector, would be critical for making these improvements throughout the country.

**W**hen SDES began, BKKBN faced three challenges: achieving increased contraceptive use among hard-to-reach populations, reducing the high percentage of unmet need for long-term family planning among women over 25, and improving the quality and availability of all contraceptive methods.



## OVERVIEW OF SDES

### SDES Strategies

- Targeting underserved districts and communities
- Addressing barriers to access
- Replicating innovations
- Building sustainable institutions

With the goal of assisting the Government of Indonesia in reducing the total fertility rate to 2.1 by the year 2005, SDES has four major objectives:

- Increase the availability of and information about all modern contraceptive methods in hard-to-reach areas
- Increase the availability, utilization, and quality of contraceptive service delivery, particularly for long-term methods
- Improve the sustainability and coverage of family planning services delivered through the public and private sectors
- Increase the role of the private and non-governmental organization (NGO) sectors in family planning service delivery

### Implementing SDES

Pathfinder works with the BKKBN central and provincial offices and a number of NGOs to implement SDES. BKKBN's Bureau of Planning is Pathfinder's primary counterpart for implementing and managing SDES grants to eleven BKKBN provincial offices, six service delivery NGOs, and four professional organizations. Through these partners, SDES has supported the following activities:

- Information and outreach to communities and religious leaders to build awareness of family planning
- Equipping and upgrading private and public clinics to increase the availability of services at provincial, district, sub-district, and village levels
- Strengthening and expanding alternative service delivery models such as community-based, work-based, and mobile services, to increase access for hard-to-reach communities
- Providing standardized training to midwives and other clinical providers in the provision of long-term methods, including counseling, to improve quality
- Developing appropriate media and messages to increase the acceptability of long-term methods

Province	Total # of Districts	# of SDES Districts	% of districts covered by SDES
Central Java	26	14	50%
East Java	35	22	55%
West Java	37	24	60%
Lampung	17	13	75%
South Sulawesi	10	8	80%
North Sumatra	7	7	100%
South Sumatra	23	12	50%

**Table 2**  
District coverage in SDES provinces

- Implementing models for quality assurance and project management to increase sustainability
- Strengthening the capacity of BKKBN provincial branches and non-governmental agencies to improve coordination and management of service delivery

Pathfinder plays an important role in ensuring collaboration between the SDES grantees and the activities of a number of U.S.-based international organizations working in family planning and reproductive health in Indonesia, including AVSC International, JHPIEGO, JHU/CCP, JSI (MotherCare), the Population Council, PROFIT, and University Research Center (URC). Areas of collaboration have included the development of a National Clinical Training Network (see page 31), quality improvement initiatives, IEC development, organizational development, income generation, and maternal and child health.

## Targeting Underserved Districts and Communities

Seven provinces were selected for the introduction of SDES with the goal of having an impact at the national level. The main criteria for selection of provinces were large population size and density. Together, the seven SDES provinces—Central Java, East Java, West Java, Lampung, South Sulawesi, North Sumatra, and South Sumatra—represent roughly 70 percent of Indonesia’s population. Additional criteria included advanced family planning programs with pockets of low contraceptive use and evidence of high unmet need, particularly in geographically remote or inaccessible mountainous and coastal regions.

Within these seven provinces, the project targeted SDES support to districts with low contraceptive use, particularly of long-term methods, and where access was limited. Due to the selection criteria, most of the areas targeted for SDES support are rural, although some include urban slums. Out of a total of 155 districts in the seven provinces, 100 were selected for SDES support. The percentage of districts covered in each province ranges from 50 percent in South Sulawesi to 100 percent in Lampung. Within these districts, SDES targets pockets of underserved and hard-to-reach communities with contraceptive use rates below the district average.

The seven SDES provinces—Central Java, East Java, West Java, Lampung, South Sulawesi, North Sumatra, and South Sumatra—represent roughly 70 percent of Indonesia’s population.

**Table 3**  
Demographic profile of  
SDES provinces,  
1994 & 1997

Method	Population*		% Urban		TFR		CPR		IMR	
	1994	1997	1994	1997	1994	1997	1994	1997	1994	1997
Central Java	28,521	29,653	27%	32%	2.77	2.64	61.1	62.4	51.1	45.2
East Java	32,504	33,844	27%	32%	2.22	2.33	55.9	61.1	62.1	35.8
West Java	35,384	39,207	34%	43%	3.17	3.03	56.7	57.6	88.8	60.6
Lampung	6,018	6,658	12%	16%	3.45	2.91	59.3	66.5	38.1	48.2
South Sulawesi	6,982	7,558	24%	28%	2.92	2.88	42.6	41.5	63.7	63
North Sumatra	10,256	11,115	35%	41%	3.88	3.74	47	46	61.4	45.2
South Sumatra	6,313	7,207	29%	30%	2.87	2.64	52.9	57.9	59.6	53

\*(in thousands)

**V**ariations in the ethnic, religious, linguistic, economic, and geographic composition of the provinces call for innovative approaches to service delivery.

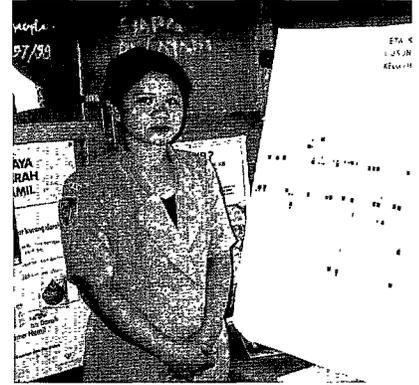
Although the provinces share the same family planning service delivery infrastructure and systems, variations in their ethnic, religious, linguistic, economic, and geographic composition call for innovative approaches to service delivery—particularly for hard-to-reach populations and areas. Economic forces such as industrial growth, women’s increasing participation in the formal labor force, and large-scale transmigration from Java to less densely populated outer islands pose additional challenges. Indonesia’s family planning program must deliver services to an increasingly mobile and migratory population.

## Addressing Barriers to Access

Given Indonesia’s geographic, ethnic, and linguistic diversity, BKKBN recognized that it needed to be more flexible and responsive to local conditions and cultures. For this reason, SDES focused on strategies for delivering services to hard-to-reach communities—those with reduced access to health care services due to geographic, social, or economic marginalization. Hard-to-reach is often defined as geographically isolated, but it can also refer to groups of the population that are marginalized or have strong cultural or religious characteristics that are less accepting of modern health and family planning services.

Implementing these strategies required strengthening BKKBN at the provincial level, increasing the capacity and involvement of the private sector, and addressing barriers to use of family planning, especially long-term methods. These barriers included:

- ***Uneven distribution of services.*** Many hard-to-reach areas lacked reliable access to family planning services, including coastal, mountainous, industrial, trans migratory, slum and urban poor locations.
- ***Uneven quality of services, particularly for long-term methods.*** Despite a well-developed and decentralized health infrastructure, service quality varied from province to province and among service delivery sites. Many facilities were substandard and lacked an adequate choice of services, while many providers did not have the clinical skills and knowledge base to provide long-term methods. Few providers were adequately trained to manage complications or provide counseling.



- **Limited availability and utilization of long-term methods.** The availability and utilization of LTMs (IUD, implants, and VS) was low throughout the country, especially in hard-to-reach areas. Limited access, a lack of information, real and perceived poor quality of services, and religious and cultural beliefs all contributed to low demand and use of LTMs.
- **Underutilization of village midwives.** In a national effort to reduce maternal mortality, the Government trained and deployed more than 50,000 village midwives (*bidan di desas*). Their effectiveness, however, was limited by inadequate training in clinical and counseling skills, lack of acceptance by their assigned communities, and insufficient local resources to support their services.
- **Untapped potential of the private sector.** The capacity of the private sector, including NGOs, private clinics, and pharmacies, to expand access to family planning and reproductive health services for clients who can pay and for hard-to-reach populations, has been largely untapped.

## Replicating Innovations

SDES serves as a mechanism for provinces to pilot and replicate innovative approaches to service delivery that could not be otherwise implemented under the standard government program. For example, in South Sulawesi the provincial BKKBN expanded the concept of the local *baruga*, a family center that serves as a meeting place for health, education, community meetings, and events (see *Spotlight on South Sulawesi*, page 17). *Barugas* were replicated throughout the province in non-SDES districts with funding from the local government and communities as well as in two other SDES provinces, South Sumatra and South Kalimantan.

In 1996, BKKBN requested that the project be expanded to four additional provinces: South Kalimantan, West Kalimantan, Aceh, and West Nusa Tenggara. The primary objective of this expansion was to replicate successful interventions initiated in the seven SDES provinces. These four provinces were selected because they have some of the highest populations after the original SDES provinces, high fertility, and low contraceptive use, especially of long-term methods, yet also have a family planning infrastructure strong enough to replicate

*BKKBN family planning field workers, such as Petugas Lapangan Keluarga Berencana in South Sulawesi, keep village maps to track family planning users.*

**S**DES serves as a mechanism for provinces to pilot and replicate innovative approaches to service delivery that could not be otherwise implemented under the standard government program.

key interventions within the three remaining years of the project. South Kalimantan was chosen as a partnership between SDES and the USAID-funded MotherCare project that is working to improve maternal health and reduce maternity mortality. In South Kalimantan, SDES provides an important linkage between reproductive health interventions, improved use of midwives, and postpartum family planning.

## Building Sustainable Institutions

SDES is putting sustainable systems in place for clinic management, training, and IEC development by enhancing the financial and program management capacity of the institutions that deliver services from the national to the provincial to the district levels. In addition, Pathfinder, through SDES, increases the self-reliance of both the public and the private sector by providing direct funding to provincial offices, rather than going through the central BKKBN, as well as by direct funding to mature NGOs.



## **Non-Governmental Organizations: Key Players in SDES**

### **Service delivery agencies**

The *Indonesian Planned Parenthood Association (IPPA)*, an International Planned Parenthood Federation affiliate, began providing family planning services in 1967, before the national program was established. IPPA runs a network of comprehensive satellite clinics throughout Indonesia and is known for its pioneering work in providing effective family planning and reproductive health services.

The *Indonesian Association for Secure Contraception (PKMI)* is the first agency to offer information, provider training, and client services for voluntary sterilization. PKMI is the leading organization in supporting VS services, IEC and outreach, and policy development and coordination at the national level.

*Nahdlatul Ulama (NU)* and *Muhammadiyah* are two national Islamic organizations that provide family planning and health services to their respective member communities. These agencies have played a critical role in increasing awareness and acceptance of family planning among religious leaders and communities throughout Indonesia.

### **Professional associations**

The *Indonesian Midwives Association (IBI)* was founded in 1951 as a professional organization. Its membership has swelled in recent years to 67,000 midwives. SDES collaborates with IBI to strengthen midwife capabilities by implementing key interventions that target midwives, including the development of IBI clinics as referral sites, resource centers, and apprenticeship and training sites.



Ob/Gyns and midwives staff this IDI clinic in Vjing Pandang in South Sulawesi.

The *Indonesian Doctors Association (IDI)* has played a role in the National Family Planning Program to increase its members' awareness of family planning, to improve their knowledge and skill development in the provision of family planning, and to assist IDI members in obtaining the equipment and supplies needed for family planning services.

The *Indonesian Pharmacists Association (ISFI)* supports greater involvement of pharmacists in the National Family Planning Program through the private sale of contraceptives in pharmacies and village distribution posts.

#### **Academic organizations**

In addition, the *Indonesian Public Health Association (IAKMI)*, the *Indonesian Demographers Association (IPADI)*, and the *Indonesian Sociologist Association (ISI)* provide demographic and sociological research to support family planning programs.



# Increasing the availability of and information about **ALL MODERN CONTRACEPTIVES IN HARD-TO-REACH AREAS**

## Improving and Equipping Village Health Posts

One concrete way in which SDES expands access to family planning is by increasing and improving the number of local sites at which women and couples can obtain a wide range of services. SDES has provided sizable funds for the renovation, refurbishing, or construction of new facilities, including government clinics at district and sub-district levels, village health posts, and private practice and NGO clinics. These facilities are designed, or redesigned, to be more client-friendly, with clean and bright waiting areas, private rooms for exams and counseling, and by maintaining infection prevention standards. Many facilities received access to electricity and running water for the first time.

In some settings, an existing clinic is expanded so it can serve more clients and offer additional services. For example, equipping and upgrading a clinic's facilities so that it can provide long-term methods, such as IUDs, implants, and VS, enables it to serve women with birth-limiting needs. In other settings, new clinics bring to peri-urban or island communities access to a level of quality and services previously unavailable in their areas. For example, clinics based at factories and plantations have increased availability and convenience for workers and their families.

In addition to strengthening 600 government clinics and 630 village health posts, SDES supported the introduction or improvement of 250 private practice and NGO clinics to improve access and quality, primarily in geographically hard-to-reach districts (see Figure 2, page 14). Many of these NGOs have a mission to serve remote and needy areas or particular populations such as Christian or Muslim communities. In South Sumatra, for example, clinics of several religious organizations are being strengthened to better reach Muslim populations. Services delivered by these NGOs are thus more socially acceptable to their constituencies.

## Expanding Community-Based Services

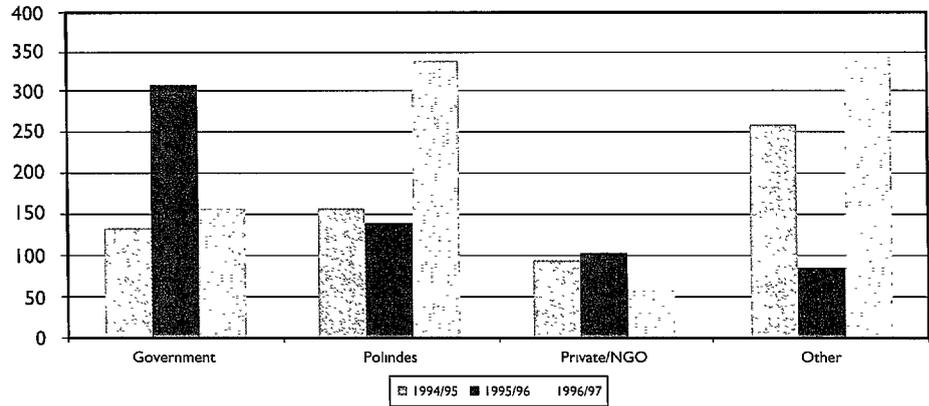
In addition to improving sites where people receive clinical services, SDES has supported the development and expansion of the community-based distribution (CBD) model. Pathfinder works with the Indonesian Pharmacists Association to support self-reliant village contraceptive distribution posts (PAKBD) and networks of village medicine posts (POD) in several SDES provinces.



*SDES areas in North Sumatra include hard-to-reach coastal and island districts, riverbank slums, and industrial complexes. Government clinics in these areas lack basic facilities and have minimal cleanliness. With SDES support, BKKBN has improved the facilities of many of these clinics and developed midwife posts that are attractive and welcoming to clients. BKKBN has also concentrated outreach efforts on rubber, palm oil, and coffee plantations.*

**Figure 2**  
Service delivery points improved, SDES, 1994-1997

\*Other refers to family planning information posts and village contraceptive distribution posts



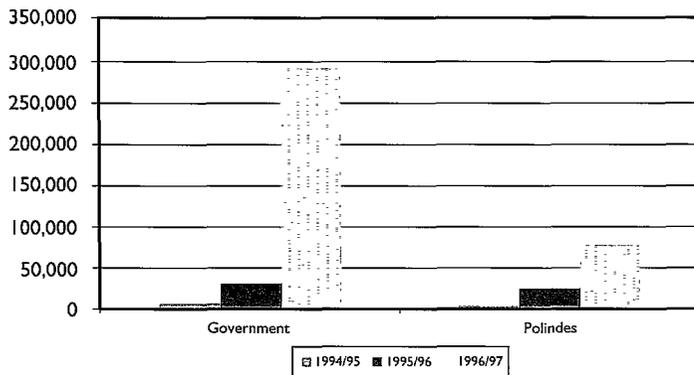
*In Central Java, residents of urban slums had little or no access to clinics or information about family planning methods. These poor neighborhoods generally lack the community network and volunteer system of family planning field workers—key to the program's success in rural areas. With SDES support, BKKBN developed IEC targeted to the urban poor and strengthened the field worker network to conduct outreach to slum areas.*

This model is being replicated in other provinces to increase private sector distribution of contraceptives and the self-reliance of the family planning sector overall.

SDES supported the establishment of 688 village contraceptive distribution centers and family planning information posts as a way to enhance community involvement and access to information and contraceptives in hard-to-reach areas. In many communities, these posts may be the only immediate source of contraceptives or information about family planning. Figure 2 shows the number of government health centers, village health posts (including *barugas*), and private and NGO clinics which have been built or renovated in the first three years of SDES, as well as the number of village contraceptive and medicine distribution centers and family planning information posts. The figures reflect the SDES project's emphasis on strengthening local-level distribution and services through both the public and the private sector.

## Increasing Community Participation

In keeping with the government's emphasis on community participation in its National Family Planning Program, the first year of SDES focused on building community support through local orientations, the involvement of local leaders, and the development and distribution of information, education, and communication (IEC) materials about long-term methods. To support the service delivery component of SDES, many BKKBN and NGO volunteer family planning workers provide information, referrals, and follow-up advice in coordination with the government and NGO clinics. Under SDES, many of these volunteer cadres have received training in IEC and play an important role not only in helping couples to use family planning, but in informing people about where to go for services. SDES has enhanced the role and motivation of the volunteer field worker by providing training in IEC and counseling. In three years, more than 236,000 people, including volunteer field workers, participated in community orientations run by BKKBN staff and field workers. Over 3,200 TBAs in several provinces also received basic education about family planning and how to identify and refer high risk pregnancies.



**Figure 3**  
Service Visits  
in SDES provinces,  
1994-1997

## Strengthening Alternative Delivery Systems

In addition to strengthening fixed-site local service delivery posts, SDES has introduced or expanded alternative systems for mobile service delivery to increase community access to information, contraceptives, and other reproductive health services. Within each province, SDES identifies and targets geographically hard-to-reach areas, many of which require mobile services to ensure regular access to and utilization of family planning. SDES provides the funding for these mobile services as well as technical assistance to monitor coordination, quality, and cost-effectiveness. BKKBN's cadets and volunteer field workers play a central role in organizing the community for mobile team visits and in coordinating with providers.

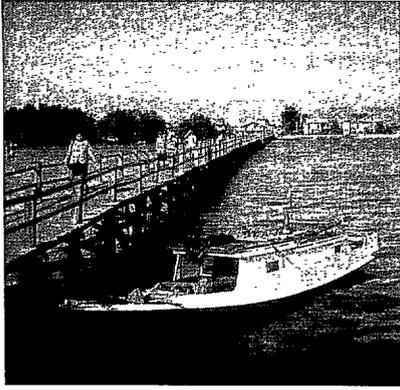
Mobile teams carry doctors and midwives from provincial or district clinics to remote areas by van or boat. In addition, specialist visits include a team of Ob/Gyns who can provide sterilization services that are not regularly offered in a particular area, due to the lack of trained providers and proper facilities.

In several provinces, SDES-supported floating clinics staffed by doctors, midwives, and counselors, regularly provide a full range of family planning and reproductive health services on board. Floating clinics provide services to remote islands where services and providers are limited. Along riverbank areas, small boats transport teams of providers to villages where long-term method services are not available. Close coordination with BKKBN staff and field workers is key to organizing the community so that they know when the boat will arrive and what services it provides.

Village midwives, although based at a *polindes* (midwife village post), are often responsible for a large coverage area. Midwife outreach visits into the community have been instrumental in increasing midwives' familiarity with the communities they serve, which in turn, increases community acceptance of their role. Midwife visits are especially important for reaching women who need postpartum care and family planning, but who rely on TBAs for delivery and postnatal care. Midwife visits are usually organized together with local BKKBN volunteers. In some provinces, the midwives work closely with TBAs to reach postpartum women in their homes. This collaboration encourages women to seek the services and advice of midwives for pre- and postnatal care as well as for labor and delivery and postpartum family planning.



*In Central Java, SDES activities are focused on hard-to-reach coastal, border, and slum areas. In these areas, SDES mobile teams deliver services, at times traveling by motorcycle to places difficult for cars to pass. Coastal locations, where fisherman spend long periods of time away from their wives, are also targeted by mobile teams. These women are less likely to use family planning because their husbands disapprove of its use during their frequent absences.*



*In South Sulawesi, SDES has focused on ways to reach people living in island and coastal sub-districts using floating clinics. SDES has introduced a fleet of small boats to transport midwives and doctors to inter-island areas where access to services is limited. On the island of Selayar, SDES has strengthened government clinics and village midwife posts to provide services to the island population, complementing services provided by the floating clinic.*

SDES support to IBI and BKKBN to train and retrain village midwives and for mobile and home-based services by midwives has contributed to an increased availability of all contraceptive methods in hard-to-reach areas. In the first three years of SDES, 5,730 midwives were trained in IUD and implant insertion and removal and more than 4,500 were trained to improve their counseling skills.

With SDES support, the increase in high-quality mobile services and midwife visits has improved access to a wider range of contraceptives in hard-to-reach areas. It also increased fieldworker and clinical provider contact with the communities they serve and with local providers, such as TBAs. The results—better availability and utilization of services—have heightened the motivation of BKKBN and private clinics to extend family planning and other reproductive health services into these underserved areas.

Women's groups, NGOs, and religious organizations often conduct special health events, often in concert with community events or festivals, to offer maternal and child health and family planning services, as well as community education. These groups and organizations work with BKKBN and providers to organize and offer services during these special occasions. The festive atmosphere promotes community participation and awareness.



### **Spotlight on South Sulawesi: Piloting Innovative Approaches to Delivering Family Planning Services**

South Sulawesi had the lowest rate of contraceptive use among all of the SDES provinces (42.6% in 1994) with an average of 3 children per couple. Three years into the project, South Sulawesi's TFR has declined to 2.8, but it still faces a struggle in increasing contraceptive use in hard-to-reach areas. Funds from SDES enable BKKBN to innovate at the province and district level and challenge them to find ways to serve the more hard-to-reach communities—urban slums, small islands and seasonally inaccessible mountain areas.

Dr. Victor Trigno has been the chief of the South Sulawesi BKKBN provincial branch since 1979. With SDES support, Dr. Trigno brought to fruition his idea for developing “*barugas*”—community buildings that serve as a home base for village midwife services—and a place for community meetings and income-generating activities. Communities pitch in to build the *barugas* to create a sense of shared ownership and partnership with the midwife who lives and provides services there. Subsequent maintenance and upkeep of the *baruga* is the responsibility of the local community. In turn, BKKBN workers ensure that the *baruga* is equipped with family planning supplies and information, and assist the midwife so all community members receive counseling.

Attenbre Tenri (pictured right) had been a practicing midwife for 20 years when she was posted from a district health center to work at *baruga* Amaliah. This *baruga* was built with seed funding from SDES and with community labor in an urban slum area of Ujung Pandang, the capital of South Sulawesi. Midwife Attenbre prefers working in the *baruga*.

*“I am able to get to know more about people in the community here, in a way that was not possible at the health center,” she says. “By working closely with one or two women, we are able to introduce new methods very effectively...like the IUD. There was much fear in this community about the*



*Attenbre Tenri, a practicing midwife at baruga Amaliah in South Sulawesi.*

*IUD. People thought it could travel through your body and kill you. But we were able to counsel one woman extensively about the method and gave her plenty of information. Once she had agreed, the procedure was done and it did not hurt her. Then, when she went back to her area, she discussed the method with her friends. They also became interested in the method. Though this is a slower way to introduce new methods, I have found it to be effective in this community."*

In South Sulawesi, the *baruga* model has provided an important boost to the village midwife program that made health services available locally. In addition to providing family planning, midwives offer prenatal care, labor, delivery, postpartum care, nutrition, and care of infants and children under five. The idea caught on quickly. There are now more than 600 *barugas* throughout South Sulawesi, 59 of which were built with SDES support in the first three years of the project. Based on their success, the model was replicated by communities and local governments throughout the province, as well as in two other SDES provinces.



# Increasing the availability, use, and quality of LONG-TERM METHODS

## Improving the Method Mix

Improving the method mix, especially access to safe and high quality long-term methods (LTMs), was a major emphasis of SDES. The success of a family planning program depends on its ability to provide methods that meet women's changing family planning needs. Increasing client access to a full range of methods helps to ensure that women have multiple choices to select from: whether they wish to defer childbearing, space their desired children, or stop having children altogether. At the outset of SDES, 48 percent of currently married women in Indonesia did not want more children, and another 43 percent wanted to delay their first or next birth – figures which held steady through 1997.<sup>11</sup> LTMs need to be part of the available mix not only to ensure that all clients are able to make free and informed choices but also because they clearly have a high impact on fertility reduction.

SDES activities to improve the overall method mix and the availability, use, and quality of LTMs had these goals:

- IEC to improve knowledge of the IUD and NORPLANT
- Community campaigns with the endorsement of major Islamic and Christian organizations to build acceptance of LTMs
- Provider training to improve clinical and non-clinical skills in delivering LTMs
- Counseling clients to make a safe choice

## Addressing Barriers to Long-Term Method Use

There are significant barriers to increasing use of some LTMs in Indonesia, including clients' lack of knowledge and providers' lack of skills. In many areas, especially traditional Muslim and Christian communities, certain family planning methods are not fully accepted. There is a particular social stigma connected to IUDs and sterilization—methods that require provider access to a client's most private body parts. Field workers and providers report that clients feel "ashamed" about accepting an IUD, which requires insertion and follow-up checks. Misinformation also leads to rumors and myths about IUDs and VS, making them less popular than other options.



*Madura island in East Java is known for its population of devout Muslims, whose leaders play an important role in community affairs. SDES activities in Madura are concentrated on gaining the commitment of these religious leaders by supporting community outreach, working through Koran reading groups and other gatherings, and developing IEC materials, called kyais, that contain quotes and citations from the Koran by famous Islamic leaders.*



*Male voluntary sterilization makes up less than one percent of all contraceptive use in the country. BKKBN Lampung embarked on an IEC effort to educate and motivate men about the benefits of this method by training satisfied vasectomy clients to provide information about the method to members of their respective communities. The users then conducted home visits in their villages to inform and counsel others.*

With time, the increased role and acceptance of private and village midwives—trained under SDES in the insertion and removal of implants and IUDs—may lead to increased acceptance of both methods. As the midwife becomes known to and trusted by the community, women will become more willing to approach her for services they would be otherwise embarrassed to receive from an unfamiliar or male provider. SDES has also sought the involvement and support of the religious community to provide leadership from the national to the local level in changing attitudes toward family planning in general, and long-term methods in particular.

### **Enhancing Providers' Skills**

Providers' attitudes toward family planning methods, their attitudes toward clients, and their skill at offering different methods all influence client choice. A provider's bias toward a particular method may disincline him/her to counsel a client about the full range of contraceptive options. Furthermore, some clients, even with complete and accurate information and counseling, defer to the provider to determine what is best for them. Private providers who rely on client volume for income may have a financial incentive to steer clients toward methods which require repeat visits, such as injectables or the pill, in lieu of those with a one-time cost, like implants, IUDs, or VS. SDES aims to reduce provider bias by training in counseling and improving skills and knowledge. By providing intensive, standardized, and high-quality training for midwives and physicians, SDES raises the confidence and ability of these providers to deliver the service that clients want, to provide it well, and to capably manage complications and follow-up.

In collaboration with JHU/CCP, SDES introduced a new Interpersonal Communications/Counseling (IPC/C) curriculum training module into the national family planning program. Training in this new curriculum assists field workers and providers to interact more effectively with clients to ensure that women and couples choose a method that best meets their needs and preferences.

Through PKMI, the SDES project has continued to support a system for identifying and counseling clients for VS. In this IEC protocol, field workers and midwives identify clients who are interested in VS; screen them to ensure that their needs, preferences, and medical histories match the criteria for sterilization services; inform them of the benefits, procedures (including that the method is permanent) and contraindications; refer them to a VS service facility, often accompanying them to the hospital or clinic; and follow-up with clients after the operation.

## **Creating Effective IEC**

Lack of knowledge about long-term methods is a serious barrier to increased use. While the SDES project improves the quality of service delivery points and the skills of providers to serve long-term method users, demand will not grow without accurate information about these methods. Rumors and myths travel quickly and service providers and family planning managers require materials to correct misperceptions.

In collaboration with SDES, JHU/CCP introduced the “P-Process” to improve the capacity of field program managers to develop effective IEC materials. The P-Process is a five-step participatory approach to developing IEC materials that involves the target audience and potential users of IEC in their design, pre-testing, redesign, and evaluation. SDES supported training for BKKBN staff and NGO managers from the SDES provinces in how to design, produce, and evaluate IEC materials, taking into consideration the demographic, geographic, economic, social, attitudinal, and cultural characteristics of their audience. Decentralizing these skills to the provincial level enables project managers to develop instructional materials based on the real needs of the communities in specific project areas. NGOs also gained the ability to produce materials that were specific to their organizational missions and target populations.

SDES has developed a number of IEC tools that provide complete and accurate information for clients on LTMs as well as other FP/RH messages. Colorful flipcharts used by field workers and providers work well to counsel clients. A variety of posters with information about LTMs are displayed at service delivery points and in strategic locations within the community. Leaflets are distributed in clinics to clients interested in learning more about specific contraceptives. Radio and television spots include commercial messages about LTMs and where to obtain services, as well as longer dramas which tell stories about the benefits of using family planning.

SDES has also supported the development of IEC materials for different levels of providers. For example, guidebooks for community leaders and field workers have been produced to increase awareness about LTMs and to instruct how to best inform and counsel potential clients. In collaboration with JHPIEGO, technical service guidelines on infection prevention and clinical services have also been developed. Other manuals on clinic management, quality improvement, IEC outreach, and recording and reporting are used by service providers in both public and private clinic settings.

**W**hile the SDES project improves the quality of service delivery points and the skills of providers to serve long-term method users, demand will not grow without accurate information about these methods.



*In West Java, SDES is working with the Indonesia Workers' Association in four industrial districts to set up family planning information posts in factories to provide IEC to workers, many of whom are young women. Most recently, the provincial BKKBN has begun rigorous community education about the health risks of early marriage and childbearing by developing special IEC materials and by targeting religious leaders who perform wedding ceremonies and are in a position to encourage young couples to postpone marriage and childbearing.*

Together these IEC materials have sparked client demand for family planning while dispelling myths and rumors that may dissuade potential clients from learning about and using specific methods. Most importantly, the IEC materials are used by the people who design them and are backed by interpersonal communication.

## Improving Quality

Improving quality in a large national family planning program the size of Indonesia's is a major challenge, particularly as access points become more widely distributed. Implementing and monitoring quality improvements is a major emphasis of the SDES project. Under SDES, quality improvements have focused on strengthening provider skills, increasing the accuracy of information given to clients, assuring that an appropriate constellation of services is available to clients, improving clinic management, and upgrading the physical facilities at service delivery points. Working in collaboration with other USAID cooperating agencies, Pathfinder is coordinating an effort with BKKBN to develop a quality assurance model for family planning in catchment areas near government health posts.

While expanding access to services and improving the method mix theoretically increase client choice, many providers and field workers still promote the method most favored in the government program at any given time. Although BKKBN has switched from a target-driven program to one of demand fulfillment, performance requirements placed on provincial and district officials tend to bias clients toward the selected "methods of choice" in public sector clinics. In recent years, considerable progress has been made in eliminating activities that are not conducive to real informed choice, such as family planning service campaigns that provide services to a large number of clients in one setting. In their place, SDES supports local events that provide information and education about different methods and where to get them.

Family planning quality is also improved through the provision of equipment to support delivery of surgical methods and through renovations to make facilities more appropriate and attractive to clients, such as providing more private areas for counseling and exams. Under SDES, considerable resources were devoted to introducing and improving local health posts to increase the availability and quality of family planning services.



In addition, improving providers' skills has greatly contributed to the quality of services delivered. The establishment of the National Clinical Training Network (see page 31) as a means to promote national standards in family planning provision is a key intervention of SDES geared toward better quality. By funding the clinical training of midwives and doctors in voluntary sterilization and IUD and implant insertion and removal skills, SDES is raising the overall quality of family planning services in both the private and public sectors. Through SDES, more than 9,000 providers, including physicians and midwives, were trained in VS and IUD and implant insertion and removal.

Under SDES, BKKBN has also put more emphasis on the provider's role in client education, promoting informed choice, and the importance of counseling. The standard for service in Indonesia has traditionally been top down, with the provider telling the client what is best without encouraging any kind of dialogue. SDES has responded by training providers as well as community educators who make home visits and lead group sessions to improve knowledge about family planning and, similarly, to better understand the attitudes and interests of clients. In addition to the clinical skills training noted above, nearly 21,000 physicians, midwives, and community workers were trained in counseling.

SDES has instituted several mechanisms to encourage continuity, including better client counseling on side effects and follow-up visits. Follow-up is conducted through field workers and village midwives who resupply clients as appropriate, counsel on side effects, and make referrals when needed. SDES has also implemented interventions to increase access to resupplies (condoms, pills, and injectables for distribution by midwives) through village contraceptive and medicine posts, floating clinics, mobile teams, village midwives, and TBAs. Under SDES, over 3,100 service providers and managers were trained in many aspects of clinic and project management and topics related to organizational development.

SDES promotes an appropriate constellation of services at a wide range of delivery points to make them convenient and acceptable to clients. SDES supports hospitals, government clinics, private physicians and midwives, village midwives, NGO clinics (in both urban and rural settings), and village contraceptive posts, and encourages referral linkages between the service points. Most SDES-supported NGO clinics recognize that they will not become sustainable just providing one type of service and thus offer a comprehensive range of maternal

*This midwife from South Sulawesi is one of thousands of midwives trained to counsel for and provide implant services.*

**M**ost SDES-supported NGO clinics recognize that they will not become sustainable just providing one type of service and thus offer a comprehensive range of maternal and child health, reproductive health, outpatient, and family planning services.

and child health, reproductive health, outpatient, and family planning services. The NGOs have also discovered that it can be more effective to reach family planning clients by offering a full range of services in one setting. Indonesia's village midwife program also supports collaboration between traditional birth attendants and village midwives to promote safe motherhood and respond to Indonesia's high maternal mortality rates.



### ***Improving the quality of midwife services***

The Indonesian Midwives Association (IBI) was founded in 1951 with the mission of helping its members to upgrade their capabilities to provide health and family planning services in their communities. For many years, however, midwives—or *bidans*—were not well recognized or valued. This situation changed dramatically in 1989, when the government introduced a village midwife program as a strategy to reduce high rates of maternal mortality. Under this program, more than 54,000 village midwives (*bidan di desas*) have received accelerated training from the Ministry of Health and have been placed in villages throughout Indonesia.

It soon became clear, however, that *bidan di desas* needed support for the program to succeed. These midwives are mostly young women and many lack self-confidence. Newly trained, inexperienced, and often outsiders to the villages in which they are placed, the midwives are not always well accepted or utilized by the communities they are intended to serve. In villages where traditional birth attendants (usually older women) are commonly used, there is a general reluctance to accept these young midwives as qualified providers.

Before the village midwife program began, IBI had 13,000 members. By 1997, IBI had grown to include chapters in all 27 provinces, with a membership of 67,000. Of these members, 54,000 were rural *bidan di desas*. As an agency, IBI was facing the challenge of providing professional support to its rapidly growing membership. Thus, SDES support came at a critical time, first supplying IBI with guidance for basic organizational development, initiating the development of model clinics and training centers, and providing continuing education/training for midwives already working as *bidan di desas*.

**Fostering peer review and problem solving.** Initiated under USAID/Indonesia's Private Sector Family Planning Project, SDES has expanded a key innovation to link newly trained and placed midwives in a peer-review program. Using competency-based checklists, groups of trained midwives

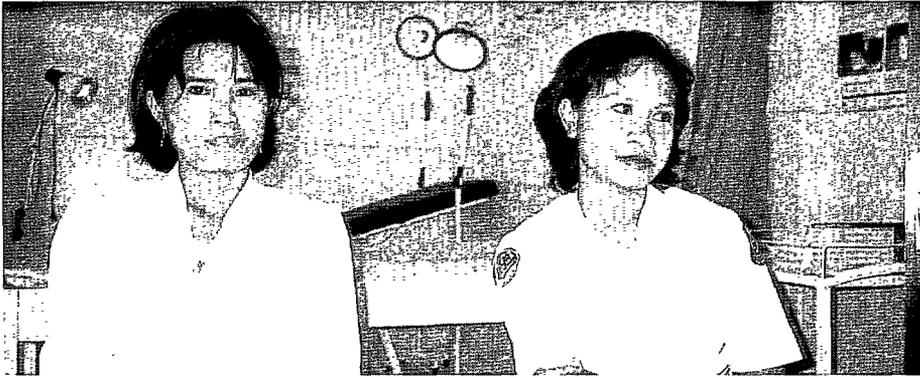


visit and review the practices of their peers. The midwives are encouraged to work together to identify incorrect practices—such as poor infection prevention—and to recognize and solve problems. IBI brings monitoring, follow-up, and refresher training to facilitate the peer review process.

**Establishing model clinics.** In 1996, SDES began supporting IBI model clinics (see photo above) where new and practicing midwives receive in-service, practical training in family planning clinical methods and counseling—including IUD and implant insertion and removal, reproductive health and MCH services, as well as quality of care and clinic management. IBI model clinics now number 16, serving both as examples for in-service training and for high-quality services that attract paying clients. The number of IBI clinics increased to 22 at the end of 1998.

IBI at the provincial and chapter level has also gained support from its own members and the local government to provide counterpart funds for improving and expanding the IBI model clinics. In cases where the SDES funds were insufficient for extensive renovation or equipment support, IBI has been able to raise additional financing from membership dues and from local government commitments, including the purchase of land or donation of unused government buildings.

Midwife Debora (shown at top of page 27) was recently posted to a rural *baruga* in a village in Jenepono district, South Sulawesi. As a young and unmarried midwife from a different ethnic group than the community in which she was placed, it was a challenge for her to be accepted. Ibu Debora recalls, “*When I first came, I wondered how I could do it. The people also wondered, because I was young and unmarried—what could I know about family planning or delivering babies?*” What created the difference for her was the additional training provided by SDES through the IBI model clinic in Jenepono district. Refresher courses in implant and IUD insertion and removal gave her the confidence, skills, and knowledge she needed to provide these methods to her community. “*Now, after I go to a course, I come back and share what I learned with the women. I show them how it is done. This gives me confidence, and it gives them confidence in me,*” she says.



**IBI at the crossroads.** The growing role of midwives and the strengthening of IBI as an organization exemplifies how the private sector can foster family planning. In many ways, IBI sees itself at a crossroads, as it is challenged to serve dual functions both as a professional organization and as a service delivery agency. SDES support has been instrumental in helping IBI renovate and rebuild model clinics, train thousands of midwives, and sponsor apprenticeships and refresher training in the model clinics. SDES has enabled IBI to undertake fundamental organizational changes to strengthen its institutional capacity as well. Operational and strategic planning, financial management, and the development of an information system are among the organizational development activities supported by Pathfinder through SDES. With the expansion and increasing self-reliance of the model clinics and continued support for *bidan di desas*, IBI is confident that the professionalism of midwives and the satisfaction of clients will continue to flourish.



# Improving the sustainability and coverage of family planning SERVICES DELIVERED THROUGH THE PUBLIC & PRIVATE SECTORS

**S**ustainability demands institutionalizing high-quality training and services, providing more comprehensive services, and strengthening the capacity of agencies to manage those services . . .

## Building Sustainable Service Delivery Systems

SDES supports the BKKBN to improve the coordination of public and private sector services to achieve wider coverage, while building the sustainability of family planning institutions. In addition to supporting institutional development of the central and provincial BKKBN, SDES works with professional associations and service-oriented NGOs to strengthen their capacities in program and financial management, training, and service delivery.

In the early years, the government provided family planning services free of charge. This was necessary to change behavioral and cultural norms to gain widespread acceptance and use of family planning. Realizing that they could not afford to continue providing free services, in 1987 BKKBN instituted the *KB Mandiri* movement, or self-reliant family planning. BKKBN actively encouraged the distribution and sale of contraceptives through the private sector. These contraceptives, known as Blue Circle and Gold Circle, were introduced for sale in nearly all pharmacies and through private providers. Over the past 10 years, BKKBN has launched campaigns to market these contraceptives as well as services provided by private doctors and midwives. BKKBN has also begun to segment the population so that free contraceptives are mainly targeted to the poorest communities.

A truly sustainable family planning program, however, requires more than a continuous and adequate supply of contraceptives, and more than paying clients to subsidize those who cannot afford to pay. Sustainability demands institutionalizing high-quality training and services, providing more comprehensive services, and strengthening the capacity of agencies to manage those services, whether it be a governmental, non-governmental, or commercial clinic.

### ***Strengthening program and financial management***

Because SDES was designed as a mechanism for direct funding to provincial BKKBN programs and to NGOs, the need for institutional support in financial management became evident early on. Few provincial BKKBN agencies or NGOs were accustomed to following international standards of financial planning and reporting that SDES required. In response, Pathfinder developed *Guidelines for*



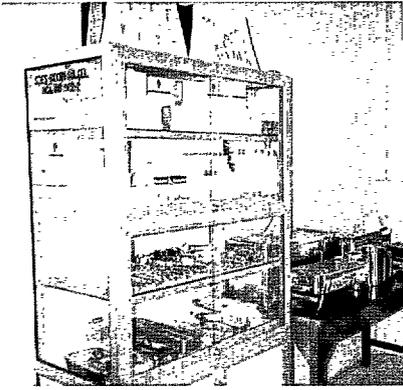
*Project Development, Monitoring and Quarterly Reporting* to guide managers through planning, budgeting, management, and reporting processes. Pathfinder also provided technical assistance and training to provincial BKKBN and NGO managers in the use of these project management tools. The tools have now been adopted by the Central BKKBN and many of the NGO grantees for use with other donor funded projects.

The number of NGOs and provincial BKKBN offices with adequate financial and reporting systems in place has grown through SDES during its first three years. Initially, due to the lack of such systems, Pathfinder provided direct funding to only three NGOs and one provincial BKKBN office. The remainder of the funds were channeled through Central BKKBN's Office of Planning to the other BKKBN provinces and NGOs so that Pathfinder could more easily monitor the use of project funds. Through program and financial management guidance, Pathfinder gradually increased the number of direct-funded agencies. By the third year, all of the SDES provinces and seven of the ten NGOs had "graduated" from indirect to direct funding. Through SDES, many of the NGOs gained their first experience with outside donor agency funds. As a result, they are now prepared to apply and qualify for other donor grants in the future.

SDES has also strengthened the NGOs' organizational capacity to manage family planning service delivery. In the first three years of SDES, private family planning services were expanded to a total of 89 NGO clinics and included funding to six service-oriented NGOs (IPPA, PKMI, IBI, IDI, Muhammadiyah, and Nahdlatul Ulama). In addition to making these private clinics ready for service delivery, SDES has supported organizational development workshops, social marketing workshops, financial management training, and clinical training to develop NGO management and clinical skills needed to set up and run sustainable clinics. SDES support is oriented towards increasing the self-reliance of these new clinics; after three years they should be capable of marketing and managing themselves. In selecting which NGO clinics to support, SDES also prioritizes existing clinics, or those that have strong support from the community level, so that the inputs provided by SDES are used effectively and serve as a catalyst for further sustainable growth.

SDES program managers recognized that the NGOs selected were not at an equal level of organizational maturity or capacity, nor would they be equally motivated

*To improve project management and reporting at the provincial and district level, BKKBN South Sulawesi adapted management tools developed by Pathfinder. To better manage project activities, each district conducting SDES activities follows the same format as the provincial office to report to Central BKKBN and Pathfinder. This facilitates the reporting process while developing analytical skills for designing, monitoring, and evaluating project activities.*



*During the first three years of SDES, the Indonesian Public Health Association (IAKMI) conducted training and provided technical assistance to three NGOs—Muhammadiyah, Nahdlatul Ulama and IBI (clinic photo shown above)—to improve their institutional capacity to manage service delivery programs. Experts in public health, organizational development, and clinic service delivery trained program and clinic managers from the three organizations. Due in part to the impact of the training, and additional technical assistance, these three “less mature” NGOs graduated to direct funding from Pathfinder in Year 3 of the project.*

to increase their “market share” and become more self-reliant. Over time, SDES project coordinators realized that agencies whose primary role was social development rather than service provision, such as the religious organizations Muhammadiyah and Nadlatul Ulama, were more interested in working with a particular community than in becoming self-reliant. To begin to introduce or increase charges for family planning to that community would be in conflict with their mission. With these agencies, SDES shifted its focus from cost recovery and income generation to increasing efficiency and better management for cost-effectiveness. Although clinics supported by these agencies may not become financially self-reliant, SDES has helped them to improve the quality and availability of their services, and to develop the capacity to receive and manage funds from donor agencies.

Financial and program management support to BKKBN and NGOs has increased the effectiveness and efficiency of both public and private sector clinics. More than 3,100 project and clinic managers were trained in financial, clinic and program management. As a mechanism for direct support from USAID to provincial BKKBN offices and NGOs, SDES built the capacity of these agencies to apply for and manage international donor funds. This has proven to the Government of Indonesia and other donors the benefit of decentralizing family planning and promoting bottom-up planning and implementation to better meet the needs of clients. By providing direct support to NGOs, SDES has improved the mix of government and private sector use of family planning in the seven provinces. Support for income-generating activities is helping NGOs to become a sustainable part of the family planning program in Indonesia.

## Institutionalizing National Training Capacity

In addition to strengthening organizations, SDES has fostered the institutionalization of high quality, standardized training through the National Clinical Training Network (NCTN). Supported by SDES, the Network is another example of collaboration between Pathfinder and other Cooperating Agencies working in the family planning sector in Indonesia.



### ***The National Clinical Training Network***

The need for a national network of clinical training centers for standardized and competency-based training throughout provincial- and district-level training sites emerged through JHPIEGO's work with BKKBN, the Indonesian Ob/Gyn Association (POGI), and the Indonesian Midwives Association. Since 1992, JHPIEGO has been working with BKKBN to identify ways to improve the existing system for in-service clinical training. An initial assessment of the system revealed that the absence of national clinical standards for training led to an uneven quality of services. Many providers lacked clinical skills, especially in implant and IUD insertion and removal; had incomplete knowledge of method complications; and lacked awareness of concepts of "quality" in family planning service provision.

SDES became the mechanism for establishing a National Resource Center (NRC) that would use competency-based training and provide ongoing technical support to the Network. The NRC now operates in two urban centers in Java: Jakarta and Surabaya. The NRC sets national guidelines, trains provincial trainers, and oversees training of district and provincial level trainers. By 1997, the Network established provincial training centers in 17 of Indonesia's 27 provinces with SDES funding centers in all 11 SDES provinces. This model was replicated in six other provinces with funding from the Asian Development Bank and the World Bank. BKKBN's policy is that all provinces should set up provincial training centers following the initial model.

The establishment of the Network will contribute greatly to the sustainability of provider training supported by SDES, including midwife training. In addition to the provincial training centers, a number of district level centers have also been set up. Given the strong support of BKKBN and MOH, the commitment of professional organizations to improve Indonesia's training capacity, and a growing cadre of motivated and skilled trainers, the Network has strong potential for sustainability beyond SDES. The challenge in the next few years is to strengthen and institutionalize high-quality training at the district level where it is most difficult to maintain quality due to shortages of human resources, facilities, and supplies. A new program to train tutors at government district health centers and to develop a pool of district level master trainers is a strategy to improve the cost effectiveness of training and expand the outreach of the Network.

**B**y 1997, the Network established provincial training centers in 17 of Indonesia's 27 provinces with SDES funding centers in all 11 SDES provinces.



### ***Institutionalizing national capacity for standardized training***

As with other components of SDES, professional organizations of providers and academic health institutions are essential partners in the development and operation of the National Clinical Training Network. The Indonesian Ob/Gyn Association (POGI) and the Klinik Raden Saleh (the Reproductive Health Division of the University of Indonesia School of Medicine's Department of Ob/Gyn) are committed to improving clinical training standards for all providers. With their involvement, the Network is a vehicle for addressing the uneven quality of pre-service training.

### **Developing national standards for family planning**

Along with its partnerships with professional organizations, government institutions, and national schools of medicine and midwifery, the National Resource Center developed a National Training Curriculum based on the "National Standards for Family Planning." The NRC plays a key role in updating standards, introducing new modules, and training trainers when new methods, such as the one-rod implant Implanon, are introduced to the Indonesian program. After establishing its role as the developer of national standards and training curriculum for family planning, the NRC moved beyond family planning to establish standards for other reproductive health topics, including maternal health.

### **Introducing competency-based training**

Competency-based training, as practiced in Indonesia, is a humanistic approach to help trainees master skills. The course emphasizes coaching, feedback, and support using models that include hands-on practice and checklists that break each skill down into a series of smaller tasks. Checklists are central to the competency-based approach. They serve as learning guides and competency assessment tools that lay out basic protocols and standards for each method. Checklists are used to evaluate competency during training and as a follow-up assessment tool to see if providers are practicing the standards with their clients. This approach is now accepted

in BKKBN and, as a result, the Ministry of Health has requested assistance to build competency-based training into their own clinical training system.

**Training master trainers**

The success of the program depends not only on clinical training sites working as a network, but on the development of a cadre of trainers proficient in training skills and in the competency-based approach that filters through the levels of the network. Those who become skilled trainers go on to receive more advanced training and can become Master Trainers—educating others to be trainers. In this way, the capacity of Indonesian Ob/Gyns, general practitioners and midwives to do pre-service training at universities, as well as in-service training in their practices, is increased and utilized throughout the Network.





## Increasing the role of **PRIVATE AND NGO SECTORS IN FAMILY PLANNING SERVICE DELIVERY**

*In Lampung, BKKBN is supporting private midwife practices—the leading source of family planning in the private sector—through training to improve clinical skills and by upgrading clinic facilities to reach a broader clientele. At the same time, BKKBN is working to increase the effectiveness of public sector village midwives by gaining the support of TBAs and by strengthening village health posts (polindes).*

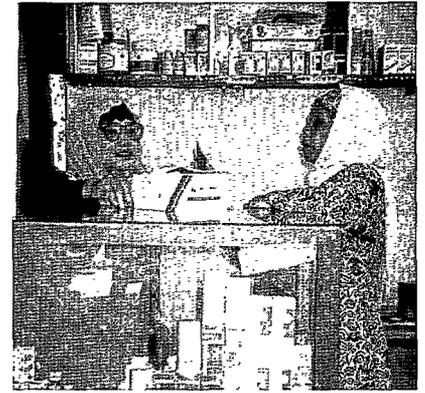
Under SDES, a key strategy is to expand the role of the private sector in providing family planning and comprehensive reproductive health services. The government's goal is to increase private sector use to 50 percent by the year 2000. At the outset of SDES, the role of private sector agencies was already expanding. In 1991, 22 percent of family planning users obtained their services through private sources. This number increased to 28 percent in 1994. In the SDES provinces, private sector use in 1994 varied from 15 percent of all family planning users in South Sulawesi, to 40 percent in North Sumatra (IDHS 1994).

Because the source of contraceptive services has historically been the public sector, the role of NGOs and other private sector providers, such as physicians, midwives, and pharmacists, until recently has been limited to collaborating with the public sector on contraceptive distribution. This scenario has held back the potential of the private sector to reach into places with quality services where the public sector cannot, and to provide healthy competition to the public sector. NGOs may be particularly well suited to serving certain hard-to-reach communities while the private sector can serve paying clientele with higher incomes.

To be sustainable, the national family planning program must now move away from fully subsidized services, but the pace of this transition will be slow. BKKBN has recently initiated several programs that enable groups within the community to collect and earn income so that they can fund services for clients who cannot afford to pay. At the same time, BKKBN has started to segment the market so that free or subsidized services are targeted to low income clients.

### **Strengthening Private Providers and Clinics**

Use of the private sector for short-term methods is very high. Almost all clients pay something for pills, condoms, and injectables, although often at a subsidized rate. Most long-term methods, however, are still provided free of charge through the government program. SDES has been working to change this through support to private sector providers as well as NGO clinics. Efforts to increase the private sector role in family planning included supporting training of private midwives and doctors in IUD, implants and VS, as well as counseling, upgrading private clinic facilities and equipment for the provision of long term methods, improving referral links between the private and public sector, and setting up village contraceptive and general medicine distribution posts (PAKBD/POD).



### **Enhancing private provider skills**

Private sector providers, particularly midwives who provide the largest proportion of these family planning services, have been assisted by the SDES project in several locations through BKKBN and professional associations of doctors and midwives (IDI and IBI).

Through training and other support to the government's *bidan di desa* (village midwives) program and to private midwives, the utilization of both public and private midwifery services has increased substantially. Private midwives are one of the major providers of family planning, reproductive and MCH services, accounting for approximately 16 percent of services to family planning users in 1994 and 28 percent in 1997. At SDES mid-term, nearly 50 percent of injectable users were receiving their services through private practice midwives. Even in government run health centers, midwives provide a large portion of the family planning services to women. Many midwives work in both the public and the private sectors, while other midwives are becoming self-reliant private providers.

### **Upgrading private facilities**

During the first three years, SDES provided significant support to upgrade private clinic facilities and equipment to provide long-term methods, and to train providers at those sites in clinical and counseling skills. IDI, PKMI, and IPPA have been particularly successful in marketing and providing a full range of reproductive health and family planning services, including IUDs, implants and sterilization to middle- and upper-income clients who are able and willing to pay for private services. Although the number of clients paying for long-term method services is far below those who pay for pills, injectables, and condoms, considerable progress is being made.

### **Establishing local contraceptive distribution points**

SDES has supported the establishment of 458 PAKBDs at the village level. These PAKBD/PODs provide an array of general medicines as well as short-term contraceptives, such as pills, injectables, and condoms. Clients may purchase condoms as well as pills with a prescription from a doctor or midwife. These posts also supply midwives with pills and injectables and sell pills and condoms to field workers who distribute and resupply these methods within their communities. A linked referral pharmacy system is supported by the Indonesian Pharmacists Association (ISFI) to improve distribution of Blue and Gold Circle contraceptives

*In South Sumatra, the economic base is largely agricultural, and includes farming, plantations, fishing, and forestry. Compared to other SDES provinces, it has a low population density with just over six million people. Since residents must travel long distances to reach health care facilities, BKKBN is helping community-based distributors set up village medicine shops (PAKBDs) that sell family planning supplies and basic medicines.*



*BKKBN - South Sulawesi has developed strong working relationships with NGOs to reach distant communities. By coordinating with the IPPA branch, BKKBN is able to improve the availability of family planning services in mountain communities in Mamaju and Polmas districts, often by delivering contraceptives and carrying the midwife by donkey.*

to the PAKBD/PODs. East Java, West Java, South Sumatra, and Lampung provinces have been particularly successful in setting up and distributing contraceptives through these posts.

## Enhancing NGO Family Planning Services

In order to increase the role of NGOs in providing family planning services, SDES has supported a range of clinics and services through the IPPA, IDI, IBI, PKMI, Muhammadiyah, and Nahdlatul Ulama. The experience of these NGOs in providing family planning services varies widely—IPPA is a pioneer in family planning service delivery while the professional organizations and the two religious NGOs had very little experience in managing services through organization-based clinics prior to SDES. IDI and PKMI have been very successful in developing a niche and attracting a range of middle to high income clients. IPPA has remained a strong community-based service organization providing a broad range of services on a sliding scale to clients from all income levels. Muhammadiyah has improved its service delivery, expanding from mostly hospital-based to community and clinic based services. Nahdlatul Ulama has built upon the strong grassroots nature of the organization to provide family planning information and services at the village level, often serving the community through their *pesantrens*, or religious boarding schools. IBI is exploring ways to provide comprehensive reproductive health and family planning services and to respond to the growing human resources needs of both private practice and village midwives.

Although government support for implant and IUD use is strong, VS services are not actively promoted as part of the national family planning program. This has resulted in limited community demand and public sector support for VS services for both women and men. In the absence of strong public sector support, the private sector can fill the gap in sterilization services by providing these services at a high quality for a reasonable fee. As PKMI's experience demonstrates, such services may enhance a clinic's ability to be financially self-sustaining while satisfying community demand for the service. NGO and private clinics that have been most successful at increasing utilization and becoming self-reliant are those that fill a niche by providing a particular service in demand—and which people will pay for—or those that provide a wide menu of integrated services, and provide them well. For example, the PKMI clinics have been able to reach self-reliance relatively quickly by providing a rare service (VS) at a level of quality which many middle and upper-middle class clients are willing to pay. These paying



clients enable the clinics to subsidize the service to clients of lower means. The more mature NGOs did particularly well when SDES worked with them to apply a business model to clinic development. The use of marketing techniques and the development of a business plan are novel approaches for NGOs that are not used to thinking like businesses. For some, this approach helps them to identify services that the community wants, to provide some services that people are willing and able to pay for, or to research the market and fill a specific need.

*In recent years, IPPA has conducted educational campaigns to inform women about early detection of cervical cancer. At several clinics, IPPA conducted community seminars to increase awareness about the importance of routine pap smear exams while developing its own capacity to conduct pap smear testing. Due to the demand for this service, SDES has funded training for lab technicians and procurement of necessary laboratory equipment to enable more IPPA clinics to provide pap smear education and services.*

## FINDINGS

**S**DES has contributed to modest gains in contraceptive use and reductions in fertility, in expanding the method mix, and increasing the use of the private sector for all methods.

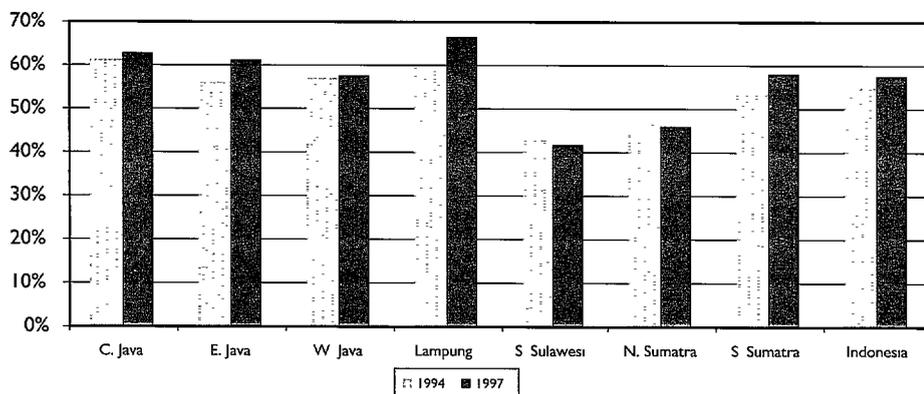
While it is too early to assess the full impact of the SDES project, this review of the first three years highlights a number of positive outcomes, some unanticipated benefits, as well as unanticipated constraints. This final section discusses changes in fertility and contraceptive use trends in SDES provinces from 1994 and 1997 DHS data and identifies important lessons learned for each project objective. This review will guide the future implementation of the project, particularly the management of internal and external constraints, the design of impact evaluation, and the replication or expansion of key interventions.

### Review of 1997 DHS Data

The results of the 1997 Indonesia DHS are summarized below to provide a general picture of shifts in fertility and contraceptive use in Indonesia overall and in the seven SDES provinces during the first three project years of SDES. Since SDES provinces account for 70 percent of the population, national trends and those in SDES provinces are mainly similar. They also suggest that SDES has contributed to modest gains in contraceptive use and reductions in fertility, in expanding the method mix, and increasing the use of the private sector for all methods. However, since DHS results are not available by district, it is not possible to determine the impact of SDES interventions on these trends. In addition, while BKKBN data for SDES districts are available, discrepancies between this data and the DHS make it difficult to assess differential trends in SDES districts without an independent evaluation. Efforts are underway to improve BKKBN reporting and to conduct an evaluation of SDES project impact in the areas of training, quality improvement, private sector use, and sustainability.

#### ***Increased contraceptive use in SDES provinces***

Throughout Indonesia, the use of modern family planning methods is on the rise. Current use of all contraceptive methods has increased overall from 54.7 percent in 1994 to 57.4 percent in 1997. Achievements, however, are not evenly distributed among all provinces. Figure 4 presents increases in contraceptive use nationally and in the seven SDES provinces. All but two SDES provinces show an increase in contraceptive use. North Sumatra and South Sulawesi both declined slightly, while all other SDES provinces exceeded the national average. Lampung province demon-



**Figure 4**  
Contraceptive Prevalence Rate, Indonesia and 7 SDES Provinces, 1994 & 1997

strated the largest increase and the highest CPR (from 59.3 to 66.5 percent), well exceeding the national average. South Sumatra and East Java also show large increases, from 53 to 58 percent and 56 to 61 percent, respectively. (Annex I provides CPR by method for the 1994 and 1997 for each of the SDES provinces.)

The 1997 DHS reported a slight reduction in the TFR for Indonesia as a whole, from 3 in 1994 to 2.8 in 1997. In the SDES provinces, TFR declined at a similar rate. North and South Sumatra demonstrated the largest drops in fertility. Fertility increased slightly in East Java, though it remains the lowest of all the seven provinces and below the national rate of 2.8. In 1997, the TFR for the 7 SDES provinces ranged from 2.3 in East Java to 3.7 in North Sumatra (see Figure 6, next page).

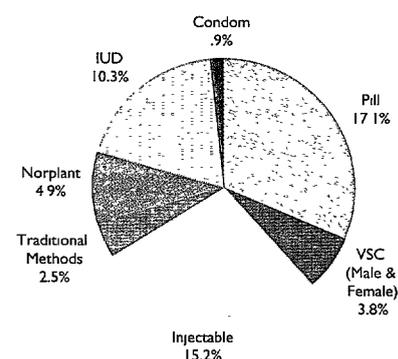
## Improved Mix of Short and Long-Term Methods

Across the country, and in SDES provinces, shifts in women's choice of methods reflect increased availability of a wider range of methods to meet needs for birth spacing and limiting. Figures 5a and 5b show method mix among current users in the seven SDES provinces in 1994 and 1997. Overall, the use of injectables and implants increased over the three year period, while IUD and pill use declined. Injectables show the most dramatic increase in use, from 15 percent in 1994 to 21 percent in 1997, overtaking the pill as the most popular method.

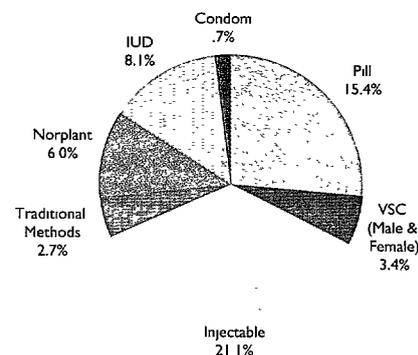
SDES provinces follow national trends in shifting use of short-term methods due to the increased availability and accessibility of injectables. In all seven provinces, the use of the pill and condoms declined at roughly the same rates as national averages. The use of injectables increased across the seven provinces; most significantly in East Java (from 11 to 20 percent) and South Sumatra (from 11 to 21 percent).

IUDs and implants are the most popular long-term methods, chosen by 14 and 10.4 percent, respectively, of current users nationally in 1997. While IUD use has dipped in the past few years, the demand for implants is growing rapidly. Strong method-specific social marketing by BKKBN has increased knowledge about and demand for implants in both the public and private sectors. Knowledge of implants increased from 77 percent in 1994 to 81 percent in 1997, and use of NORPLANT® increased from 5 to 6 percent in the same time period.

**Figure 5a**  
Method Mix, Indonesia, 1994

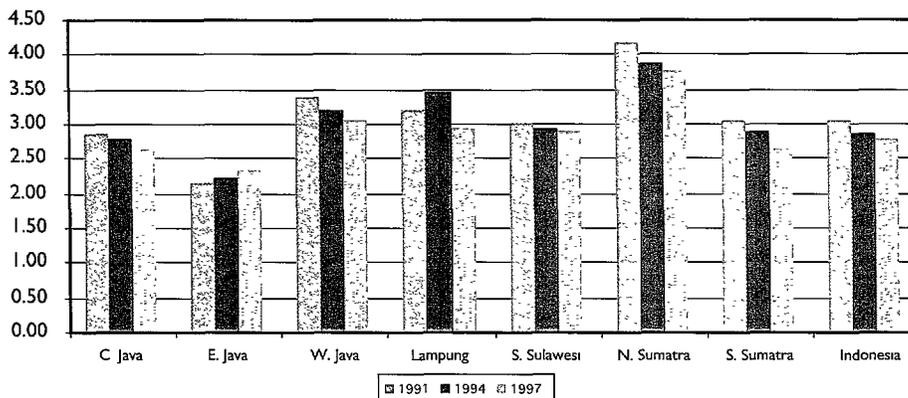


**Figure 5b**  
Method Mix, Indonesia, 1997



**Figure 6**

Total Fertility Rate, Indonesia and 7 SDES Provinces, 1994 & 1997



**A**cross the country, and in SDES provinces, shifts in women's choice of methods reflect increased availability of a wider range of methods to meet needs for birth spacing and limiting.

Long-term method use as a proportion of all methods increased in two SDES provinces (Lampung and South Sulawesi) while the use of NORPLANT increased in all but one SDES province. NORPLANT use increased most significantly in Lampung, from 2.7 to 11 percent. Contrary to the national trend, the percentage of sterilization use increased slightly in four provinces: North Sumatra (from 5.3 to 6.5), South Sumatra (from 3.4 to 4.3), Lampung (from 2.9 to 3.1) and South Sulawesi (from 1.3 to 2). The result of these provincial and method variations is a leveling-off of long-term method use nationwide. The reasons for declines in some provinces and increases in others have yet to be thoroughly investigated. However, there are several possible explanations for the lack of significant increases in long-term method use overall:

**Offsetting trends:** According to the BKKBN service statistics, annual new IUD clients declined steadily from a 1989 high of 1.15 million to almost half that number in 1995. Since then, the number has increased to 800,000 new clients in the last year. Over the last three years, new VS clients have remained steady at around 100,000 per year, and new implant clients have increased. While these trends may offset each other, they may also be independent. There is little evidence, for example, that current or prospective IUD clients have been switching to implants. However, there is some anecdotal evidence that when NORPLANT is out of stock, potential NORPLANT users are more likely to switch to injectables or not choose an alternate method than to choose an IUD.

**Provider limitations:** Although the implant has been a popular method, the MOH, until recently, prohibited midwives from performing insertions and removals. In the second year of SDES, the MOH changed this policy and midwives are now allowed to provide this service, thereby expanding access to interested clients.

**Financial disincentives:** The country's pricing structure provides an incentive for private providers to promote methods which require more client visits, such as injectables, rather than long-term methods.

**Lack of policy support for all long-term methods:** Support for promoting some long-term methods (IUD and sterilization) was notably absent at the policy level since the start of SDES. Particularly in 1996, a pre-election year, the government was reluctant to officially endorse or vigorously promote VS. This resulted in a lack of information and acceptance of VS within the community. In addition, MOH policies permit VS services to be provided in "certified centers" only, which

Method	Public		Medical Private		Other Private <sup>2</sup>	
	1994	1997	1994	1997	1994	1997
Pill	32.1	33.7	14.6	31.9	53.1	34.4
IUD	65.8	60.2	25.4	32.1	8.8	7.8
Injectable	41.9	31.2	50.4	61.3	7.7	7.5
Norplant	77.7	71.4	7.9	16.8	14.4	11.5
Condom	20.4	16.3	66.3	75.5	13.4	5.9
Sterilization (Female)	70.9	70.1	26.8	29.4	0.8	0.1
Sterilization (Male)	77.3	86.5	14	8.7	8	4.8

**Table 4**

Source of supply by method, Indonesia, 1994 & 1997<sup>1</sup>

limits access to these services, leading to the predominance of implants as a one-method long-term method program. No special effort was made to promote IUDs, although they are officially part of the national program. The result of these two factors was essentially an overreliance on NORPLANT to meet women's needs for limiting births.

**Supply imbalances:** While the proportion of implant use increased, supplies dwindled. SDES has placed a significant portion of its resources in increasing demand for and access to implant services. However, many provinces had insufficient implant supplies, and in some cases experienced complete stock-outs as early as the second project year.

**Uneven quality of services:** The quality of clinical services in many districts falls short of what would be needed to increase the attractiveness of clinical methods. While SDES has embarked on interventions to improve the quality of services, by midterm the impact of those interventions on the proportion of couples using long-term methods had not yet been evaluated.

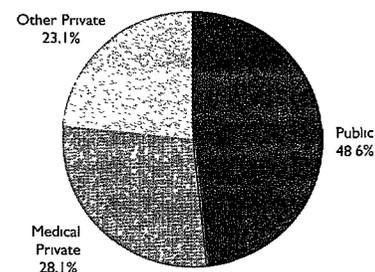
**Increased availability of a range of methods in the public and the private sector**

With SDES support, 250 private and NGO clinics have been established or renovated and equipped to provide a full range of reproductive health and contraceptive services. Since 1994, private sector utilization has increased by more than one-third to nearly 42 percent (see Figures 7a and 7b). Most of this increase is accounted for by a notable jump in the use of private midwives, from 16 to 28 percent.

Table 4 compares the source of supply by method for Indonesia in 1994 and 1997. Notably, utilization of private clinics and hospitals ("other private") increased for all methods, with the exception of male sterilization. Injectable, IUD, and implant use increased significantly within the private medical sector.

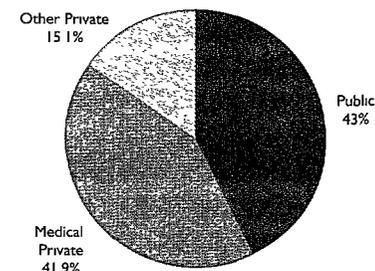
**Figure 7a**

Source of services, Indonesia, 1994



**Figure 7b**

Source of services, Indonesia, 1997



## Lessons Learned

### **Objective 1: Increase availability in hard-to-reach areas**

*Enabling provinces to develop innovative local strategies has increased access to and the availability of appropriate services for populations in hard-to-reach areas.*

SDES has made a major contribution to the national program by targeting specific programs to hard-to-reach communities that are often overlooked by BKKBN's broad-scoped national program. In so doing, SDES has fostered a culture of innovation at the provincial level. Local BKKBN officials have been able to develop and pilot new ways to improve the use, quality, and coverage of family planning services according to the resources and needs of their province. While some provinces started new partnerships with church-based NGOs, others introduced clinics to factories, trained traditional birth attendants, built *barugas* to increase community ownership and participation, or introduced boat transport for outreach and services.

*SDES provided a mechanism for successful approaches to be replicated in non-SDES districts, and to be adopted on a larger scale as part of the national program in other provinces.*

One of the unanticipated outcomes of SDES was to serve as a mechanism for successful innovations to be tried in other provinces, including non-SDES areas, or to be implemented on a wider scale within a province. Initial support from SDES also provided provinces and NGOs with the opportunity and ability to leverage funding from both domestic and international sources to expand and replicate innovative, successful SDES interventions. Evaluation of the cost-effectiveness of key interventions will help to identify which ones could be adopted on a wider scale.

*Community-based workers and volunteers are an essential link between hard-to-reach communities and the alternative mobile and community-based distribution systems that are essential to expand the impact of the national family planning program.*

SDES interventions catalyzed community participation in family planning. The involvement of community volunteers and alliances with religious or ethnic-based organizations, as well as local community and women's associations, were critical to building the acceptability of family planning services among hard-to-

reach populations. By working in partnership with community volunteers and systems, and by coordinating with both mobile and fixed service delivery teams, BKKBN field workers were able to be more effective and efficient.

*Working with the NGO community builds acceptability of family planning among hard-to-reach communities.*

Because NGOs are trusted by and have established lasting relationships with the communities and constituencies they serve, they are often more trusted by populations that may be skeptical of the government's intentions. In particular, SDES works with several religious NGOs whose members serve as clinic staff and community educators in order to reach out to populations that may be less accepting of modern family planning methods.

**Objective II: Increase the availability, use, and quality of long-term methods**

*The continued support and involvement of the religious community—from the national to the local level—will be essential to increase acceptance of long-term methods.*

While BKKBN has made great progress under SDES to improve the availability and quality of long-term method provision and in working with religious leaders of all faiths to increase the general acceptance of family planning, support for IUD use and VS remains low, particularly for male sterilization. Sustaining the involvement of religious leaders and expanding work with religious-based NGOs to promote delayed marriage and family planning as a matter of family health and well-being will be critical for increasing acceptance and use of long-term methods.

*SDES provinces can take leadership in supporting policy shifts in favor of an expanded method mix that includes all long-term methods.*

Although the absence of policy support for sterilization and IUDs was a fundamental constraint to the achievement of this objective, SDES provinces are moving forward to identify areas where these methods will have acceptability, and where capacity for quality delivery exists. These efforts are a sign of the increased capability of provincial BKKBN to do their own planning, rather than relying on central planning and policy. During the SDES mid-project review meeting, BKKBN and NGO grantees reviewed lessons learned and challenges facing the second half of the project. As a result, several new innovative projects were designed. For example, South Sulawesi proposed midwife home visits to encourage the use of IUD and North Sumatra developed a pilot intervention to improve VS services.

**S**ustaining the involvement of religious leaders and expanding work with religious-based NGOs to promote delayed marriage and family planning . . . will be critical for increasing acceptance and use of long-term methods.

**I**ncreasing integration of family planning with postpartum and MCH services may be an untapped resource for increasing contraceptive use among both high- and low-parity women.

*In order for SDES to fully increase utilization of all methods, the management of contraceptive supplies and services needs to be compatible with IEC and social marketing activities.*

One barrier to increasing implant use during the past three years has been a dwindling supply and in some cases complete stock-out of implants at a time when demand was growing. SDES supported the development of IEC materials, trained field workers and providers, and generated demand for implants. However, when the supply of implants began to diminish, as early as 1996 in some provinces, anticipated achievements were not reached.

*Enhancing the skills and roles of midwives in both private and public practice was central to increasing the availability—and the acceptability—of a wider range of methods in rural areas.*

Increasing integration of family planning with postpartum and MCH services may be an untapped resource for increasing contraceptive use among both high- and low-parity women. The placement of more than 54,000 village midwives has increased access to FP and MCH services, but the skills of newly trained midwives must be improved in order to win the acceptance and trust of the communities served. Although SDES has implemented activities in several provinces in collaboration with TBAs to increase postpartum IEC and services, more needs to be done to integrate these essential health services at the village level.

*In order to standardize and institutionalize quality improvements, links between the BKKBN and Ministry of Health quality initiatives need to be improved.*

SDES has focused on quality improvement of non-clinical aspects of service delivery, including improving CBD workers and systems; follow-up by field workers; provider skills to deliver services and manage side effects; interpersonal communication and counseling skills through training and practice; and logistics, supply, and resupply of contraceptives. However, the MOH still has the mandate to manage the clinical aspects of family planning service delivery. Coordinated work is needed on the service delivery side to improve the clinical quality of care as well as other aspects of service delivery. Thus, the implementation of any quality assurance process for family planning in Indonesia requires parallel processes and commitment of resources on the part of the MOH and the BKKBN.

*Acceptance of a client-centered approach is still limited within the BKKBN culture.*

SDES supported a transition away from a target-based program toward the use of more effective and strategic planning for the promotion and supply of all methods. However, more work is required to instill a broader understanding of client rights within BKKBN cadres, as well as to generate wider commitment to improving quality, such as through the use of protocols and guidelines for service provision and counseling, including informed consent and related issues.

***Objective III: Improve the sustainability and coverage of family planning services delivered through the public and private sectors***

*An expanded family welfare/resilience mandate has stretched human and financial resources, limiting program sustainability and impact.*

Since 1994, BKKBN has shifted its program from an exclusive focus on family planning to a three-pronged family welfare program. BKKBN staff and field workers are now responsible for reproductive health programs (including family planning), poverty alleviation activities, and family welfare/resilience. This broadening of BKKBN's focus reflects progressive thinking about ways to integrate family planning with other community needs. However, the human and financial resources of BKKBN have not expanded accordingly. While BKKBN remains committed to family planning, their staff and field workers have less time to devote to these activities. Workers are responsible for carrying out more tasks and must devote more time to tracking a greater number of indicators with less time for family planning. Reporting systems need to be streamlined and improved in order to enhance information-based planning and decision making. It is anticipated that future achievements in contraceptive use will be limited by the broadened mandate of BKKBN.

*Supply issues must be addressed if the sustainability of the national family planning program is to be fully realized.*

By the end of the third year, demands for NORPLANT were not being met due to a limited supply. At the same time, use of other long-term methods began to decline. While BKKBN has increased knowledge of and demand for NORPLANT, it has paid less attention to cost and sustainability. Since it is the most expensive method in the program, it has been difficult for BKKBN to maintain adequate supplies.

SDES supported a transition away from a target-based program toward the use of more effective and strategic planning for the promotion and supply of all methods.

**L**ong-term strategies to enhance and sustain the participation of the private commercial and NGO sectors are needed.

The transition to sustainability, particularly in a multisectoral program, requires substantial institution-building within the public sector to ensure its capacity to coordinate different sectors.

Long-term strategies to enhance and sustain the participation of the private commercial and NGO sectors are needed. It will be important to retain a flexible model for self-reliance that embraces different types of NGOs. In addition, strategic approaches to address commercial sector interests are needed in order to realize the potential for fuller coverage through private sector involvement in the national family planning program.

**Objective IV: Increase the role of the private and NGO sectors in family planning service delivery**

*Although the government is still the major provider of family planning, utilization of private sector services is growing and will become increasingly important for program sustainability.*

SDES's expanded support to the private sector has resulted in increased access to services, improved coordination between the public and private sectors, and created demand for high-quality services for which clients are willing to pay. Increasing the service delivery capacity of both mature and emergent NGOs and improving the coordination of public and private sector providers are key components in increasing access, particularly to hard-to-reach populations, and in providing services to an ever-growing number of clients who are willing and able to pay.

*Realizing NGO potential to contribute to the national family planning program in sustainable ways requires long-term planning and technical assistance.*

Through SDES, many of the NGOs acquired their first experience with external donor agency funds, and as a result are now prepared to apply and qualify for donor grants in the future. To reach this stage, however, even the mature NGOs needed more technical assistance than was anticipated. During the first year of the project, it became apparent that not all NGOs shared the same degree of organizational readiness or capacity. SDES worked with each individual NGO to develop appropriate goals and strategic plans that met their particular needs, capacities, and missions. NGOs still need more assistance in such areas as program planning and proposal development, problem solving, setting goals and monitoring progress, and programmatic and financial sustainability.



## Conclusion

SDES can be used to catalyze broadscale change in Indonesia's national family planning program. While the contribution of SDES, along with other USAID-funded projects, makes up a small percentage of the overall program budget, SDES interventions have improved the family planning program—and reach beyond as well—throughout BKKBN and the private and NGO sectors. This benefit has been one of the unanticipated outcomes of the program.

The design of SDES was built upon the assumption that a mature family planning program such as Indonesia's would still require substantial financial support but minimal technical assistance. Given the broad goals of the program, however, it became clear early on that a great deal of assistance was needed. Despite the fact that BKKBN has been operating for 25 years, the organization still required guidance in several key areas, including quality, training, IEC, strategic planning, institutional development, and financial management. It has taken time to build BKKBN receptivity in some areas, particularly concerning quality and supply issues. Yet, many provinces are now becoming more self-reliant and taking initiative in adopting and institutionalizing new approaches, such as working in partnership with NGOs and midwives.

The 1997 data shows some positive trends, although it cannot be predicted to what extent they will continue, or to what extent SDES contributed to them. This mid-term assessment substantiates the need for evaluation of the project impact to determine what aspects of SDES have made a difference toward improving the quality and sustainability of public and private sector family planning services in Indonesia.

# END NOTES

## Text Notes

<sup>1</sup>1971 figures are from the Central Bureau of Statistics (CBS). Indonesia Demographic and Health Survey (IDHS), 1991, 1994, 1997. DHS figures are not available for Indonesia prior to 1991.

<sup>2</sup>IDHS, 1994.

<sup>3</sup>Population Reference Bureau/The World Bank, 1997.

<sup>4</sup>Due to the late release of the 1997 DHS results, the publication of this midterm assessment was delayed until early 1999.

<sup>5</sup>Curtin, et.al. 1992. At the time of publication, only preliminary DHS results had been published.

<sup>6</sup>IDHS, 1994.

<sup>7</sup>Ibid.

<sup>8</sup>Ibid.

<sup>9</sup>Unmet need is defined as the percentage of currently married women who either do not want any more children or want to wait before having their next birth, but are not using any method of family planning. In 1994, the total unmet need for family planning was 11 percent, of which about half was for limiting and half for spacing births. Unmet need for spacing methods was highest among women aged 15-19 at 12.7 percent and highest for limiting methods among women aged 35-39 and 40-44 at 9.4 and 9.6 percent, respectively. Source: IDHS, 1994, pg.104-105.

<sup>10</sup>USAID/Indonesia Transition Plan, 1992.

<sup>11</sup>Ibid.

## Table Notes

### *Table 1*

<sup>1</sup>CBS Welfare Indicator 1996, Indonesia Demographic and Health Survey (IDHS) 1997.

<sup>2</sup>CBS, Estimation of Fertility, Mortality and Migration, based on Intercensal 1995, IDHS 1990, 1994, and 1997.

<sup>3</sup>CBS & Unicef, Maternal, Infant and Under-Five Mortality in Indonesia, 1995.

<sup>4</sup>CBS, NFPCB, IDHS, 1994 and 1997.

<sup>5</sup>TFR calculated using Own Children Method based on 1971, 1980, and 1990 censuses and Indonesia DHS for 1991, 1994, and 1997.

*Table 2*

Source: Pathfinder International SDES project database.

*Table 3*

Source: IDHS, 1994, and 1997.

*Table 4*

<sup>1</sup>IDHS, 1994, 1997.

<sup>2</sup>Other private includes village delivery posts (polindes), health posts (posyandu), family planning posts, traditional birth attendants, and friends/relatives.

## **Figure Notes**

*Figure 1*

Sources:

1971,1980 from CBS; 1985 from SUPAS.

1991,1994 and 1997 figures from IDHS.

*Figure 2*

Source: Pathfinder International SDES project database.

*Figure 3*

Source: Pathfinder International SDES project database.

*Figure 4*

Source: IDHS, 1994 and 1997.

*Figure 5a and 5b*

Source: IDHS, 1994 and 1997.

*Figure 6*

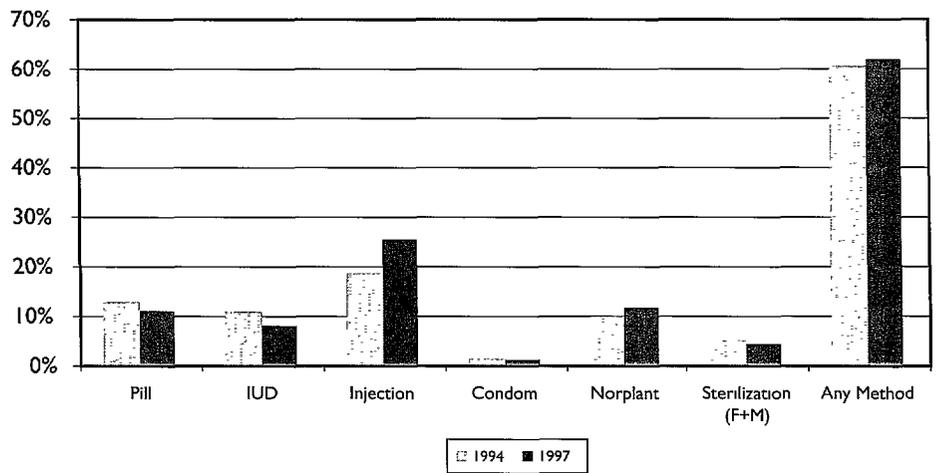
Source: IDHS, 1994 and 1997.

## **Annex Notes**

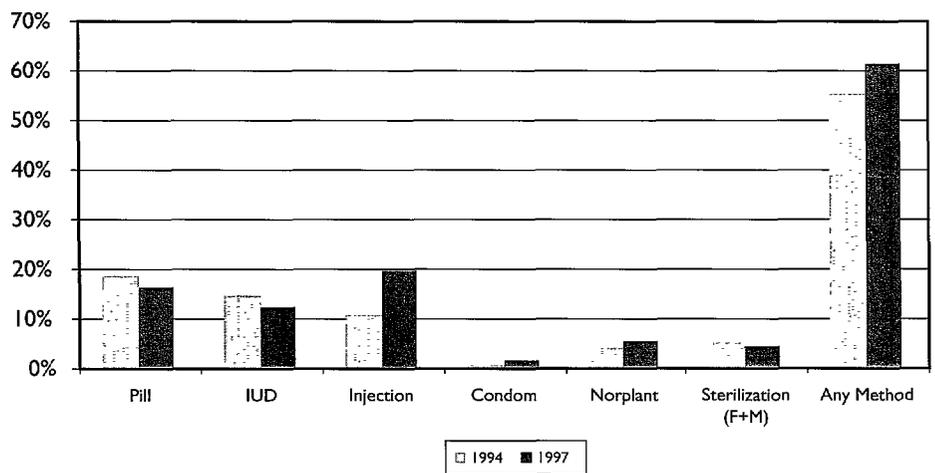
Source: IDHS, 1994 and 1997.

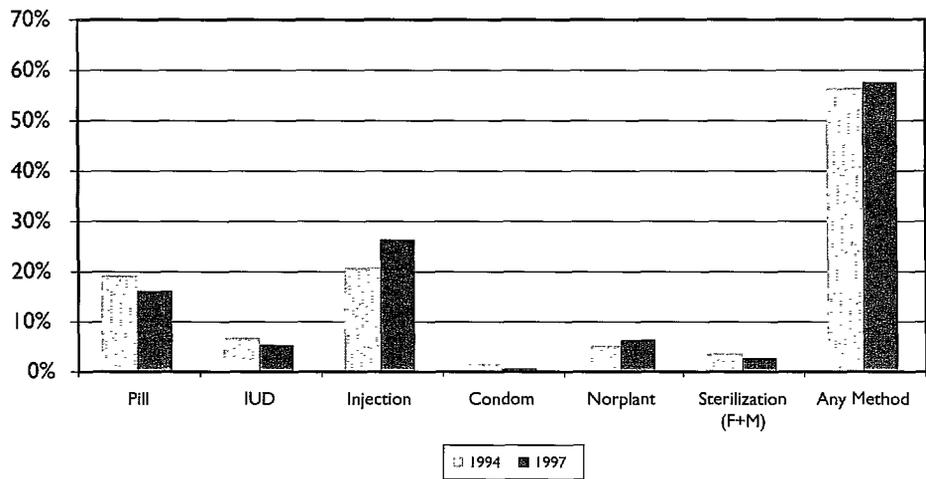
# ANNEX

**Annex Figure 1:**  
Method mix, Central Java,  
1994 & 1997

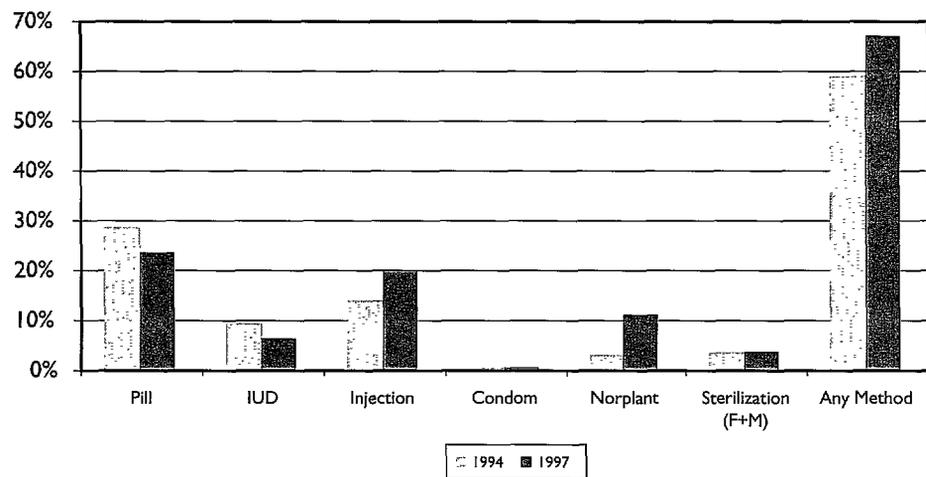


**Annex Figure 2:**  
Method mix, East Java,  
1994 & 1997



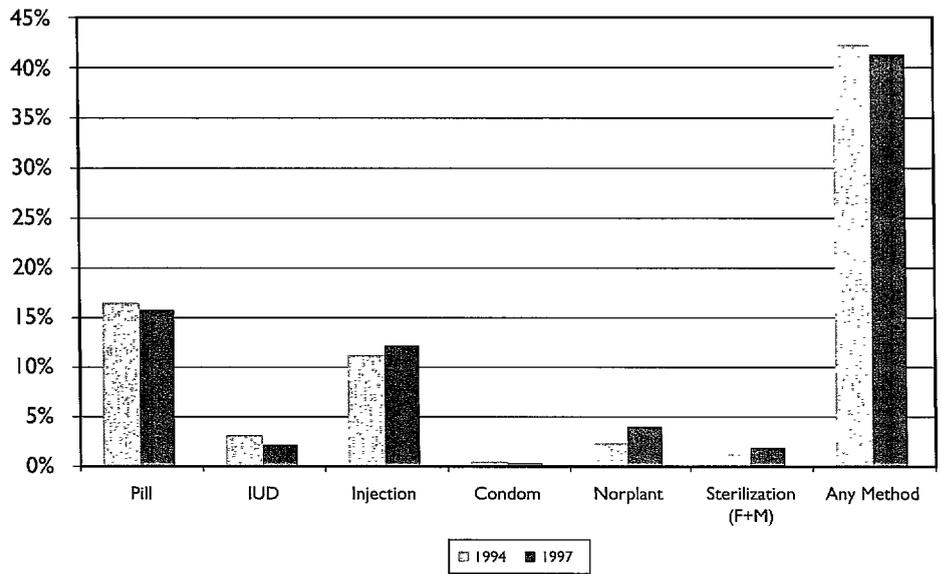


**Annex Figure 3:**  
Method mix, West Java,  
1994 & 1997

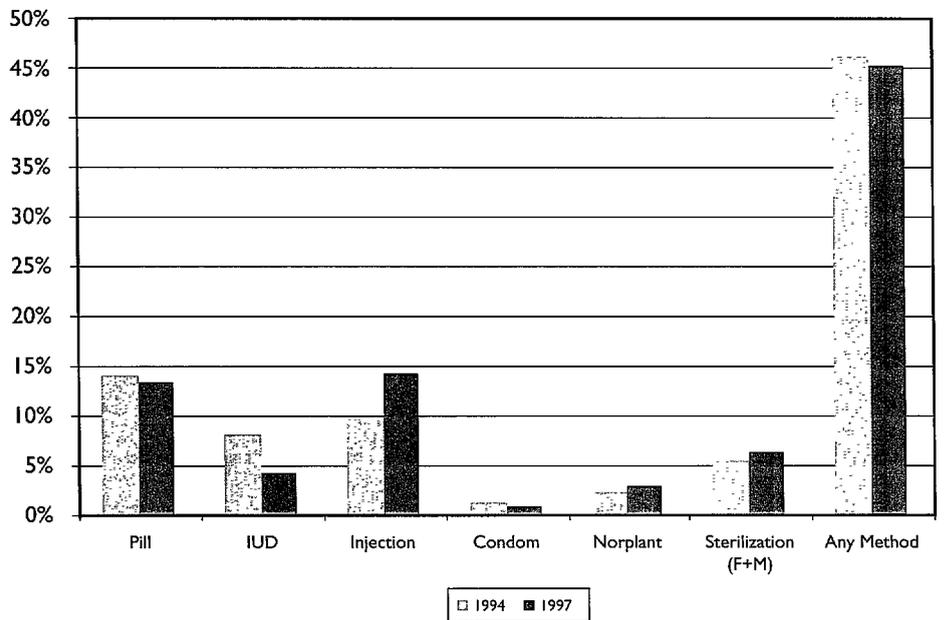


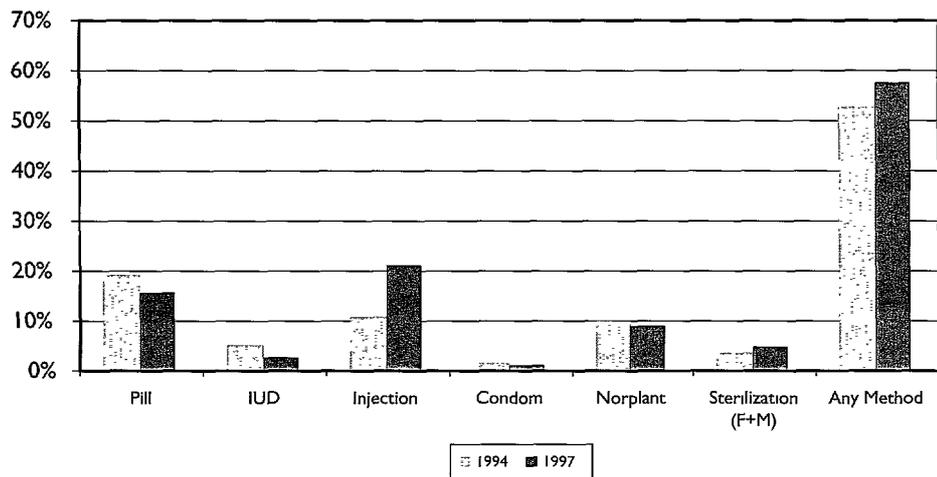
**Annex Figure 4:**  
Method mix, Lampung,  
1994 & 1997

**Annex Figure 5:**  
Method mix, South Sulawesi,  
1994 & 1997



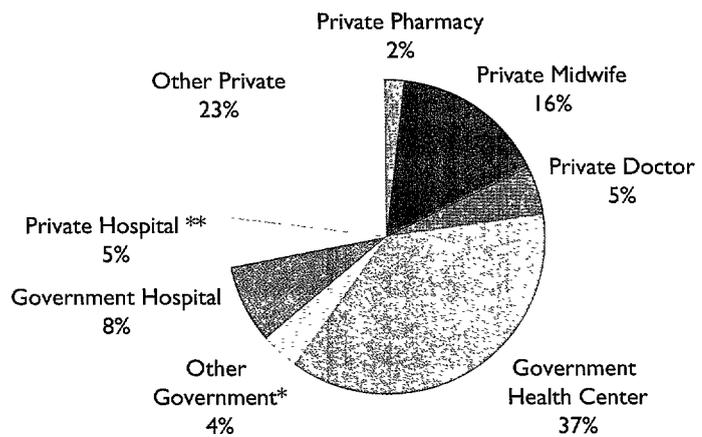
**Annex Figure 6:**  
Method mix, North Sumatra,  
1994 & 1997



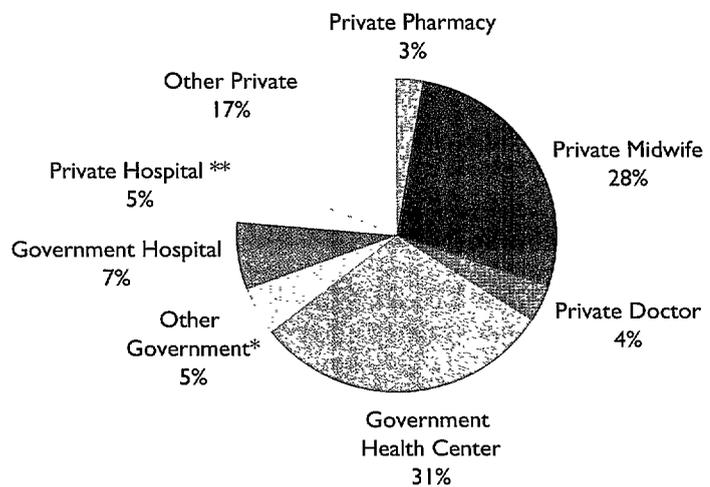


**Annex Figure 7:**  
**Method mix, South Sumatra,**  
**1994 & 1997**

**Annex Figure 8:**  
Source of family planning for current users of modern methods, 1994



**Annex Figure 9:**  
Source of family planning for current users of modern methods, 1997



\*Includes family planning fieldworker and family planning mobile units  
\*\*Includes private family planning clinics