FP2020 Indonesia
Country Committee

A rights-based strategy for accelerating access to family planning services to achieve Indonesia's development goals

Developed by the family planning strategy working group, with input from the rights and empowerment group, and with technical assistance from UNFPA

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JOINT FOREWORD

FP2020 Indonesia Country Committee

Indonesia's family planning programme is an international success story. Since it was introduced in the 1970s, the programme has succeeded in cutting the nation's total fertility rate by more than half, from an average of 5.6 children per woman to around 2.6. However, programme results began to waver in the mid-1990s and further struggled under a shift to decentralization in the early 2000s. In the past decade, efforts have been underway to revitalize the family planning programme.

Following the commitments made at the FP2020 Summit in London in 2012, Indonesia established a Family Planning Country Committee to create a framework to guide coordinated efforts toward revitalizing the national family planning programme. The Committee is led by the National Population and Family Planning Board (BKKBN), and co-chaired by the United States Agency for International Development (USAID) and the United Nations Population Fund (UNFPA). Together, the members aim to facilitate the sharing of information, best practices and opportunities for collaboration among stakeholders, as well as support dialogue toward consensus on a national strategy for achieving Indonesia's FP2020 commitments. These commitments include taking a rights-based approach to family planning, with the aim of fulfilling every individual's right to choose a family planning method that meets his or her fertility goals.

This document, produced by the Country Committee's working group on a family planning strategy, provides an inter-sectoral and inter-programme strategic framework for revitalizing the national family planning programme in Indonesia. It is meant to serve as a reference and guidelines for different programmes and sectors within the Government of Indonesia, as well as non-government organizations and the private sector, to support and implement Indonesia's national family planning programme.

This strategic document aims to comprehensively address the various facets and determinants of the family planning programme, and provides details of the priorities and steps involved for timely and effective implementation of the programme to achieve its goals. The document outlines four strategic areas of focus: sustaining an equitable and high-quality family planning service delivery system in the private and public sectors; increasing demand for and sustained use of modern-method contraception; enhancing governance at all levels to support an effective and sustainable family planning programme; and supporting research into and innovation of programmes to improve service delivery and to share results via South-South Cooperation.

The working group would like to acknowledge the strong leadership provided in this process by BKKBN and the Ministry of Health (MoH), via the constructive contributions of Dr. Anung Sugihantono as the Director of Nutrition and Maternal and Child Health at MoH; Prof. Fasli Jalal in his former capacity as the chairperson of BKKBN; Dr. Julianto Witjaksono, in his former capacity as Deputy of Reproductive Health and Family Planning at BKKBN; and Dr. Gita Maya Koemarasakti as the Director of Maternal Health at MoH. The group would also like to express its appreciation for the continuous support and guidance provided by the National Development Planning Ministry/Agency (Bappenas) via its excellent facilitation in consultations and meetings with various elements and sectors. The group also extends it appreciation to the valuable technical assisstance provided by Dr. Saramma Thomas Mathai.

Finally, we hope that this strategic framework on family planning can be used as a reference to guide the assurance of quality, stewardship and demand creation for family planning in Indonesia, as well as fulfill the commitments made by the Government at the FP2020 Summit and in relation to the post-2015 development agenda.

Jakarta, 3 March 2015

Chair	Co Chair	Co Chair
Ir. Ambar Rahayu MNS	Zohra Balsara	Jose Ferraris
(BKKBN)	(USAID)	(UNFPA)

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1. BACKGROUND

1.1 Introduction

Indonesia is a signatory of the Millennium Declaration, which outlines the global agenda for human development through a set of inter-connected and mutually reinforcing goals called the Millennium Development Goals. Family planning (FP) indicators are included in Goal 5b on achieving universal access to reproductive health by 2015. This goal consists of indicators such as the contraceptive prevalence rate, adolescent fertility rate and unmet need for family planning.

Overall achievement of the MDG 5 targets has not been satisfactory. Progress on the targets of reducing maternal mortality, unmet need, and increasing the contraceptive prevalence rate, has become stagnant over the past decade. Additionally, there have been significant geographical, rural/urban and wealth index disparities within these indicators.

Implementation of the programme has been further challenged by decentralization since 2000, which changed the direct line of authority to the district rather than the central government. It has been acknowledged that there is a need to revitalize the family planning programme to become more effective and efficient in meeting women's reproductive needs. BKKBN (the National Population and Family Planning Board) as the leading agency for family planning has initiated several efforts to revitalize the family planning programme, among others by implementing the KB Kencana initiative. The initiative aims to improve the roles of districts and municipalities in population and family planning programmes by establishing a model for comprehensive management.

In 2012, a global partnership on family planning was launched, called Family Planning 2020 (FP2020). FP2020 aims to support the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. FP2020 is working with governments, civil society, multi-lateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020.

In line with the global as well as national commitments, and parallel with the preparation of the National Medium Term Development Plan for 2015-2019, two working groups have been established under the FP 2020 country committee. The working groups are (a) Family Planning (FP) Strategy working group and (b) Rights and Empowerment working group. The primary purpose of establishing the working groups is to ensure that the national FP strategy and programme is grounded in rights-based approaches, and that its implementation ensures the right of every woman to choose a family planning method that meets her fertility goals. The working group on the FP strategy specifically aims to develop a framework for a rights-based national FP strategy, building on existing

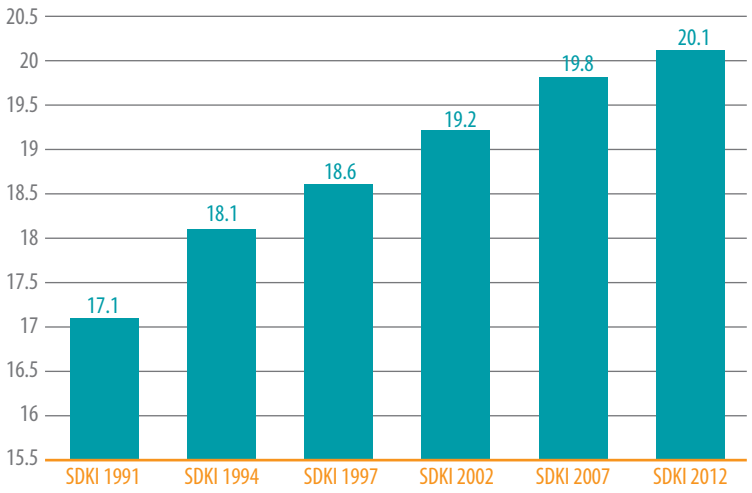
documents and current policies. The approach of the strategy is inter-sectoral and inter-programme coordination. The strategy will serve as a reference and provide guidance for different programmes and sectors, as well as non-governmental organizations and the private sector, in contributing their efforts to implement the family planning programme in Indonesia. In developing the strategy, representatives from various sectors and professional organizations, as well as experts and academicians, were involved. The main contribution of the Rights and Empowerment working group is to ensure that the strategy is right-based by overcoming barriers. The group focuses on identifying barriers, issues and opportunities to family planning programme. The group also has responsibility for monitoring the implementation of the strategy to ensure that rights are not violated.

1.2 Context

1.2.1 Teenage fertility and age of marriage

The age at first marriage has generally increased, as seen in the increase of the median age of marriage from 17.1 in 1991 to 20.1 in 2012, although the proportion of early marriage and early childbearing remains high. IDHS 2012 reported that 19.5 percent of women aged 15-19 years, have begun childbearing or are currently pregnant.

Figure 1: Trend in Median Age of First Marriage of Ever Married Women, 25-49 years



Source: IDHS 1991, 1994, 1997, 2002, 2007, 2012

Marriage is universal in Indonesia, and pre-marital pregnancy is not considered socially acceptable. As people are delaying marriage, they are exposed to premarital sex which can have big implications, especially for young and unmarried adolescents, such as unwanted pregnancy, abortion and childbirth at a young age (children who have children).

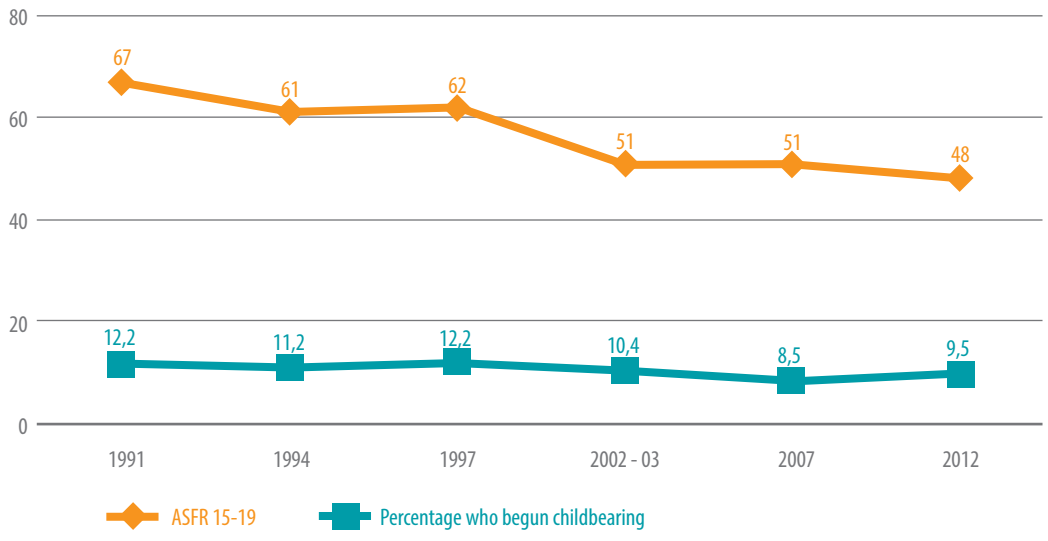
Several existing policies do not protect children and youth, such as Law No. 1 of 1974 on Marriage, which sets the permissible age of marriage at 19 years for men and 16 years for women. The international definition of the age of the child is defined as a period of up to 18 years of age. This means that the law on marriage is contradictory to international

regulations concerning the elimination of child marriage, which states that marriage under the age of 18 and teen pregnancy are practices that are harmful and dangerous to women, both medically and psychologically.

Knowledge of reproductive health among adolescents is also limited. The Adolescent Reproductive Health Survey (ARHS) shows that knowledge among adolescents about reproductive health and sexuality is low. For example, only about half of unmarried women and men aged 15-24 years know that pregnancy can occur after sexual intercourse. Unmarried individuals also have difficulty gaining access to family planning services because the policy set forth in Law No. 52 of 2009 on Population stipulates that the targets of the national family planning programme are limited to married couples. The 2012 ARHS also reported that about 0.7 percent of women and 4.5 percent of men aged 15-19 years had ever experienced sexual intercourse. There were only slight differences in sexual experience by age and place of residence, however, there were significant different by education. Unmarried women who have not completed primary school are four times as likely to have had sex than those who have continued to higher education.

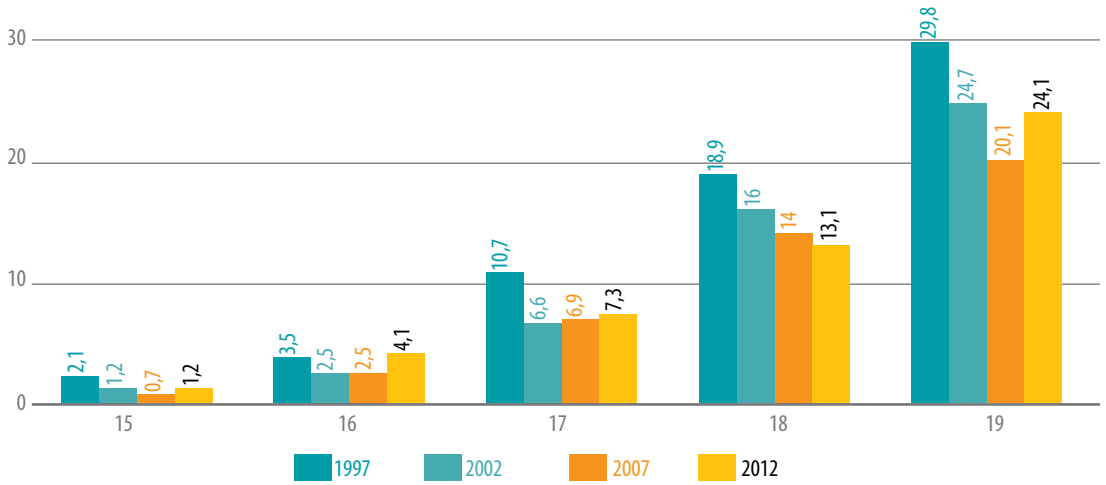
Figure 2 shows that Indonesia is unlikely to achieve its MDG target on adolescent fertility. The figure also shows an increase in the percentage of 15-19 year-olds who have begun childbearing, which is further validated by Figure 3. Trend analysis shown in Figure 3 illustrates that in all age groups, except at the age of 18 years, the percentage that has begun childbearing has increased. This has serious implications for maternal and newborn health.

Figure 2: Trend in Age-Specific Fertility Rate at 15-19 years of age, and percentage of adolescents who have started childbearing



Source: IDHS (Suharti, Bappenas 2014)

Figure 3 Distribution of women aged 15-19 years who have begun childbearing or are pregnant

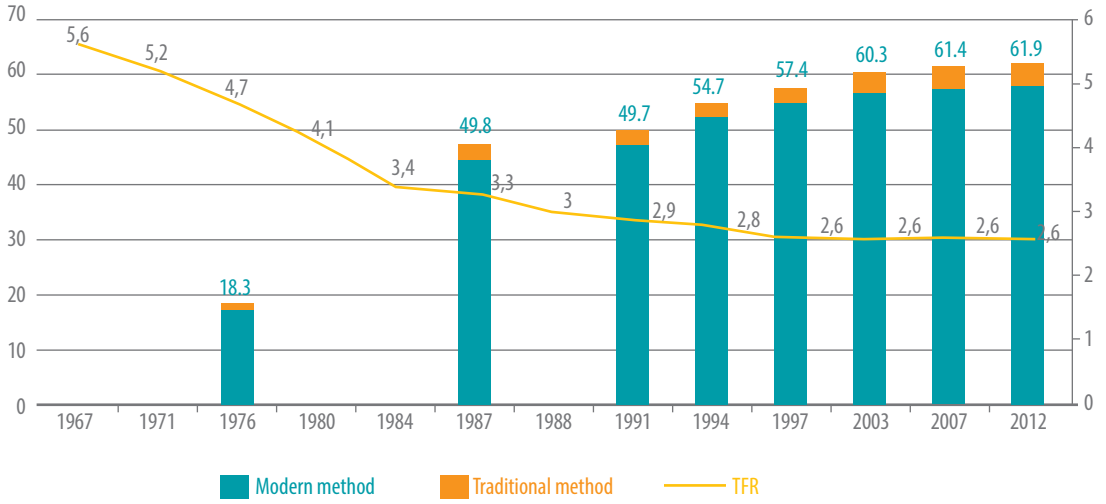


Source: IDHS 1991, IDHS 1994, IDHS 1997, IDHS 2002/03, IDHS 2007, IDHS 2012

1.2.2 Fertility and Contraceptive Use

Indonesia has gone through a demographic transition, signified by a decline in fertility and mortality. Prior to the introduction of the family planning programme in Indonesia in the late 1960s, the total fertility rate (TFR) was 5.6. Over the subsequent period, the adoption of contraception along with changes in people's perceptions regarding the ideal number of children and ideal age for marriage caused a dramatic decline in fertility levels. During this period, the total fertility rate (TFR) declined from 5.6 in 1968 down to 2.6 births per woman, or a drop of around 50%.

Figure 4: Trends in the Total Fertility Rate and Contraceptive Use in Indonesia, 1964-2012



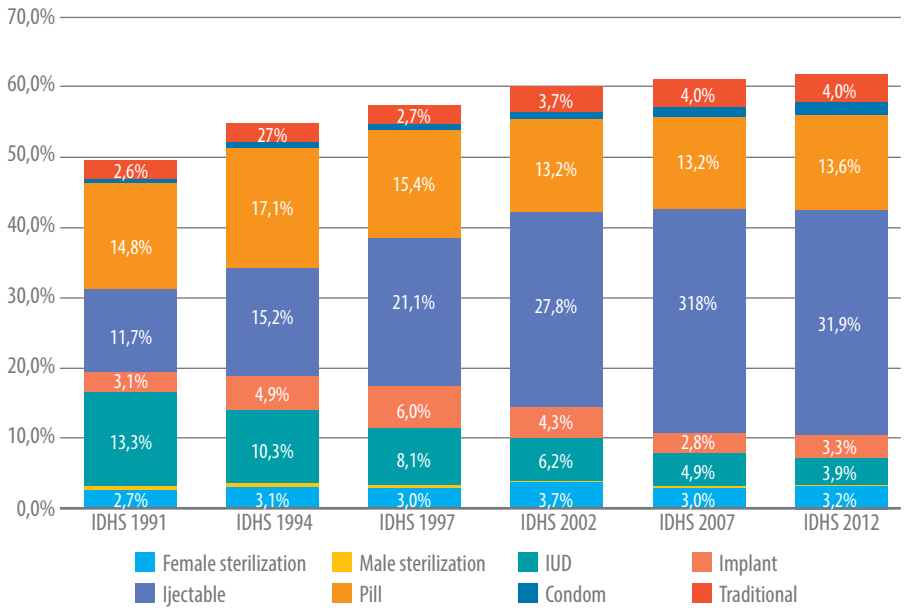
Source: Population Census 1980, 2000; Indonesian Demographic and Health Surveys 1991, 1994, 1997, 1997, 2002/3, 2007, 2012

The latest data on the national contraceptive prevalence rate (CPR) showed a rate of 61.9 percent for all methods and 57.9 percent for modern methods in 2012. Contraceptive use has stagnated at this level in the past two decades, with some provinces even experiencing a decrease in contraceptive use.

During the past two decades, there was a major shift in the contraceptive method mix, with a dramatic increase in the proportion of women using injectables and decrease in the use of long-acting methods such as IUDs and implants. Permanent methods such as sterilization (male and female) remain low, as is the use of condoms. Besides modern methods, traditional methods were used by around 4 percent of currently married women in 2012.

Figure 5 shows contraceptive use by age group. From the figure it can be seen that the contraceptive use by age shows a stagnant pattern over the past 20 years, with a slight increase found among the age group of 25-29 year-olds and 40-44 year-olds. The use of injections is increasing in all age groups, while the trends for other contraceptive methods are decreasing.

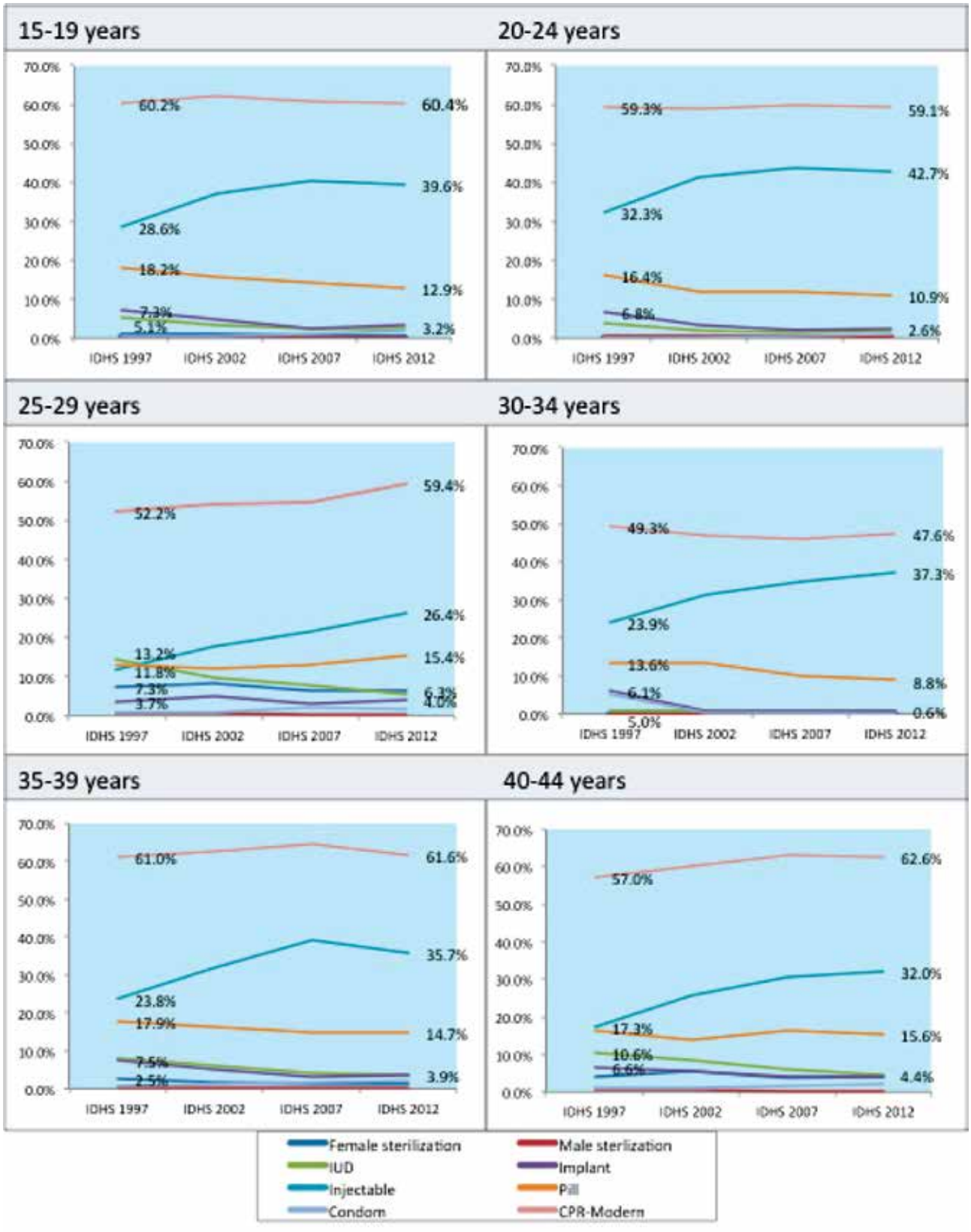
Figure 5: Contraceptive method use in Indonesia, 1991 to 2012



Source: Indonesian Demographic and Health Surveys 1991, 1994, 1997, 1997, 2002/3, 2007, 2012

Figure 6 shows age-specific use of contraceptive methods, and shows injectables as the predominant method, irrespective of age.

Figure 6: Contraceptive use by age group



Source: Indonesian Demographic and Health Survey 1997, 2002/03, 2007, 2012

Figure 7: Method mix among women aged 30-49 years

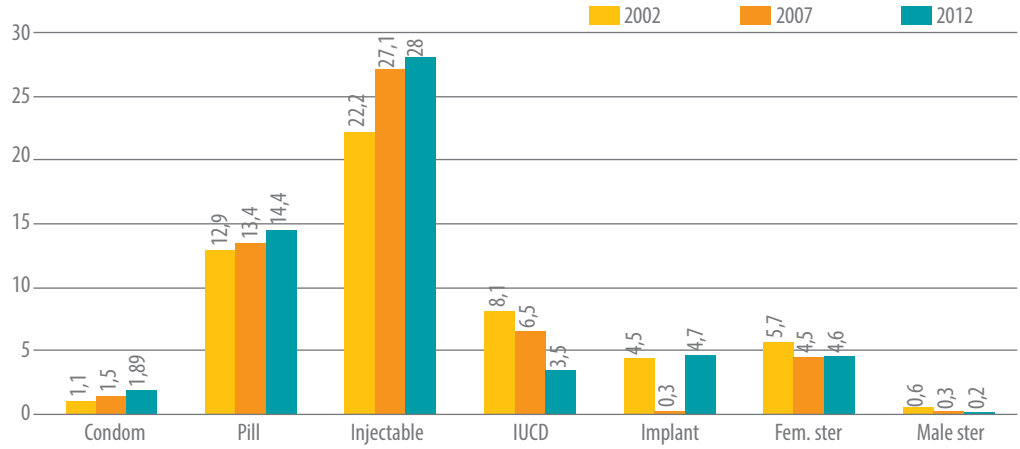
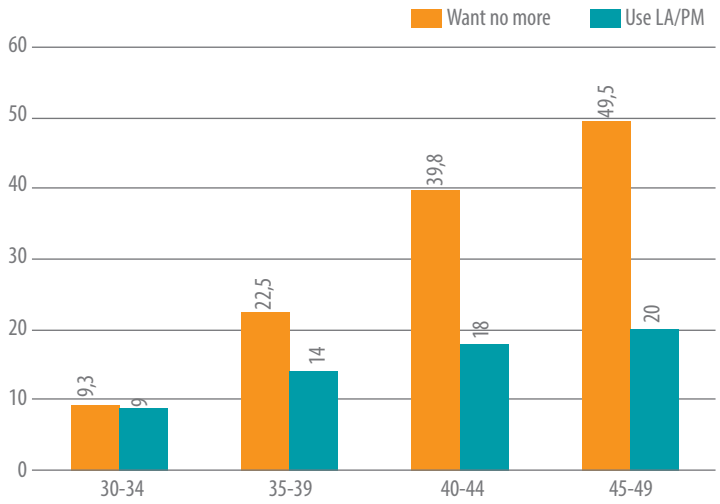


Figure 7 shows that even among older women who may have completed their reproductive goals and want to limit the number of their children, the use of short-acting contraceptive methods such as pills and injectables are high. The finding is further confirmed by Figure 8, which shows a high proportion of women aged 30-49 years who do not want to have any more children, but among whom very few are using a long-acting or permanent method of contraception.

Figure 8: Use of long-acting (LA) and permanent methods (PM) among women aged 30-49 years who do not want any more children



The 2012 IDHS reported a total contraceptive discontinuation rate of 27%, with the highest rates for short-acting methods, pills accounting for 41% of the total discontinuation rate, male condoms account for 31% and injectables make up 25%. An analysis of demographic and health survey (DHS) data from several countries on contraceptive failure rates and abortions showed that the proportion of unintended live births/pregnancies in Indonesia was 19.8%, predominantly due to non-use of contraceptives, followed by use of short-acting methods. The above analysis also showed that 15.8% of unintended pregnancies in Indonesia could be avoided by switching over to long-acting or permanent methods of contraception. Besides the costs saved to the family planning programme, the benefit of avoiding unwanted births or unwanted pregnancies ending in abortions is a key consideration.

On the providers' side, there were further notable shifts concerning sources of modern methods of contraception. Over the years, reliance on private medical providers as suppliers of contraceptive needs has increased. While data from the 1997 IDHS indicated that the share of government and private medical providers of contraceptive services was virtually equal (43% and 40%), by 2012 the share of private medical providers had sharply increased to 73 percent as the government share fell to 22 percent.

1.2.3 Unmet need

In 2012, eleven percent of currently married women who either did not want to have any more children or wanted to delay pregnancy were not using any contraceptive method. A wide variation of of unmet need for family planning was found among the provinces. The lowest rate of unmet need was found in Central Kalimantan (Kalimantan Tengah), at 7.6 %, and the highest in Papua, at 23.8 %.

Figure 9: Family Planning unmet need by province in 2012

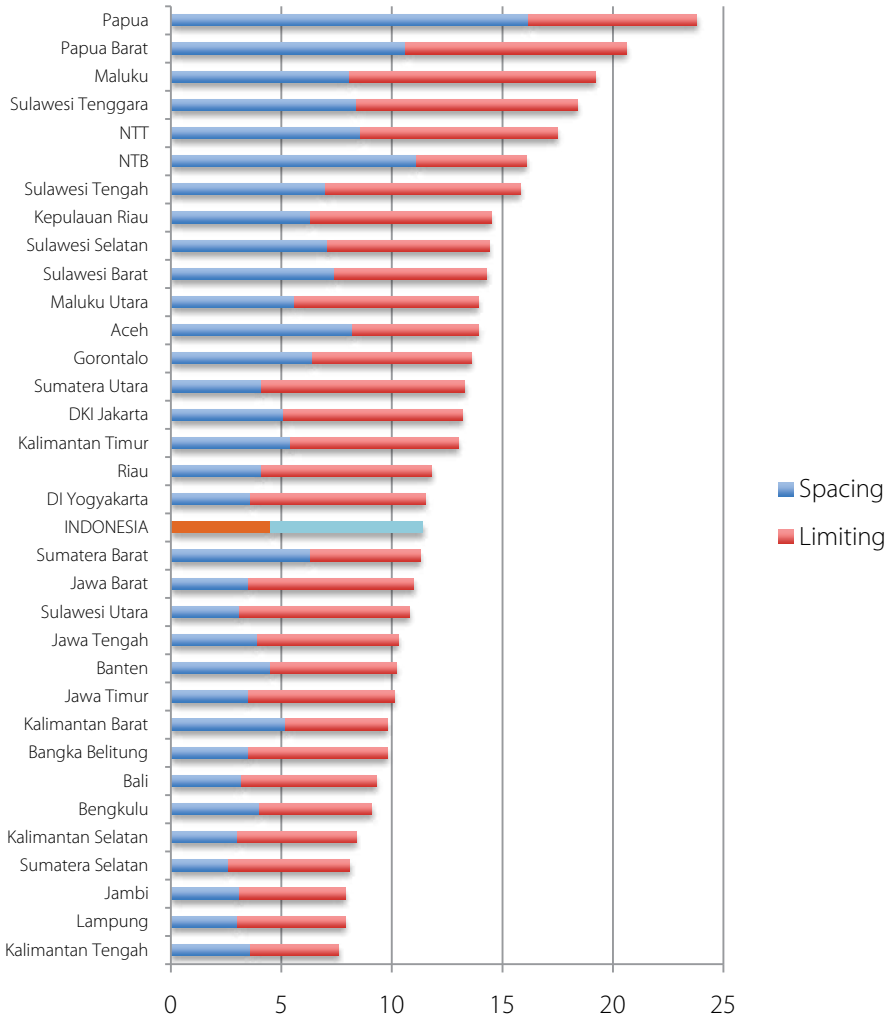
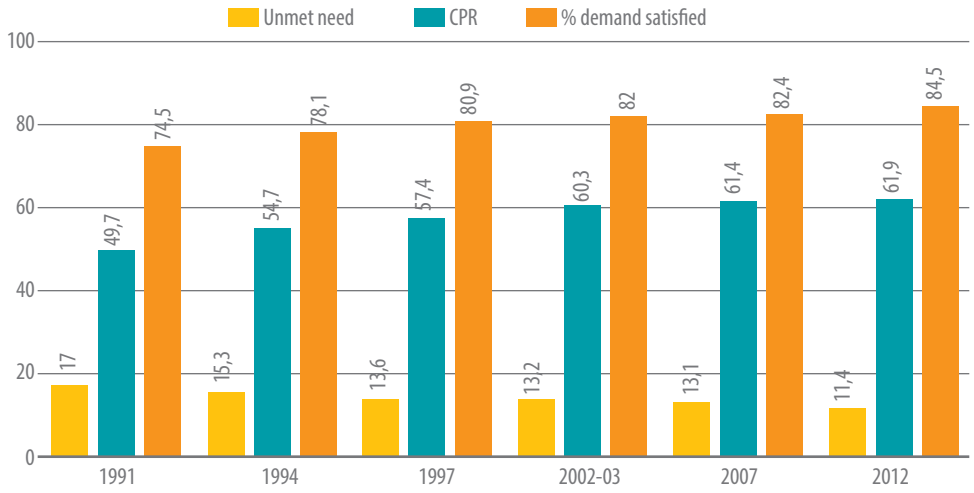


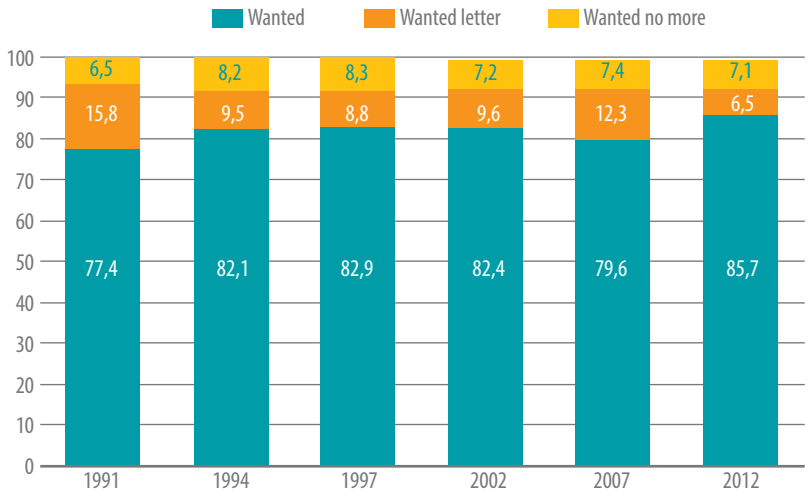
Figure 10 shows the contraceptive prevalence (all methods), unmet need and proportion of demand satisfied, which are FP2020 core indicators. As seen in the figure, the unmet need has been declining over the years. The percentage of demand satisfied has increased slightly, although the CPR has been stagnant.

Figure 10 Unmet need, CPR and demand satisfied 1991 -2012



With about 80 percent of births being wanted, Figure 11 shows that on an average around 18 percent of births are either wanted later or not wanted at all. The proportion of those who 'wanted no more births' was 7.1 in 2012 and has remained stagnant since 1991. The proportion of those who 'wanted later births' has shown a significant decrease from 2007.

Figure 11: Births in the five years preceding the survey by planning status in Indonesia, 1991-2012



The explanations and findings discussed above show that while the family planning programme has expanded in Indonesia, prevailing data suggests that unintended pregnancies do occur. The unintended pregnancies may be due to the unmet need for family planning, as well as the shift in the choices of contraceptives from long-acting intra-uterine devices to short-acting injectables that require regular re-injection every one to three months.

1.3 Issues Related to Programme Management in Family Planning

A recent assessment conducted by UNFPA (UNFPA, 2012) shows the many challenges faced by districts authorities in implementing the family planning programme. These include the non-availability of family planning health workers *(Petugas Lapangan Keluarga Berencana/PLKB),* lack of capacity of the programme staff and limited funding for the family planning programme. Lack of capacity and capability of the staff responsible for family planning activities at the district level has been pointed out as a major challenge, even in districts with a fully functional, independent family planning office (*Badan Kependudukan dan Keluarga Berencana Daerah/ BKKBD)*. The non-availability of *PLKB* is another key challenge noted by many observers. The original plan was to have a *PLKB* responsible for a maximum of two villages. However, the number currently varies, with a very low ratio in some districts, particularly in the eastern part of Indonesia. On average currently, one *PLKB* serves 3.6 villages.

The ability and capacity of the regional family planning work units (Satuan Kerja Perangkat Daerah keluarga Berencana/*SKPD KB*) to undertake advocacy to budget decision-makers in a district, such as the Mayor, the Regional Development Planning Board (Bappeda) or the Regional House of People's Representatives, is also limited, as reported by the assessment. The high turnover of staff and rate of transfer to other positions, unmatched educational background, and lack of work experience in the family planning programme, are some of the main problems repeatedly found in many districts. These problems have contributed to the low fund allocation for the family planning programme.

Another important issue is the availability of health personnel such as midwives in the field. Midwives are the main providers of the family planning programme in Indonesia. While the number of midwives is reported to be high compared to other health personnel, such as general practitioners and specialist doctors, they are not well distributed and tend to be concentrated in cities. The ratio of the different health professionals by population can be seen Table 1 below.

Table 1: Ratio of Health Professionals to Population in 2013

Health Professionals	Numbers	Ratio per 100,000 population
General practitioners	94,727	38.1
Nurse	288,405	116.1
Midwives	137,110	55.2

Source: Indonesian Health Profile 2014, MOH

1.4 Contraceptive Commodity Security

A recent evaluation conducted by BKKBN and UNFPA showed a range of complex issues and challenges in logistics management of contraceptives as follows:

- The use of target-based methodology to determine the need for contraceptives, rather than the actual use data, causes overestimation of family planning programme coverage.
- In terms of warehousing of family planning commodities, the recommended standard for storage of contraceptives is not more than 25 degrees Celsius. It was observed that in the vast majority of storage facilities the temperatures recorded were 30 degrees or higher.
- The limited capacity of the warehouses, and the lack of experience and skills among logistics staff were found to be the underlying reasons for the above findings.
- Problems were found in the distribution of contraceptives at Service Delivery Points (SDPs). The assessment reported a stock-out rate at 42 percent among SDPs.

2. RATIONALE FOR REVITALIZING THE FAMILY PLANNING PROGRAMME

2.1 Summary of points

Based on the above situational analysis, a plan for revitalization is needed to address the key issues plaguing the programme as follows:

- *Stagnating fertility rate and continued gap between wanted and actual fertility*
- *Coverage gaps:*
  - Stagnating trends in CPR for modern methods and unmet need.
  - Contraceptive method-mix in favour of short-term spacing methods and low use of long-acting and permanent methods by women who do not want to have any more children and are over 30 years old.
- *Equity gaps*
  - Disparity between rich and poor.
  - Slow progress in trend lines of family planning indicators of selected provinces since 1994 (geographical disparities)
- *Gaps in service provision*
  - Gaps in supply chain management of contraceptives.
  - Gaps in the quality assurance of contraceptive commodities.
  - Quality gaps related to information, informed choice, access to services, lack of integration with other services, continuity of care, lack of skills of providers, supervision and inadequate supplies and infrastructure.
  - Gaps in data quality and accuracy.
  - Gaps in financing at the central, provincial and district levels, as well as utilization of the limited budget.
- *The impact of decentralization* with weakened administrative capacity to manage and advocate for family planning programmes.
- Concerns related to capacity and capability of BKKBN at all levels in managing and implementing various elements of the national family planning programme.
- Restrictive policies with regard to provision of contraceptives to unmarried individuals.
- Weak coordination of family planning activities with the Ministry of Health (MoH) at the national, provincial and district levels such as reporting on family planning, training, supervision, etc.
- Early age at marriage in some districts as well as an increased proportion getting married between the ages of 16-18 years.

The above concerns and the issues identified below call for a revitalization of the current family planning programme.

2.2 Demographic dividend

Indonesia is in the middle of a demographic window of opportunity. The Government is striving to reap the full benefits of the demographic dividend through supportive economic and labour policies. However, unless the family programme is strengthened to achieve fertility reduction, it will not be possible to achieve the full potential.

2.3 Maternal mortality reduction

Indonesia is unlikely to achieve its MDG target on maternal mortality reduction, as recent estimates point to an increase in the maternal mortality ratio. Family planning is one of the critical interventions for reducing maternal mortality, and contributes to reducing approximately one-third of maternal deaths. As indicated in an earlier section, unintended pregnancies in Indonesia are about 20%, predominantly due to non-use of contraception or use of short-acting methods. The consequences of unintended pregnancies, such as abortions and related complications, are well known; thus reducing unintended pregnancies through quality family planning services can contribute to improved maternal health.

2.4 Universal health coverage

The introduction of Universal Health Coverage (UHC) under the BPJS Kesehatan (*Badan Pengelola Jaminan Sosial Kesehatan*/ National Health Insurance Agency) scheme provides an opportunity to deliver equitable and high-quality family planning services, and aim for higher coverage with modern methods of family planning services.

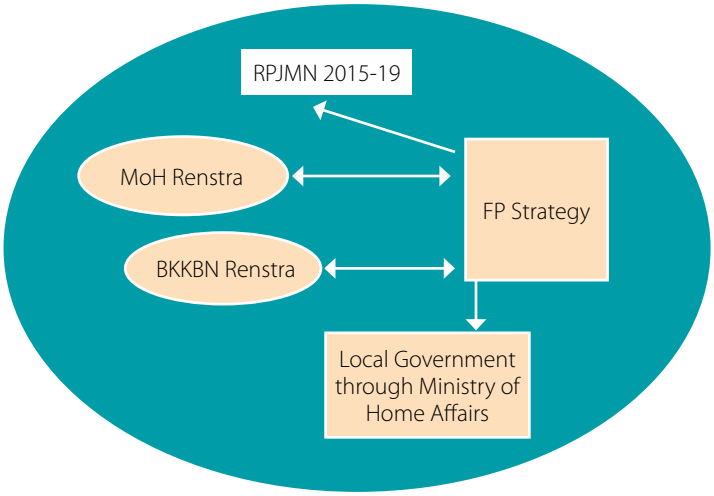
2.5 Law No. 23 of 2014 on Local Government

The recently introduced Law No. 23 of 2014 on Local Government defines the role of the MoH and BKKBN in the provision of family planning services, as well as the roles of the provincial and district administrative structures. The law contributes to enhancing the stewardship role of BKKBN and also accountability of the institutions.

3. A RIGHTS-BASED STRATEGY FOR ACCELERATING ACCESS TO FAMILY PLANNING SERVICES TO ACHIEVE INDONESIA'S DEVELOPMENT GOALS

3.1 Vision

The rights-based strategy is in line with Nawacita[1] vision. It is also aligned to the National Medium Term Development Plan (*Rencana Pembangunan Jangka Menengah Nasional/RPJMN*) for 2015-2019. It is built on the Strategic Plan (Renstra) of BKKBN and MoH related to family planning and contributes to achieving the targets of both institutions.



3.2 Mission

To catalyse collective action by BKKBN, MoH, NGOs, private sector partners, professional associations, partner development agencies and **local governments** to achieve universal access to high-quality family planning services, according to the needs of individuals and couples, and to support their reproductive intentions.

3.3 Objective

To contribute to reduced maternal mortality, population growth and fertility rates by addressing unmet need, removing barriers to access and improving the quality of services to provide modern methods of contraception to be used voluntarily by the women and men of Indonesia. The above steps are also expected to contribute to the country's ability to reap the benefits of the potential demographic dividend.

1 Nawacita means is nine priority agendas of the Indonesian government, directed by the President and the Vice President of Indonesia, Jokowi and Jusuf Kalla.

Targets are set as per RPJMN

Indicator	Baseline (2012)	Target 2015-2019
Maternal Mortality Ratio	346	306
Annual growth rate (%) (medium projection 2000-2010)	1.49	1.19
Total Fertility Rate	2.6	2.3
Adolescent Age Specific Fertility Rate	48	35
Contraceptive Prevalence Rate all methods (%)	61.9	66
Proportion of long acting and permanent method users as proportion of modern method users (%)	18.3	23.5
Unmet need (%)	11.4	9.9

3.4 Definition of family planning

The definition of family planning used in the strategic framework is based on the international definition of family planning and adheres to the definition used in the International Conference on Population and Development (ICPD) Programme of Action (PoA) and its principles and actions on family planning and adolescents. However, in the case of adolescents, the focus in the strategic framework is on prevention of unwanted pregnancy rather than spacing or limiting births.

3.5 Target group:

Women, men and adolescents of reproductive age, in the age cohort of 15-49 years.

3.6 Overall objective of the strategy

To provide guidance for quality FP services, stewardship and governance, and demand creation to help translate the commitments made by the Government at the FP 2020 Summit in London in 2012, as part of the MDGs and under the post-2015 development agenda.

3.7 Strategic Outcomes

The strategic plan seeks to establish a coherent and rights-based framework building on past successful programme elements and innovations introduced under BKKBN's KB *Kencana* and MoH's family planning action plan. It tries to comprehensively address the various facets of determinants of family planning utilization. It provides details of the priorities and steps involved for timely and effective implementation of the programme to achieve the stated goals. The strategic objectives focus on four main synergistic areas, to create an enabling environment, and support inter-dependent supply and demand and operations research/innovations that can enable couples and individuals to meet their reproductive intentions.

Strategic outcome 1: Equitable and quality family planning service delivery system sustained in public and private sectors to enable all individuals and couples to meet their reproductive goals.

Strategic outcome 2: Increased demand for modern methods of contraception, met with sustained use.

Strategic outcome 3: Enhanced stewardship/governance at all levels, and a strengthened enabling environment for effective, equitable and sustainable family planning programming in public and private sectors to enable all individuals and couples to meet their reproductive goals.

Strategic outcome 4: Fostered and applied innovations and evidence for improving efficiency and effectiveness of programmes, and for sharing via South-South Cooperation.-

The plan is expected to provide guidance for quality assurance and rights-based approaches.

3.8 Demographic and geographic focus

- Improve CPR and reduce unmet need through improved method mix with differential strategies for different age groups according to their reproductive goals.
- Focus will be on high-population-density provinces. The strategy will be implemented in phases, with the first phase to cover a limited number of provinces, ensuring significant coverage of the country's population (at least 80%), while the second phase will cover all provinces, incorporating changes from lessons learned in the implementation of the first phase.

3.9 Alignment with national policies and action plans

The strategy is well aligned with the RPJMN strategic issues as well as BKKBN's and MoH's family planning action plans.

3.9.1. Areas of alignment with RPJMN strategic issues

FP strategy (proposed strategic objectives)	RPJMN strategic issues related to family planning
Strategic outcome 1: Equitable and high-quality family planning service delivery system sustained in public and private sectors to enable all citizens to meet their reproductive goals	*Strategic issue 2:* Improving access to and quality of family planning services: *Strategic issue 3:* Increasing understanding and awareness among adolescents regarding reproductive health and preparation for family life. *Strategic issue 7:* Strengthening data and information:
Strategic outcome 2: Increased demand for modern methods of contraception met with sustained use	Linked to strategic issues 1 and 3. *Strategic issue 4:* Family development

Strategic outcome 3: Enhanced stewardship /governance at all levels and strengthened enabling environment for effective, equitable and sustainable family planning programming in the public and private sectors to enable all citizens to meet their reproductive goals	*Strategic issue 1:* Strengthen advocacy for family planning, reproductive health and family formulation: *Strategic issue 5:* Strengthening the legal foundation and the policy on population and FP *Strategic issue 6:* Strengthening the institution of family planning
Strategic outcome 4: Fostered and applied innovations and operations research for improving efficiency and effectiveness of programmes and for sharing through South-South Cooperation	
M&E: Indicators for each output	Targets and indicators as specified under each strategic issue.
	Framework: Regulatory framework, financing framework, institutional framework

3.9.2. Areas of alignment with the BKKBN Strategic action plan for 2015 (currently under development)

3.9.3. Areas of alignment with MoH family planning action plan 2014-2015

FP strategy (proposed strategic objectives)	MoH family planning action plan
Strategic outcome 1: Equitable and quality FP service delivery system sustained in public and private sector to enable all to meet their reproductive goals	Strategy 2: To increase availability, affordability, and quality of family planning services, including IEC and counselling services
	Strategy 4: To reduce the unmet need by improving access, counselling, and to strengthen post-partum use of contraceptives as well as decreasing the reluctance to continually use contraceptives through increased use of long acting and permanent methods (*MKJP*) and family planning coaching.
	Strategy 5: To lower the rate of pregnancy among teens aged 15-19 years old by encouraging them to get married at older age and improving their knowledge of adolescent reproductive health.
Strategic outcome 2: Increased demand for modern methods of contraception met with sustained use	Strategy 3: To increase the demand for family planning services due to changes in values regarding he ideal number of children in the family:
Strategic outcome 3: Enhanced stewardship /governance at all levels and strengthened enabling environment for effective, equitable and sustainable family planning programming in public and private sector to enable all to meet their reproductive goals	Strategy 1: To strengthen the commitment of stakeholders, both the government and non-government stakeholders, in organizing family planning services
Strategic outcome 4: Fostered and applied innovations and operations research for improving efficiency and effectiveness of programmes and for sharing through south-south collaboration	
M&E: Indicators for each output	M&E – Indicators for activities

3.10 Guiding principles

Indonesia is a signatory to various human rights instruments and the ICPD PoA. The guiding principles listed below are in the context of the commitments made. While it is recognized that socio-cultural and economic issues are determinants of universal access to family planning FP, national policies, strategies and guidelines determine how family planning FP programmes are implemented and whether they address rights of individuals and families (rights-holders). The stagnation of CPR and unmet need is an indication that women, men and adolescents are not able to exercise their rights (particularly women and young girls). The continuing differences in CPR and unmet need among districts is an indication of the inability of the population to exercise their rights. Low funding levels and frequent stock-outs affect the availability of contraceptives and services, and also increase the cost of services. The implications of the above can lead to unwanted pregnancies and clandestine abortions (as abortion is not legal), particularly among unmarried adolescents. Indonesia is committed to reduce unmet need by 2019, both through its commitment to the ICPD PoA as well as the MDGs and post-development agenda.

The strategy is guided by the following principles of human rights:

- *The right to access family planning information and the highest standard of care:* The right to family planning is based on human rights standards for health, as also enunciated in the ICPD PoA. It rests on the basic rights of all couples and individuals to decide freely and responsibly on the number, timing and spacing of their children2. Everyone has the right to access comprehensive contraceptive information that is unbiased, the right to make an autonomous decision on the type of contraceptive used (without being influenced by a provider or spouse), in an environment that is private and confidential (with full information accessibility).

- *Equity in access:* Overcoming barriers to differential levels of access to services between geographical areas and financial barriers is critical for ensuring equity and overcoming disparities in access and utilization. Considering the huge population of young population, particularly those who are unmarried and whose access to information and services is limited due to legal, social, religious and cultural restrictions, the implications of denying their rights is huge. To improve access for young people, in addition to enabling policies, the provision of services is critical.

- *Health systems approach applicable to the public and private sector.*

- *Integration of family planning continuum of care across reproductive cycle:* Family planning services play a key role throughout the reproductive cycle, enabling couples to have the number of children they want to have, at the age they want to have them, ensuring the elimination of unwanted pregnancies and births, as well as the need for abortions and their consequences, and the prevention of STIs and HIV via sexual transmission. The contribution of family planning services across the continuum of maternal and child care to reducing mortality and improving health among mothers and children is well documented. The integration of family planning with maternal and child health services in particular is proven to be cost-efficient for clients and the health system.

2 ICPD PoA: Principle 8, Paragraphs 7.17,7.20, 7.18

- *Ethical and professional standards in the delivery of family planning services:* Although this point is part of the right to the highest standard of care, it is presented as a separate point here to highlight the responsibility of duty bearers and institutions that provide family planning services. Duty bearers also have the responsibility to ensure responsible, voluntary and informed consent, and avoid bias towards specific methods. A related key principle is the removal of unnecessary legal, medical, clinical and regulatory barriers to information and access1.

- *Evidence-based programming:* Designing new approaches and advocacy-based messages based on formative research, operations research and data, including from monitoring and evaluation constitute one of the ten elements of a successful family planning programme.

- *Transparency and accountability:* These are critical attributes to the leadership and management of programmes, particularly in decentralized settings, and contribute to creating an enabling environment. Accountability is one of the core principles under human rights. Commitment to transparency and accountability is critical for implementing rights-based approaches, and for ensuring equity in access.

- *Gender-sensitive services:* Enabling women, particularly young women, to decide on whether to use contraceptives, as well as decide on the type of contraceptives used, is important not only from a health perspective but also from the perspective of empowerment. Increasing male involvement by informing men about various methods of contraception, and particularly male methods, is another critical element of creating an enabling environment. Male involvement is also critical for supporting female spouses/ partners in their decisions and sustained use of contraceptives.

- *Cultural sensitivity:* Cultural acceptance of methods, the procedures involved and service delivery approaches are important for acceptance and continuation of contraceptive use.

- *Partnership:* Public-private partnership among health institutions is critical for improving access to services and also to ensure that the highest quality standards are being implemented. Partnership among and between community groups, particularly women's groups, civil society organizations including faith-based organizations, parliamentarians, and so on are critical for improving access, particularly for disadvantaged groups, as well as building community support and the accountability of the health system to the people it serves1 .

Diagram 1: Strategic objectives and outputs

Medium Term Strategic Development Plan 2015-2019
Reduce MMR, reduce TFR, increase CPR, decrease unmet need, etc.

Strategic outcome 1: An equitable and high-quality FP service delivery system sustained in public and private sectors to enable all to meet their reproductive goals

Output 1.1: Increased availability of FP services, with improved and equitable access in the public sector, to enable all to meet their reproductive goals

Output 1.2: Private sector resources harnessed for equitable access to quality FP services, with attention to client rights

Output 1.3: Improved contraceptive commodity security system

Output 1.4: Improved capacity of human resources to deliver quality FP services

Output 1.5: Strengthened management information system ensuring quality, completeness and alignment integration with the health system

Output 1.6: Improved quality of FP services with attention to client rights and integration of services across the continuum of the reproductive cycle.

Strategic outcome 2: Increased demand for modern methods of contraception met, with sustained use

Output 2.1: Increased availability of a comprehensive BCC strategy

Output 2.2: Increased involvement of health workers, women's groups and religious leaders in mobilizing support for FP and addressing barriers to FP, as well as the issue of equity

Strategic outcome 3: Enhanced stewardship/ governance at all levels and a strengthened enabling environment for effective, equitable and sustainable FP programming in the public and private sectors to enable all to meet their reproductive goals

Output 3.1: Enhanced capacity for stewardship within and between sectors at BKKBN at the central and provincial levels for efficient and sustainable programming

Output 3.2: Strengthened coordination with MoH at the central, provincial and district levels to strengthen the health system's contribution to FP at appropriate points in the reproductive cycle

Output 3.3: Enhanced leadership and capacity of the SKPD KB Directors and District Health Managers to effectively manage the FP programme

Output 3.4: Enhanced capacity for evidence-based advocacy at all levels of Government and the community, focusing on the centrality of FP in achieving development goals, for increased visibility of FP programmes and leveraging resources

Output 3.5: Strengthened capacity for evidence-based policies that improve the effectiveness of the FP programme while ensuring equity and sustainability

Output 3.6: Functional accountability systems in place that involve civil society

Strategic outcome 4: Innovations and operations research fostered and applied to improve the efficiency and effectiveness of programmes, and for sharing through South-South Cooperation

Output 4.1: Best practices and models available for promoting South-South Cooperation

Output 4.2: Operations research for improving efficiency and effectiveness of FP programmes are applied, evaluated and scaled up as indicated

Guiding principles: Right to access to FP information and the highest standard of care, Equity in access, Health systems approach, Integration of FP across continuum of care across reproductive cycle, Ethical and professional standards in the delivery of FP services, Evidence-based programming, Transparency and accountability, Gender sensitive services, Cultural sensitivity, Partnership

3.11 Outputs and activities:

Indicators specific to strategic objectives and outputs are presented in the log frame matrix.

Strategic outcome 1: Equitable and quality family planning service delivery system sustained in public and private sectors to enable all to meet their reproductive goals.

The strategic objective is built from the building blocks of the health system. There are six outputs which are *interlinked*.

The proposed package of services includes (a) Non-clinical services (Sexual and Reproductive Health/SRH information for adolescents, pre-marital counselling for couples - in collaboration with MoH, counselling (includes prevention of STIs and HIV), post-partum and post-abortion counselling; (b) Clinical provision of modern methods of contraception at various levels of service, referral services, follow-up and complications management.

Outputs:

Output 1.1: Increased availability of family planning services, with improved and equitable access in the public sector, to enable all to meet their reproductive goals.

Output 1.2: Private sector resources harnessed for equitable access to quality family planning services with attention to client rights.

Output 1.3: Improved contraceptive commodity security system.

Output 1.4: Improved capacity of human resources to deliver quality family planning services.

Output 1.5: Strengthened management information system ensuring quality, completeness and alignment integration with the health system.

Output 1.6: Improved quality of family planning services with attention to client rights and integration of services across the continuum of the reproductive cycle

Output 1.1: Increased availability of family planning services, with improved and equitable access in the public sector, to enable all to meet their reproductive goals.

Key activities:

- Development of family planning standards and guidelines by BKKBN, MoH and other related stakeholders.
- District-wise mapping of facilities in the public and private sectors, using functionality as a criterion (in terms of current provision of family planning services and identifying gaps for lack of functionality) and categorization of facilities according to the type of family planning services provided, which is mutually agreed on by MoH and BKKBN, along with availability of mobile services and details of their functioning (frequency, type of services provided, etc.) and availability of social marketing programmes.
- Based on the mapping, undertaking the following:
  - Strengthening of facilities based on the gaps identified from mapping to achieve equitable access to short-term and long-term methods
  - Upgrading selected facilities as referral facilities based on the mapping to ensure equitable access
  - Strengthening mobile services to provide quality services, including follow-up and management of side effects at regular intervals

- Accreditation of facilities: Review and expansion of the scope of current standards for accreditation of *puskesmas* (primary health centres) developed by Directorate General of Health Services of MOH (*Bina Upaya Kesehatan*/BUK) to include family planning services for eligibility to be registered with BPJS (the National Health Insurance Agency), linked to Output 3.2:
- Review and revision of guidelines for provision of services by stratification of clients according to age, parity, reproductive events, etc., ensuring that rights are not violated.
  - Pre-marital counselling (health workers, in collaboration with faith-based organizations, using MoH guidelines and other guidelines developed by NGOs), referrals to youth-friendly services (YFS) and follow-up
  - Post-partum and post-abortion family planning clients
  - Promotion of long-acting and permanent methods (LA/PM) for those aged 30-49 years.
  - Referral services specifying roles of referral and receiving institutions
- Introduction of YFS for family planning and Reproductive Health (RH).
  - Revision /development of a strategy for the introduction of YFS in collaboration with MoH, which will be introduced in a phased manner starting with areas with high adolescent fertility rates
  - Collaboration with NGOs that provide YFS services, particularly for referral services.
  - Revision /development of guidelines led by MoH, including handling of referrals by peer educators and health workers
  - Training of providers, including referrals for specialist services.
  - Organization of a publicity campaign about the YFS
- Based on the mapping, introduction of social marketing programmes focusing on adolescents. (linked to Output 1.2).
- Provision of family planning services during humanitarian crises: Guidelines for the provision of family planning services to displaced populations (in the event of an earthquake, volcanic eruption, flood, etc.) as part of the Minimum Initial Services Package (MISP) to improve access to all spacing methods and emergency contraception. The guidelines will also include provision of contraception to victims of gender-based violence (GBV) .

Output 1.2: Private sector resources harnessed for equitable access to quality family planning services with attention to client rights.

Key activities:

- Development of a sustainable business model of public-private partnership through a network of franchised private health institutions and providers, focusing on increased access to equitable, affordable and quality services. The business plan would include the type of model of the network and also full or fractional franchisee models[3]. The roles and responsibilities of the franchisees will be defined. A marketing strategy will be part of the business model.
  - Branding the network
  - Developing quality standards for service provision as well as for reporting
  - Decision on a fixed fee structure for family planning services

3 Full franchisee where the franchisee only manages the business that is franchised, and fractional franchises where the franchise forms a part of a larger business.

- Development of accreditation criteria for registering with BPJS (mandatory reporting as part of the accreditation), linked to Output 3.2
- Partnership with the Private Medical Association of Indonesia and/Indonesian Midwives Association (IBI) for establishing the franchisee network, recruiting and building capacities of franchisees, building the network brand, developing quality assurance (QA) systems and ensuring compliance to standards through regular monitoring, etc. (linked to Output 1.6)
- Provision of seed money for initiating the model and continuing until the model is sustainable with a definite plan for phasing-out

- Social marketing of contraceptives for improved access for adolescents, either building on existing programmes or starting new ones, ensuring confidentiality and reduced costs (linked to Output 1.1).

Output 1.3: Improved contraceptive commodity security system

Key activities:

The key activities are grouped under two major components:

- Quality assured procurement of contraceptives, including developing a system of e-procurement (linked to Output 3.1)
- Quality contraceptive commodity security system:
  - Review of manufacturer's standards for various contraceptives and implementation.
  - Improving warehousing:
    - Review and revision of current warehousing standards of BKKBN
    - Supporting/facilitating input to improve the facilities as per standards
    - Development of guidelines for storage of contraceptives in hospitals, *puskesmas* and facilities below the *puskesmas*
    - Training for the various levels of warehouse managers, including pharmacists at the lower level institutions (pharmacists/storekeepers of private facilities that provide family planning services will be included in the training)
    - Monitoring adherence to standards at all levels, including private sector by national level staff (provincial-level monitoring), provincial-level staff (district-level monitoring, public and private sector major facilities), district-level staff (monitoring *puskesmas* and other public sector facilities, private sector facilities and providers)
    - Allocation of funding for the same
  - Strengthening supply chain management: Evaluation of the three models currently being implemented, including in terms of efficiency, cost-effectiveness and sustainability (the three models are improved current distribution systems of BKKBN, integrated system with MoH and using postal services for distribution).
  - Strengthening Logistics Management Information System (LMIS) and forecasting:
    - Review of current LMIS and assess its efficiency in being able to predict stock-outs and modify as needed
  - Building capacity for forecasting at national, provincial and district levels and for hospitals and *puskesmas* (linked to 1.4).
  - Revision of the current strategy for contraceptive commodity security that reflects quality assured procurement.

Output 1.4: Improved capacity of human resources to deliver quality family planning services

Key activities:

- Family planning services
  - Training in family planning services of midwives and doctors
    - ➢ Assessment of the quality of current training at the district level, including skill level of trainers, certification process at the field level and involvement of the training division of MoH, training management information system, analysis of allocation of funds at various levels for training and follow-up
    - ➢ Development of a training development strategy based on the new regulation related to in-service training and certification including follow-up training at the district level (for continuous professional development) and quality assurance of training
    - ➢ Revision of the current training as needed, based on the assessment above
    - ➢ Improving the training management information system to be followed by training institutions and for reporting to BKKBN and in-service training division of MOH/*PPSDM* (this should be linked to health providers' information systems, both private and public)
  - Development of a consensus on training of nurses on the use of implants, and development of a strategy for the same.
  - Pre-service training in family planning.
    - ➢ Review of the current curriculum and strengthening family planning training during postings in Obstetrics and Gynaecology (O&G) and during internships
    - ➢ Expansion of the contents of family planning in the curriculum of basic training of midwives
  - Development of a regulation that supports the above activities, including the training of nurses in family planning and expanding the scope of family planning activities of midwives (linked to Output 3.1) .
  - Training of health workers in pre-marital counselling and for follow-up (follow-up by district level trainers), linked to Outputs 1.1, 3.2.

- Management of programmes
  - Training in management information systems (linked to Output 1.5).
  - Training in management and leadership of district managers of SKPD KB and District Health Officers (DHOs), linked to Output 3.3.
  - Training in Quality Assurance (QA) of supervisors and managers (linked to Output 1.6).
  - Training in warehousing, LMIS and forecasting (linked to Output 1.3).

Output 1.5: Strengthened management information system for ensuring quality, completeness and alignment integration with the health system.

Key activities:

- Review of current reporting and recording system.
  - Joint review with MoH on the current system of reporting on family planning services at the district level that includes

- Reporting from ***puskesmas*** level to district level, as well as reporting system by family planning field workers (F1, reports from hospitals, reporting from private sector facilities that are registered with SKPD KB and others)
- Reports on family planning sent by SKPD KB and DHO
- System of data collection from health worker records by PLKB (FP field workers)
- Joint review of current system of reporting by provincial BKKBN office and provincial Health Office
- Alignment of data collected by cadre and the household data collected by local government

- Development of a system of integrated reporting of family planning from health facilities, including private sector.
- Capacity-building of supervisors to review and analyse the Management Information System (MIS), linked to Output 1.4.
- Development of a system of tracking clients through tickler files, alert systems built into computerized recording systems (linked to Strategic Objective 4).
- Introduction of pilot projects for computerized reporting (linked to Strategic Objective 4).

Output 1.6: Improved quality of family planning services with attention to client rights and integration of services across the continuum of reproductive cycle.

Key activities:

- Review of current standards for family planning FP services (counselling – general and method-specific, instructions on use of a method, procedures, referrals, follow up, screening for STIs and HIV and dual protection) and revision as needed (linked to 3.2).
- Establishment of quality assurance/quality improvement (QA/QI) system:
  - Review of current Quality Assurance system (QA) for family planning services – guidelines, implementation and efficiency and effectiveness
  - Improvement of the system and integration with maternal health services and establishing QA circles at various levels of the health and family planning system
  - Review of job description of the supervisors in the district health system as well as in the *SKPD KB* to ensure that it includes supervisory responsibility and amendment of the job description to fill the gaps
  - Capacity-building of supervisors (Midwife Coordinators and others) in supportive supervision and QA (linked to Output 1.4).
  - Creating an enabling environment to ensure that supervisory activities are supported
  - Establishment of continuous quality monitoring system and actions taken
- Engagement of community-based organizations in quality assurance

Strategic outcome 2: Increased demand for modern methods of contraception met with sustained use.

Outputs

Output 2.1: Availability of a comprehensive BCC strategy

Output 2.2: Increased involvement of health workers**,** women's groups and religious leaders in mobilizing support for family planning and addressing barriers to family planning as well as equity issue**.**

Output 2.1: Availability of a BCC strategy

Key activities:

- Updating/development of a new strategy for BCC available that is comprehensive and targeted, and:
  - includes monitoring and evaluation elements
  - includes specific strategies for sustaining performance in districts with good performance and improving performance in districts with poor performance
  - includes focus on male involvement
  - includes focus on adolescents
- Orientation of provincial directors of BKKBN on the same and orientation of the district officials by provincial directors of BKKBN.
- Development of local-specific materials and disseminating the same using strategic channels of communication with maximum reach.
  - Core messages include cultural and religious barriers and rumours about contraceptives, as relevant. Messages are gender-sensitive and are targeted to specific groups.
  - Integration of family planning messages with maternal and child health care messages as well as HIV and STI prevention messages
- Development of a system of regular review of the reach of the channels and impact of the messages developed.
- Printing and distribution of posters and booklets on family planning and ensuring availability in *puskesmas, polindes, podes* and hospitals.
- Developing a system of M-FP (mobile family planning) messaging (linked to Output 1.6)
  - Entering into a MOU with a mobile company
  - Development of a plan for using mobile messaging to remind about re-supplies, provide information, etc.
- Incorporation of family planning messages in health education sessions during antenatal clinics, child health clinics and STI and HIV treatment centres through SKPD KB coordination with DHO.

Output 2.2: Increased involvement of health workers, women's groups and religious leaders in mobilizing support for family planning and addressing barriers to family planning as well as equity issue**.**

Key activities:

- Support to faith-based organizations to promote family planning during religious discourses and using opportunities such as pre-marital counselling.
- Strengthening family planning component in *Posyandu*
  - Activation of FP services on Table 5 of the *Posyandu*
  - Health workers to promote family planning while registering mothers, weighing children, etc.
- Introduction of performance-based incentives to health workers for increasing male involvement, youth involvement and community involvement (linked to Output 3.5)
  - Providing materials for increasing male involvement through education and holding discussions in villages
- Capacity-building of youth leaders to become peer educators for family planning information and services among adolescents and young people.

- Development of strategies to revitalise the successful *Siaga* movements of the past based on in-depth review of the evaluations of the movement to identify gaps and developing plans to fill the gaps that are relevant in the current scenario.

Strategic outcome 3: Enhanced stewardship/governance at all levels and strengthened enabling environment for effective, equitable and sustainable family planning programming in public and private sector to enable all to meet their reproductive goals

Outputs

Output 3.1: Enhanced capacity for stewardship/governance within and between sectors at BKKBN central and provincial levels for efficient and sustainable programming

Output 3.2: Strengthened coordination with MoH at central, provincial and district levels for strengthening health system contribution to family planning at appropriate points in reproductive life cycle

Output 3.3: Enhanced leadership and capacity of the Directors of SKPD-KB and District Health Offices to effectively manage the family planning programme

Output 3.4: Enhanced capacity for evidence-based advocacy at all levels of Government and community focusing on the centrality of family planning in achieving development goals for increased visibility of family planning programmes and leveraging resources

Output 3.5: Strengthened capacity for evidence-based policies that improve the effectiveness of family planning programme while ensuring equity and sustainability

Output 3.6: Functional accountability systems in place that involve civil society

Output 3.1: Enhanced capacity for stewardship/governance within and between sectors at BKKBN at the central and provincial levels for efficient and sustainable programming

Key activities:

- Overseeing and guiding the overall provision of family planning services (public and private) in the interest of protecting the reproductive rights of the public
  - Development of guidelines and guidance notes on the following:
    - Collaboration and coalition building across sectors, including civil society to influence factors that determine family planning at the national, provincial and district levels
    - Guideline for *SKPD KB* on advocating for family planning programmes and overseeing family planning services and its monitoring
    - Role of the private sector in provision of family planning services and its responsibilities
    - Regulation related to design of performance measures that are rights-based
    - Setting targets for provinces and districts based on trends in family planning use, focusing on equity (using the recent district-wise data published by BKKBN)
    - Inclusion of family planning commodities and services under capitation system for reimbursement under UHC (in collaboration with BPJS and MoH)

    - ➢ Mobilization of community to utilize family planning
  - Orientation of relevant officials on the above-listed guidelines.
  - Monitoring of adherence to guidelines and systems.
- Procurement of contraceptives
  - Implementation of the regulation related to the procurement of quality-assured commodities (commodities meeting WHO pre-qualification standards)
  - Establishing a system of e-procurement.
- Systems development
  - Developing a system of performance-based disbursements to districts on meeting pre-defined benchmarks related to the family planning programme (transfer of funds from BKKBN to districts for achieving results in family planning).
- Strengthening collaboration across sectors
  - Review of MoU signed by relevant ministries such as MoH, Ministry of Religious Affairs, Ministry of Home Affairs, etc. for the promotion and expansion of family planning services and sustainability and updated as needed.
- Capacity development
  - Development of capacity of provincial staff of BKKBN to undertake analysis of district level budgets for family planning from various sources, annually, to ensure allocations are adequate as per minimum standards.

Output 3.2: Strengthened coordination between with MoH at central, provincial and district levels for strengthening the health system's contribution to family planning at appropriate points in the reproductive cycle.

Key activities:

- Based on the MoU signed with MoH for strengthening health system contribution to family planning:
  - Development of standards for family planning (linked to Output 1.1)
  - Review of service standards for family planning services and updating under the leadership of MOH in collaboration with professional organizations to ensure no health system barriers and integration with other health services across the continuum of reproductive health care (linked to Output 1.6)
  - Development of processes for family planning training certification, integrated MIS, commodity security and supervision (linked to Outputs1.5, 1.3)
- Development of strategy for strengthening post-partum and post-abortion family planning.
- Development of criteria for accreditation of facilities for family planning services both in the public and private sectors, developed for eligibility for registration under BPJS (linked to Outputs 1.1, 1.2)
- Coordination of district-level training in family planning between *SKPD KB* and DHO from the planning stage.
- Planning of joint supervisory visits by PLKB and widwives and coordinators at regular intervals and an enabling environment, such as approval of the activity by DHO, allocation of adequate funds for travel, etc.

Output 3.3: Enhanced leadership and capacity of the Directors of SKPD-KB and District Health Offices to effectively manage the family planning programme.

Key activities:

- Review of the current roles and responsibilities of DHOs and *SKPD KB* to identify areas of potential collaboration.
- Capacity-building of Directors of SKPD-KB and District Health Offices
  - In planning, developing work plans, budget analysis and advocacy for increased resources (financial and human resources) for family planning
  - Advocating to religious leaders, community leaders and women's groups to discuss importance of family planning for socio-economic development and the importance of adequate allocations for services and operational budget
  - Establishing QA/QI mechanisms (linked to Output 1.6).
- Monitoring implementation of minimum standards.
- Support to Directors of SKPD-KB and District Health Offices to hold regular meetings with religious leaders, community leaders and women's groups for advocacy.

Output 3.4: Enhanced capacity for evidence-based advocacy at all levels of Government and community focusing on the centrality of family planning in achieving development goals, for increased visibility of family planning programmes and leveraging resources.

Key activities:

- Developing a district comprehensive strategy for advocacy for family planning (based on the national strategy) with a road map for implementation of the strategy at all levels, including the community level, and a checklist for monitoring the implementation of the same.
- Developing training materials for training of media personnel and parliamentarians to advocate for family planning.
- Monitoring the implementation of the advocacy efforts.

Output 3.5: Strengthened capacity for evidence-based policies that can improve the effectiveness of the family planning programme while ensuring equity and sustainability.

Key activities:

- Undertaking province-specific studies on the contribution of family planning towards socio-economic development and achievement of the development goals.
- Supporting district family planning officials on yearly analysis of budget allocations for family planning services, particularly for tracking operational budgets.
- Development of local human resources policies that support effective, equitable and sustainable programming. Some examples are: job description and selection of Director of *SKPD KB*, equitable distribution of midwives, rotation policies, matching jobs and qualifications, performance-based incentives for health workers, etc. A new area of policy that needs to be developed includes job descriptions of *PLKBs*, recruitment mechanisms, distribution (at what level of district organization), monitoring performance, etc.

- Review of current transportation allowance for clients who need sterilization and do not live close to hospitals (linked to output 1.1 and Strategic Objective 4).
- Orientation of District Heads/Mayors and parliamentarians about the importance of family planning in improving maternal health and socio-economic development and the need for adequate budget allocation for services and programme management
- Enhancing the capability of Bappedas to include family planning in local plans.

Output 3.6: Functional accountability systems in place that involve civil society

Key activities:
- Building capacity of women's groups (rights and empowerment groups) and other civil society organizations to be 'watch dogs' to monitor violation of the rights of clients, access of adolescents and young people to services, etc. (linked to Output 1.6) :
- Creation of new committees in *puskesmas* and hospitals and building their capacity to ensure that client rights are protected.

Strategic Outcome 4: Fostered and applied innovations and evidence for improving efficiency and effectiveness of programmes and for sharing through South-South Cooperation

Outputs:
Output 4.1: Best practices and models available for promoting South-South Cooperation

Key activities:
- Evaluation of models under *KB Kencana* for efficiency, effectiveness, sustainability and replicability.
- Evaluation of innovations from within the country (including donor assisted projects) for replicability.
- Documentation of the above as best practices.
- Identification of models for promotion under South-South Cooperation.

Output 4.2: Operations research for improving efficiency and effectiveness of family planning programmes are applied, evaluated and scaled up as indicated.

Key activities:
- Undertaking operations research for improving efficiency and effectiveness of family planning programmes and conducting evaluations of the same.
- Identification of operation research areas that are effective and have the potential for promotion under South-South Cooperation.

3.12 Monitoring and Evaluation framework

The implementation of the strategy will be monitored and evaluated using the indicators proposed under 3.15 and Track 20. In addition to monitoring by key stakeholders (BKKBN, MOH and others), as stated under output 3.6, civil society organizations, possibly under the leadership of the Rights and Empowerment group will monitor the programme from a rights perspective.

3.13 Proposed list of indicators[4]

Results chain	Indicators
Goal (RPJMN 2015-2019)	MMR TFR Adolescent Age Specific Fertility Rate CPR modern method Unmet needs Proportion of long acting and permanent methods
	Proposed performance indicators
Strategic outcome 1: *Equitable and quality FP service delivery system sustained in public and private sectors to enable all to meet their reproductive goals*	• Proportion of provinces/districts with increased proportion of clients aged 30-49 years using long-acting and permanent methods • Proportion of provinces/districts with increased proportion of clients aged 15-19 years using contraceptives • Proportion of provinces/districts with women aged 20-24 years who became parents before they were 18 years old • Proportion of provinces/districts with more than 60% of the demand satisfied (instead may consider separate indicators on CPR for modern methods and another one on unmet need • Proportion of provinces/districts with discontinuation rates for specific methods of contraception reduced • Proportion of provinces/districts with facilities where no charges are levied for FP services • Percentage of new acceptors
Output 1.1: Increased availability of FP services, with improved and equitable access in the public sector, to enable all to meet their reproductive goals. Key activities:	• Proportion of districts with populations having access within two hours to functional FP service delivery points that provide IUD and implant services (criteria for being classified as 'functional') • Proportion of districts with at least one facility per 50,000 population that can provide female and male sterilization services • Proportion of remote districts with mobile services for difficult-to-access areas • Proportion of districts where at least 90% of post-partum clients are given FP advice/service • Proportion of districts where more than 90% of village level clinics provide FP services • Proportion of districts that have incorporated FP into pre-marital counselling activities of religious institutions • Proportion of districts that have developed a system of village workers ***(cadres)*** contacting newly married for FP advice • Proportion of districts that have developed a system of youth-friendly FP services • Proportion of districts where all facilities registered with *BPJS* (universal health coverage) provide at least long-acting methods of FP.

4 For further discussion by the concerned partners in the context of the respective strategic plans:
- Level of disaggregation
- Data sources
- Responsible institutions

Output 1.2: Private sector resources harnessed for equitable access to quality FP services with attention to client rights ***Key activities:***	• Business plan available at national level for involvement of private sector in FP (social franchising) • Criteria for accreditation of facilities for registration with *BPJS* developed that include capacity for providing long-acting FP methods • Proportion of districts that have implemented a business plan • Proportion of districts where all accredited facilities and providers provide long-acting methods of FP • Proportion of districts where all clients receive free FP services (with no extra charges) in private-sector accredited clinics • Proportion of districts with a social marketing mechanism in place with specific focus on adolescents and young people
Output 1.3: Improved contraceptive commodity security system with no stockouts	• Proportion of provinces/districts with no stock-outs in primary health care facilities • Proportion of provincial and district warehouses that meet the standards • Proportion of provincial and district warehouses that have a well-functioning logistics management information system • Proportion of provincial and district warehouses that complete commodity forecasts at specified intervals • Proportion of service delivery points that have the capacity to put in timely requests • Proportion of key personnel trained in contraceptive logistics
Output 1.4: Improved capacity of human resources to deliver quality FP services	• Training management system in place as per the training development strategy and consistent with the new regulations on in-service training at national, provincial and district levels • FP incorporated into pre-service training curriculum of midwives and nurses (selected methods) • Proportion of district training facilities that provide competency-based training for long-acting/permanent methods • Proportion of districts where health workers are trained in pre-marital counselling
Output 1.5: Strengthened management information system ensuring quality, completeness and alignment integration with health system	• Proportion of districts where FP units (SKPD KB) have the capacity to monitor the quality of data and take appropriate actions (criteria for quality to be determined) • Proportion of districts where all accredited private sector facilities report regularly • Proportion of districts where FP field workers (PLKB) have the skills to monitor the quality and completeness of reports from PHCS and CHWs • Proportion of districts where the FP reports from district health office and FP district units are aligned • Proportion of districts with a system of tracking clients to identify clients who have discontinued use of contraceptives
Output 1.6: Improved quality of FP services with attention to client rights and integration of services across the continuum of reproductive cycle	• Proportion of districts where more than 90% of the facilities adhere to national standards (key criteria include counselling, ensuring privacy and confidentiality, full information on all methods and informed consent if needed, screening for STIs and HIV, advice on dual protection • Proportion of districts where post-partum care service sites counsel about FP methods • Proportion of districts where all facilities screen FP clients for STIs and HIV and advise on dual protection and refer for treatment (overlap with first indicator) • Proportion of districts where a functional supervisory system is in place at all levels (need to define criteria for functional) • Proportion of districts with a functional quality assurance system in place at various level (need to define criteria for functional) • Proportion of districts with community organizations are engaged in monitoring quality of FP services

Strategic outcome 2: *Increased demand for modern methods of contraception met with sustained use*	• Knowledge about ~~of~~ long-acting methods and where to source services among women 30-49 years • Proportion of men who learned about FP through peer educators • Proportion who acquired knowledge of long-acting methods through community theatres • Proportion of districts that use M-Health approaches to convey messages of FP and to remind about re-supply • Level of knowledge of importance of delaying pregnancy among those aged 15-19 years • Proportion of young people who learned about FP from television/radio and know where to source contraceptives • Proportion of districts that have developed their own system for promotion of FP through local TV channels • Proportion of health facilities with evidence-based IEC materials, posters and other print materials (incorporating the results of the KAP study done by rights and empowerment group) • Proportion of districts that have developed peer educators to educate adolescents, young people and men on FP/RH and regularly supervise them
Output 2.1: Availability of a comprehensive BCC	• Updated /new strategy for BCC available that is comprehensive with focus on adolescents and men (criteria as per checklist), including monitoring and evaluation • Locale-specific strategic channels of communication with maximum reach are identified and appropriate materials developed • Core messages include cultural and religious barriers and rumours about contraceptives, as relevant messages are gender-sensitive and are targeted to specific groups • System for regular review of the reach of the channels and impact of the messages is developed • System of M-FP messaging developed • Proportion of districts that use M-FP messaging • Differential strategy for good performing districts and poor performing districts developed • Proportion of districts that incorporate FP messages during ANCs, child health clinics, in HIV prevention messages (dual protection)
Output 2.2: Increased involvement of health workers, women's groups and religious leaders in mobilizing support for FP and addressing barriers to FP as well as equity issue	• Proportion of districts where religious groups are actively involved in promoting FP • Proportion of districts where FP is strengthened in *Posyandus* (health workers hold talks on FP) • Proportion of districts where performance-based incentives introduced for health workers to increase male involvement, youth participation and community involvement • Proportion of districts where capacity of youth empowerment groups is built to promote FP • Proportion of districts with increased engagement of opinion leaders in *Siaga* movement

Strategic outcome 3: *Enhanced stewardship /governance at all levels and strengthened enabling environment for effective, equitable and sustainable FP programming in public and private sector to enable all to meet their reproductive goals*	• Evidence of regular coordination meetings with relevant ministries to strengthen inter-sectoral linkages for promotion, expansion and sustainability of FP services and actions taken • Evidence of regular coordination meetings with MoH and actions taken • Trends in FP use (not targets) monitored regularly and action facilitated at provincial level • Proportion of provinces that report regular coordination meetings with provincial health authorities and actions taken • Proportion of provinces that have the capacity to monitor access and equity • Policy on FP information and services for adolescents and young people approved with support from relevant ministries and implemented • Proportion of districts that have received pre-determined disbursements for achieving performance-based benchmarks agreed upon • Generic job description of Directors of SKPD-KB and District Health Offices and other staff as relevant, including selection process, approved by district administrative units • Proportion of provincial BKKBN offices who regularly (annually) undertake analysis of district level budgets for FP from various sources, annually, to ensure allocations are adequate • Evidence of functioning systems for improving/monitoring management capacity of districts to advocate for, increase resources and manage FP programmes • System for monitoring the implementation of the policy on quality assured procurement of contraceptives is available • Policy empowering community institutions/ citizens to have greater voice in the management of FP programmes implemented • Proportion of districts where advocacy strategy has been implemented
Output 3.1: Enhanced capacity for stewardship /governance within and between sectors at BKKBN central and provincial level for efficient and sustainable programming	• Guidance for district FP units (SKPD KB) on advocating for FP programmes and overseeing FP services updated and monitored • Guidance note on collaboration and coalition-building across sectors including civil society to influence factors that determine FP use for national, provincial and district level developed and disseminated. • Regulation related to design of performance measures that are rights-based developed and monitored • System of targets to provinces and districts developed based on trends in FP use, focusing on equity and monitored • MoU updated with relevant ministries such as MoH, Ministry of Religious Affairs, Ministry of Internal Affairs for promotion and expansion of FP services and sustainability. • Proportion of provinces that have implemented an MoU with provincial health authorities for better coordination and integration of FP services across the continuum of the reproductive cycle • System of performance-based disbursements based on meeting pre-defined benchmarks related to the FP programme (transfer of funds from BKKBN to districts for achieving results) developed • Support provided to provincial BKKBN offices to undertake analysis of district-level budgets for FP from various sources, annually, and to ensure allocations are adequate • Proportion of provincial offices whose capacity has been built to undertake district-level budgets for FP from various sources to ensure allocations are adequate • Proportion of districts that have increased operational budgets (within the prescribed minimum and maximum range)

Output 3.2: Strengthened coordination with MoH at the central, provincial and district levels for strengthening health system contribution to FP at appropriate points in reproductive life cycle	• MoU signed with MoH for strengthening the health system's contribution to FP • Service standards for FP services are reviewed and updated under the leadership of MoH in collaboration with professional organizations to ensure there are no health system barriers and to ensure integration with other health services across the continuum of reproductive health care • Strategy for strengthening post-partum post-abortion FP is developed • FP training coordinated with relevant MoH divisions (planning, certification) • Criteria for accreditation of facilities for FP services both in the public and private sector developed for eligibility for registration under BPJS • Proportion of districts that report regular review and planning meetings led by District Health Officer where FP reports are shared, including from the private sector, and actions are taken • Proportion of districts where recording and reporting of FP services from the *Puskesmas* level to the district level are harmonized • Report of contraceptives distributed to public and private sector facilities regularly shared with District Health Office • Proportion of districts where training in FP is coordinated with the District Health Office • Proportion of districts where joint supervisory visits are conducted by PLKB and Midwife Coordinators
Output 3.3: Enhanced leadership and capacity of the Directors of SKPD-KB and District Health Offices to effectively manage the FP programme	• Proportion of districts where the Directors of SKPD-KB and District Health Offices trained in planning, developing work plans, budget analysis and advocacy for increased resources (financial and human resources) for family planning • Proportion of districts where the Directors of SKPD-KB and District Health Offices hold regular meetings with religious leaders, community leaders and women's groups to discuss the importance of FP for socio-economic development. • Proportion of districts where the managers have advocated successfully for an increase in allocation for FP (focus on operational budget) during development planning meetings • Proportion of districts where managers monitor *UPT* (technical implementing unit)
Output 3.4: Enhanced capacity for evidence-based advocacy at all levels of Government and community focusing on the centrality of FP in achieving development goals, for increased visibility of FP programmes and leveraging resources	• A comprehensive strategy developed that provides a road map for implementation of the strategy at all levels and in the community, and monitoring and evaluation of the same (criteria as per checklist) • Proportion of districts with trained media personnel and parliamentarians on FP • A system of regular monitoring of advocacy efforts is in place
Output 3.5: Strengthened capacity for evidence-based policies that improve the effectiveness of the FP programme while ensuring equity and sustainability	• Proportion of districts where District Heads/Mayors are oriented toward the importance of FP in socio-economic development • Proportion of districts where yearly analysis of budget allocation for FP services is available for advocacy to district officials • Developed local human resources policies that support effective, equitable and sustainable programming • Transportation allowance introduced for clients who need sterilization and do not live close to hospitals
Output 3.6: Functional accountability systems in place that involve civil society.	• Proportion of districts where women's groups (rights and empowerment groups) report on the violation of the rights of clients, access of adolescents and young people, etc. • Proportion of districts where women's groups/civil society groups are involved in monitoring equity of access to FP services

Strategic outcome 4: *Fostered and applied innovations and evidence for improving efficiency and effectiveness of programmes and for sharing through South-South Cooperation*	• Number of best practices from *KB Kencana* focused districts applied elsewhere • Number of best practices promoted through South-South Cooperation
Output 4.1: Best practices and models available for promoting South-South Cooperation	• Models under *KB Kencana* evaluated for replicability • Innovations from within the country evaluated for replicability
Output 4.2: Operations research for improving efficiency and effectiveness of FP programmes are applied, evaluated and scaled up as indicated	• Number and type of operations research conducted and evaluated for improving efficiency and effectiveness

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