Study for Standardization
of Family Planning Facilities and Services 2018

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REPORT

Study for Standardization of Family Planning Facilities and Services 2018

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DECLARATION

This study was initiated and funded by the United Nations Population Fund (UNFPA) Indonesia majorly aimed to provide input for the standardization of family planning services under JKN scheme. The study mapped out the capacity of existing health facilities in providing FP services. The study also aims to assess whether these family planning facilities provide services according to their category quality standard and discuss recommendation of the credentialing systems. As the principal investigator on behalf of the Center for Health Policy and Management Faculty of Medicine, Nursing, and Public Health *Universitas Gadjah Mada*, Sandra Olivia Frans thanks to UNFPA Indonesia, Ministry of Health, BKKBN and BPJS, and all team members of Study for Standardization of Family Planning Facilities and Services 2018 that had devoted their attention and cooperation during the study.

EXECUTIVE SUMMARY

Family planning (FP) services in Indonesia have experienced some success in the past by reducing the total fertility rate by half and doubling the contraceptive prevalence rate. However, in the past decade, this progress had stalled. The preferred contraceptive method of participants had shifted from long-acting reversible contraception to short-term hormonal methods. In addition, after decentralization in early 2000s, the National Population and Family Planning Board (BKKBN), the main agency that manages family planning services and supplies, has suffered a loss of its power to some extent. The United Nations Population Fund monitoring report in 2016 revealed problems including insufficient contraceptive stock, low quality of services, and non-compliance with standards at service delivery points.

In 2014, Indonesia embarked on its journey to Universal Health Coverage by introducing the National Health Insurance system administered by the healthcare and social security agency (*Badan Penyelenggara Jaminan Sosial Kesehatan*/BPJS Health). Family planning services are included in its benefits package. There are three major impacts of the National Health Insurance system on family planning services. The most significant impact is how services are paid at different levels of service delivery. The other major impacts are contraceptive stocks availability and private sector collaborations. Ensuring the stock availability is the task of the central and/or local governments, not BPJS.

This study was designed to map family planning (FP) facilities listed and categorized in BKKBN data and those listed in BPJS Health data. The study aims to demonstrate how these two lists overlap each other. The study also aims to assess whether these family planning facilities provide services according to their category quality standard (Basic, Intermediate, Advanced, or Comprehensive). Finally, this study provides recommendations for future credentialing standards for family planning facilities.

This study was conducted at 119 health facilities in ten districts in five provinces, namely Nanggroe Aceh Darussalam, South Sumatra, Jakarta, East Java, and East Nusa Tenggara. In each province, we selected one municipality and one district. Data collection was conducted in November and December 2018.

Desk review result showed that BKKBN and Ministry of Health (MoH) used a different nomenclature to categorize family planning facilities. BKKBN used *Fasilitas Kesehatan KB (*FP Health facility), which contains 4 categories: Basic (*Sederhana*), Intermediate (*Lengkap*), Advance (*Sempurna*) and Comprehensive (*Paripurna*). Meanwhile MoH mainly used Primary Level of Health Facility (FKTP - *Fasilitas Kesehatan Tingkat Pertama*) and Advance Referral Level of Health Facility (FKRTL - *Fasilitas Kesehatan Rujukan Tingkat Lanjutan*) to refer what family planning services that a facility is expected to perform. BPJS Health followed the

nomenclature used by the Ministry of Health. There was also a difference in their categorization of family planning facilities. According to BKKBN, IUD/implant insertion/removal was provided at an Intermediate FP Facility, one level above the Basic FP facility. According to MoH, a Basic FP facility could perform IUD and implant insertion/removal when a trained midwife or doctor was present.

Our findings also suggested that there were differences of their categorization of family planning facilities and actual services that they provided. For instance, according to our data, Basic FP facilities made up a large majority of facilities. However, our field validation indicated that only 11% of our sample were Basic FP facilities; while a large number (68%) were actually Intermediate FP facilities. It might show that the classification list was not regularly update, or BKKBN might not be consistent to define Basic FP facility. On the other hand, not all Advanced FP facilities provided FP services referring to category standard. Looking at the fact that the credential system by BKKBN was not properly used, we encouraged BKKBN to simplify the classification systems to use MoH classifications only, i.e. Primary Level of Health Facility (FKTP) and Advanced Referral Level of Health Facility (FKRTL). Moreover, there was no international standard to differentiate FP facility based on the service they provided. However, MoH guidelines of FP services did not describe FP services as clear as did BKKBN guidelines. Family planning services were also neither included nor clearly stated in the accreditation of health facility. Hence, given the government wanted to simplify the credential system of FP services by using MoH classification of health facility, they should include FP services in their assessment of health facility. There shall be a clear mechanism to maintain the accreditation systems that should include FP services, so the quality of services is updated regularly. Therefore, continuous technical assistance shall be given to each facility to ensure that every family planning services meets the standard. We recommend that every FKTP shall perform Intermediate FP services in BKKBN's classification. Furthermore, every FKRTL shall perform advanced FP services. The comprehensive FP services, which includes specifically for infertility services shall only performed by selected referral facilities.

The study also recommends BPJS Health and MoH to look back at the procedure of claiming FP services to make it visible for FP facilities in the grass root level to claim the service they have provided.

Yogyakarta, January 2019

Research Group CHPM FKKMK UGM

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1.1. Background

1.1.1. Summary of Family Planning Services in Indonesia

BKKBN Indonesia has made effective interventions to control population growth. Indonesia doubled its contraceptive prevalence rate (CPR) to nearly 60%, and halved its total fertility rate (TFR) from 5.61 in 1968 to 2.86 in 1994[1]. It had been mainly achieved by a strong commitment of the leaders of the country and central command of policy execution by BKKBN. Several efforts made at the time were educating married couples about family planning (FP), promoting contraceptive methods, training medical workers, training and providing FP fieldworkers, and providing contraceptives[2]. Indonesia TFR declined slowly by 2.34 in 2000, then stagnated for over a decade and recently slightly reduced to 2.28 in 2015[3]. Even though TFR had been declined and CPR became 61.6% in 2015, Indonesia's maternal mortality ratio (MMR) was still considered high at 305 per 100,000[4] live births. This figure is still far from the Sustainable Development Goals (SDGs) health targets that is to contribute in reducing global Maternal Mortality rate to be 70 per 100,000 births by 2030[5]. Furthermore, the research shows a correlation between increased contraceptive uses and reduced maternal mortality by preventing high-risk, high-parity births[6]. Therefore, strengthening health systems related to FP services is important to reduce MMR in Indonesia.

Another problem of FP program in Indonesia is that even CPR has plateaued, preferred contraceptive methods have shifted from long-acting reversible contraception (LARC) to short-term hormonal methods; such as pills and injections. By 2013, three quarter of married women were using short-acting hormonal methods of all users[7]. In addition, data on informed choice show that only 36.5% of women are provided information about side effects and what to do when experiencing such problems, and only 51.3% of the women are provided information about other methods.[8]

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[1] Hull, T.H. and Mosley, H. 2009. *Revitalization of family planning in Indonesia*. *Bappenas*, BKKBN, and UNFPA

[2] Molyneaux, J. & Gertler, P 2000, 'The impact of targeted family planning programs in Indonesia', *Population and Development Review*, vol. 26, pp. 61-85.

[3] *Profil Penduduk Indonesia Hasil Supas,* page 39.

[4] *Profil Penduduk Indonesia Hasil Supas,* page 52.

[5] See more 2017 Health SDG Profile: Indonesia http://www.searo.who.int/entity/health_situation_trends/countryprofile_ino.pdf?ua=1

[6] Stover, J. & Ross, J. 2020, 'How Increased Contraceptive Use Has Reduced Maternal Mortality', *Maternal and Child Health Journal,* vol. 14, issue 5, pp. 687-695.

[7] *Profil Penduduk Indonesia Hasil Supas,* page 42.

[8] Indonesia Demographic and Health Survey, 2017 https://dhsprogram.com/what-we-do/survey/survey-display-522.cfm

There are several potential causes for this trend. Firstly, many health providers lack competence in family planning services. Secondly, family planning counseling is not properly administered. Thirdly, alternative options are often unavailable. UNFPA monitoring reports in late 2016 revealed a troubling situation of understocked contraceptives[9]. Further observation of central warehouse records indicates that most provincial warehouses (34 provinces) do not have sufficient stocks of contraceptives. This situation can lead to the limitation of choices given to clients. Anecdotal information indicates that the stalling of family planning indicators is mainly due to low-quality family planning program delivery and non-compliance to the standards, affecting the service quality. Since the advent of universal health care in 2014, FP services in Indonesia have also been affected by this new system.

1.1.2. Family Planning Services under the Universal Health Coverage

Universal health coverage (UHC) is considered a basic right for humans. The government is ideally responsible to provide quality health care to their people[10]. Indonesia's UHC scheme or *Jaminan Kesehatan Nasional (*JKN) was launched on January 1st, 2014 and initially consolidated all previous social health insurance (SHI) schemes that covered a half of population under one fund-management agency called BPJS-Health (*Badan Penyelenggara Jaminan Sosial-Kesehatan*). It has set a target to cover the entire population by 2019 that is projected to be 250 million. JKN scheme enables all social levels to have access to effective and high-quality promoting, preventive, curative, and rehabilitative health services. People can access the scheme with relatively low premium, and fully subsidy of premium for those that are in 40% threshold of lowest welfare level of all households in Indonesia[11]. Family Planning is one of the JKN Scheme benefits under health promotion and preventive services in addition to individual health counseling, basic immunization, and health screening. According to Guidelines of FP Service Implementation under JKN scheme, FP services are services to regulate the birth of children, ideal spacing and age for childbirth, and pregnancy through promotion, protection, and assistance in accordance with reproductive rights to build a quality family through the provision of family planning services that include the handling of side effects and complications of contraceptive.

Implementation of FP Services in National Health Insurance is explained in the Cooperation Agreement between BKKBN and BPJS Health Number 83/KSM/G2/2014 and Number 0199/KTR/0314. Furthermore, the implementation refers to the Regulation of the

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[9] See https://indonesia.unfpa.org/ for more information about the report of understocked contraceptive pills

[10] WHO 2017, 'All roads lead to universal health coverage' viewed on 18 October 2018 < http://www.who.int/news-room/commentaries/detail/all-roads-lead-to-universal-health-coverage>

[11] Guidelines of FP Service Implementation under JKN Scheme *(Pedoman Penyelenggaraan Pelayanan KB dalam JKN (BKKBN, 2014)), page 7*

Head of BKKBN Number 185/PER/E1/2014 concerning Implementation Guidelines for FP Services under JKN scheme. Despite the inclusion of FP as one of the benefit packages, good political will of the government is needed to meet their people's FP needs. Implementation of family planning services under the scheme faces many challenges. Even after almost four years of implementation, gaps in regulations and guidelines for family planning are still yet to be addressed. Among the most important issues to be addressed are credentialing of FP facilities and standardization of services for quality of family planning services.

Implementation guidelines of FP under JKN scheme dictate that FP facilities using BPJS should be registered using the FP Health Registration Form (K/0/KB/13). FP offices at the district level collaborating with the district health offices have the responsibility to register FP facilities that are using BPJS but still not registered in BKKBN's systems. Updates of FP facility can be done anytime. The establishment of a new FP facility that has Collaboration Agreement with BPJS shall be reported every six months.

Until now, Indonesia maintains (at least) two credentialing systems for health facilities providing FP services: one is under BKKBN registration that classifies FP clinics into four classifications (*Sederhana, Lengkap, Sempurna,* and *Paripurna*), and the other is under BPJS registration that classifies health facilities into two types: *FKTP* (primary health care facility) and *FKTRL* (secondary and tertiary health care). Having two registration systems with different criteria and credentialing mechanism can result in inefficient. As a result, several unexpected situations may happen, such as: firstly, FP facilities registered in BKKBN but not in BPJS may find difficulties to claim the services provided. This may result in demotivation of health providers to run FP services; secondly, facilities registered in BPJS list, but not in BKKBN list may find it difficult to get commodities, leading to discontinued use; thirdly, BPJS credentialing system does not include specific assessment for family planning services that may lead to non-standardized and less quality of family planning service provision. Although the registration system under BKKBN includes classification of facilities, but the assessment for classification is only based on FP instruments a clinic has without any assessment of competencies from the provider.

Looking at the situations mentioned above, it is urgently important to integrate the two systems. Strong evidence and information are needed to develop policy and regulations regarding the standardization of family planning facilities and services. The study is expected to map out existing FP facilities registered under the two different registration systems. Results from the study will help BKKBN to integrate the registration system. Mapping all existing FP services in the country will inform the government on the magnitude of problems in integration and therefore can better help BKKBN and BPJS plan their actions more effectively and efficiently.

1.2. Objectives

The main objective of the study is to map out family planning facilities registered under two different registration systems, namely K/0-BKKBN and BPJS's list of FKTP and FKRTL and examine whether the classification of the facilities have met the required standards for family planning services. The expected results of this study are to:

a. Produce mapping of all facilities (public and private) providing family planning services registered under BKKBN and BPJS:
   - Identify classification of each facility according to BKKBN's and BPJS's criteria.
   - Identify gaps between the two lists and provide recommendation for synchronization of the lists.
b. Review quality of FP services under UHC:
   - Review existing standards for credentialing of FP facilities under BKKBN's and BPJS's lists.
   - Conduct a field assessment to validate classification of FP facilities, identify gaps of standards in FP services by the registered facilities, and include a brief assessment of the implementation of post-partum family planning.
c. Provide recommendation to improve standards and credentialing of FP facilities under UHC.

2. DESK REVIEW

2.1. Integration of Family Planning Services under National Health Systems[12]

National Health System (SKN-Sistem Kesehatan Nasional) is held in an integrated and mutually supportive manner to ensure an optimal achievement of public health outcomes. Through the approach contained in 2015-2019 RPJMN strategic issues, there are seven SKN components: Health Efforts, Human Resources of Health, Medicine and Medical Devices, Financing, Information Systems/Regulations/Management, Community Empowerment, and Development Research. Optimized SKN components are crucial to improve both quality and access of family planning services. Family planning services under SKN are in line with the health effort component that prioritizes promoting and preventive efforts.

Referring to the regulation of the Ministry of Health Number 75 of 2014 concerning Public Health Centers, efforts carried out by *Puskesmas* consist of essential public and community health development efforts. Family Planning Service is one of the five Essential Public Health Efforts that include health promotion services; environmental health services; maternal, child, and family planning health services; nutrition services; and disease prevention and control services. Likewise, for hospitals, according to the regulation of the Ministry of Health Number 56 of 2014 concerning Hospital Classification and Licensing, family planning services are general medical services that must be available in hospitals. Family planning services consist of:

1. Essential health efforts for *Puskesmas* and general medical services at hospitals.
2. Efforts to regulate pregnancy for couples of childbearing age to form healthy and intelligent future generations.
3. Efforts to prevent unwanted pregnancies.
4. Efforts to meet the reproductive rights of clients.

Continuity of Care in FP services is comprised of reproductive health education in adolescents, counseling for women of childbearing age/prospective brides, family planning counseling for pregnant women/promotion of postpartum family planning, postpartum family planning services, and interval family planning services. According to the 2014-2015 National Family Planning Service Plan, one of the strategies is to increase the availability, affordability, and quality of family planning services through Communication, Information, and Education

[12] Directorate General of Maternal and Child Health, Ministry of Health, Indonesia, Guidelines of Family Planning Services Management

(*KIE-Komunikasi Informasi dan Edukasi*) services and systematic counseling. This counseling helps clients choose the right FP method and continue to use the method correctly.

The Presidential Regulation Number 12 of 2013 concerning National Health Insurance and the regulation of the Minister of Health No. 28 of 2014 concerning Guidelines for Implementing National Health Insurance state that Family Planning Services are one of the promoting and preventive benefits. During the transition to universal health coverage from 2014-2019, family planning services for those have not yet been registered as JKN scheme participants can be funded by the Regional Health Insurance (Jamkesda). FP services covered includes counseling, basic contraception, vasectomy, tubectomy, and complications of family planning in collaboration with institutions in charge of FP.

To improve the accessibility of services, Puskesmas is supported by the Puskesmas service network and network of health service facilities. Puskesmas service network consists of puskesmas pembantu, puskesmas keliling, and village midwives. Meanwhile, the network of health service facilities consists of clinics, hospitals, pharmacies, laboratories, and other health care facilities.

2.2. Facilities Providing FP Services

2.2.1. Classification of Health Facility According to the Ministry of Health[13]

Before we examine the classification of health facilities, it is important to understand the definition of a health facility according to the regulation of the Ministry of Health Number 71 of 2013 about Health Services in National Health Insurance. Health facilities are defined as facilities used by the government, regional government, and/or the community to carry out individual health care efforts. Health facilities are categorized into two types: Primary Level Health Facility (FKTP) and Advanced Level Referral Health Facility (FKRTL).

Primary Level Health Services (FKTP) are non-specialist (primary) health services including outpatient and inpatient services. Primary outpatient service describes an individual health service that is non-specialist conducted at first-level health facilities for the purposes of observation, diagnosis, treatment, and/or other health services. Primary hospitalization or inpatient service describes individual health services that are non-specialist and carried out at first-level health facilities for the purposes of observation, care, diagnosis, treatment, and/or other medical services, where participants and/or family members are hospitalized for at least one day. Advanced Level Referral Health Services (FKRTL) are specialist or sub-specialist

[13] Guidelines of FP Service Management (*Pedoman Manajemen Pelayanan KB*), Ministry of Health Indonesia, 2014, page 14.

individual health care services that include advanced outpatient care, advanced hospitalization, and inpatient care in a special care room.

Health care providers include all Health Facilities in collaboration with BPJS Health in forms of primary level Health Facilities and advanced level Health Facilities.

Primary health facilities as referred above can be in forms of:

- health center or equivalent;
- doctor's practice;
- dental practice;
- *pratama* clinic or equivalent; and
- primary D class hospital or equivalent.

Advanced referral health facilities can be in forms of:

- main clinic (*Klinik Utama*) or equivalent;
- general hospital; and
- special hospital.

The primary level health facility in collaboration with BPJS Health must provide comprehensive health services including promoting, preventive, curative, and rehabilitative health services, midwifery services, and medical emergency health services including supporting services that include simple laboratory examinations and pharmacy services in accordance with statutory provisions. To implement comprehensive health services, health facilities that do not have supporting facilities must establish networks with supporting facilities. Required supporting services can be obtained through referral to other supporting facilities.

2.2.2. Family Planning Services in Primary and Advance Level Health Facility[14]

According to Ministry of Health Regulation Number 71 of 2013, regarding health services in the National Health Insurance, health service providers include all health facilities that have collaborated with BPJS-Health. Based on the method of payment under JKN, the Primary Level Health Facility (FKTP) and the Advanced Level Referral Health Facility (FKRTL) provide FP services in stages:

1. Primary Level Health facility (FKTP) should include:
   - counseling services;
   - basic contraception (pills, injectables, IUDs and implants, condoms);
   - services for vasectomy

[14] Guidelines of FP Service Management (*Pedoman Manajemen Pelayanan KB*), Ministry of Health Indonesia, 2014, page 14.

−treatment of side effects and mild to moderate complications

−contraceptive use;

−referral services that cannot be handled in FKTP.

2. Advanced Level Referral Health Facility (FKRTL) should include:
   a. counseling services;
   b. IUD and implant contraceptive services
   c. Tubectomy
   d. Vasectomy

In line with the Ministry of Health Regulation 1464/PER/X/ 2010, midwives are authorized to provide maternal health, child health and reproductive health services for women. FP services include providing counseling and counseling for women's reproductive health and family planning, as well as providing oral contraceptives and condoms. In addition, midwives also implement government programs for FPs by providing injectable contraceptives, IUDs, and implants. IUDs and implant services should be provided by trained midwives.

As part of the network of *Puskesmas,* Independent Practice Midwives must be registered with the Health Office and with the BKKBN through the KB/BKKBD SKPD in order to get a distribution of contraceptive devices and drugs. FP services under the JKN scheme shall pay attention to service quality and are oriented to aspects of patient safety, effectiveness of action, and suitability to patient needs and cost efficiency. Financing arrangements for FP services have been regulated by the Ministry of Health Regulation Number 59 of 2014 concerning the standard of health service rates in the Implementation of Health Insurance. However, financing procedures for clients who are not JKN member are governed by local regulations.

2.2.3. Accreditation of Health Facilities in Indonesia and Family Planning Service Related

Puskesmas Accreditation

To carry out its functions optimally, *Puskesmas* needs to be managed properly, both the performance of the service and resources used. The community demands safe and quality health services that can fulfil their needs. Certain efforts to improve quality, risk management, and patient safety need to be applied in managing health facilities to provide comprehensive health services to the community through community and private sector empowerment efforts. To ensure that the improvement of the service quality can be done continuously, assessments by an external agency using the agreement standard through accreditation mechanism are required. In accreditation mechanism, *Puskesmas* are obliged to be assessed periodically at

least every three years. Accreditation status of primary health facility has also become one of the credential requirements to be eligible to collaborate with BPJS.

Puskesmas accreditation approach is for the benefit of patients' safety as well as patient's and family's rights, and also considering the right of health providers. Besides, the National Health System principles that emphasize human rights and gender responsive are also included in *Puskesmas* accreditation standard. It ensures that all patients receive better quality of service and information based on their needs, regardless of social class, economic level, gender, and race.

Puskesmas accreditation assesses three groups of *Puskemas* services[15], namely:

a. Management Administration Group, described in:
    i. Chapter I. *Puskesmas* Services Implementation
    ii. Chapter II. Leadership and *Puskesmas* Management.
    iii. Chapter III. Improvement of *Puskesmas* Quality
b. Public Health Efforts Group, described in:
    i. Chapter IV. Targets-oriented Public Health Efforts
    ii. Chapter V. Leadership and Management of Public Health Efforts
    iii. Chapter VI. Target Performance of Public Health Efforts
c. Individual Health Efforts, described in:
    i. Chapter VII. Patient Oriented Clinical Services
    ii. Chapter VIII. Clinical Services Support Management
    iii. Chapter IX. Clinical Quality Improvement and Patient Safety

In Chapter 1, *Puskesmas* Service Implementation does not mention specifically any health services nor family planning service. Instead, it mentions the importance to analyze community needs and program planning, accessibility of the health services, and evaluation process. It emphasizes on the importance of *Puskesmas* services to meet the needs of users and public as well as to provide information of the health services. Also, the regulation of the Ministry of Health Number 46 of 2015 about accreditation of *Puskesmas, Klinik Pratama, Tempat Praktik Mandiri Dokter, dan Tempat Praktik Mandiri Dokter Gigi* (Puskesmas, Primary Clinic, Private Medical Doctor Practice, and Private Dentist Practice) does not mention family planning service.

[15] Indonesian Ministry of Health Regulation, No. 46 Year 2015, about: Accreditation of Puskesmas, Primary Clinic (*Klinik Pratama),* Independent Medical Doctor Practice and Independent Dentist Practice

Hospital Accreditation

Under the Indonesian law, hospitals have to undergo a certain procedure and meet a certain standard to be considered as accredited. The accreditation status should be renewed after three years. During the accreditation process, KARS (the Indonesian Commission for Hospital Accreditation) uses the standard established by international organization, striving to help hospitals to meet international standards. KARS is an independent, non-profit organization that was established in 1996 by Indonesian Government to improve and ensure the quality and patient safety in hospitals by accrediting the hospitals. Since 2011, KARS has been a member of International Society for Quality in Health Care, an international accreditation organization. The Indonesian accreditation commission adopted the standard, organization, and assessment process in issuing an accreditation for a hospital[16].

According to the National Standard of Hospital Accreditation (2017)[17], there are at least four groups of standard to be met. The first one is targets that are related to patient safety. The targets are: to identify patients correctly, increase effective communication, increase drug safety, ensure right procedure for every patient, reduce the risk of infection in the hospital, and reduce patient trauma in the hospital. The next one is standard services focusing on patient; such as patient rights, access, patient assessments, drug services, and communication and education management. The third standard is hospital management standards, and the last one is achieving national program that are reducing maternal and infant mortality rate, reducing HIV/AIDS and TB infections, and controlling micro bacterium resistance and geriatric services. Again, the standard reference mentions nothing about family planning services.

2.2.4. Classification of Health Facilities Providing Family Planning Service under BKKBN systems

Family planning services under the JKN scheme are conducted at FP facilities in collaboration with BPJS Health. FP Facilities are facilities that are able and authorized to provide FP services, located, and integrated in FKTP and FKRT. The facilities can be administered by the national government, local government, or privately (including the community). Under BKKBN classifications, the facilities are classified into four categories based on the scope of the services, namely *Faskes or Fasilitas Kesehatan KB Sederhana* (Basic FP Health Facilities), *Faskes KB Lengkap***,** (Intermediate FP Health Facilities), *Faskes KB Sempurna***,** (Advanced FP Health Facilities) and *Faskes KB Paripurna* (Comprehensive FP Health Facilities). Such healthcare facilities are either classified as Primary Level (FKTP)

[16] see more: http://www.searo.who.int/indonesia/areas/health_systems/hospital_accrediation/en/

[17] Standard National of Hospital Accreditation, 1st Edition, 2017, Hospital Accreditaion Committee

or Advanced Level Referral Healthcare Facilities (FKTRL) under the BPJS categories described above. FKTP includes Basic (*Sederhana*) and Intermediate (*lengkap*) Family Planning Healthcare Facilities. Meanwhile, FKRTL includes Advanced (*Sempurna*) and Comprehensive (*Paripurna*) FP Healthcare Facilities (BKKBN, 2014).

A Basic FP Health Facility (*Sederhana*) is a facility that can provide basic family planning services, counselling, provision of pills, injections, condoms, and side effect treatment based on the health facility's ability. The health facility should be able to do referral. Henceforth we will use 'Basic FP Facility' to not to confuse readers with the definition of Health Facility by the MoH described in 2.2.2, even the nomenclature used by BKKBN is *Faskes/ Fasilitas Kesehatan KB or* FP Health facility. An Intermediate FP facility (*Lengkap*) is a facility that can provide basic FP services, and IUD/Implants insertion and removal and/or vasectomy services. An Advanced FP Facility (*Sempurna*) is a facility that can provide intermediate FP services plus tubectomy or tuba ligation services. A Comprehensive FP Facility (Paripurna) is a facility that can provide advanced FP services and recanalization and infertility treatments.

Table 1 shows the different services provided by different type of facility according to BKKBN classification.

Table 1 Classification of Family Planning Facilities by Service Scope According to BKKBN Classification[18]

No.	Service Coverage	Basic FP Facility (*Sederhana*)	Intermediate FP Facility (*Lengkap*)	Advanced FP Facility (*Sempurna*)	Comprehensive FP Facility (*Paripurna*)
1.	Counseling	√	√	√	√
2.	Provision of Condom	√	√	√	√
3.	Pills	√	√	√	√
4.	Injectables	√	√	√	√
5.	IUD/Implants insertion and removal	–	√	√	√
6.	Vasectomy	–	–/√	√	√
7.	Tubectomy	–	–	√	√

[18] Guidelines of FP Service Implementation *(Pedoman Penyelenggaraan Pelayanan KB dalam JKN (BKKBN, 2014))*, page 10

8.	Tuba ligation reversal and infertility prevention	–	–	–	√
9.	Side effect prevention (in accordance with ability) and provision of referral letter	√	√	√	√

Table 2 Staff Members Providing FP Services in Advanced Level Health Facilities [19]

No.	Family Planning Services	Staff Member
1.	Tuba Ligation	Obstetrician - gynecologist, anesthesiologist
2.	Vasectomy	Urologist/surgeon/general practitioner that has been trained to do vasectomy
3.	IUD Insertion/Removal	Doctors/midwives that have been trained in CTU IUD
4.	Implant Insertion/Removal	Doctors/midwives that have been trained in CTU implant
5.	Administration staff	Administrative staff that has been trained in family planning tools and service provision

Table 2 clarifies that only doctors or midwives that have been trained in IUD/implant insertion/removal can perform this service. Vasectomy can only be performed by a medical doctor that has been trained. Additionally, vasectomy can be conducted at the intermediate FP facility level (see Table 3).

Table 3 Classification of FP Facility Based on the Minimum Requirement of Human Resources[20]

FP Facility Classification	Human Resources	
Basic (*sederhana*)	Doctors/midwives/nurses	At least there is one of them
	Administrative staff	Optional
Intermediate (*lengkap*)	Doctors/midwives/nurses	At least there is one of them

[19] Guidelines of FP Service Implementation *(Pedoman Penyelenggaraan Pelayanan KB dalam JKN (BKKBN, 2014)),*, page 11

[20] Ibid

	Administrative staff	Optional
Advanced (*sempurna*)	Doctors	Mandatory
	Midwives	Mandatory
	Nurses	Mandatory
	Administrative staff	Mandatory
Comprehensive (*paripurna*)	Doctors	Mandatory
	Midwives	Mandatory
	Nurses	Mandatory
	Administrative staff	Mandatory

Regarding the staffing, it is clear that according to BKKBN guideline, a basic and an intermediate FP facility can be run by either a doctor or a midwife/nurse. These health providers are expected to have been trained to do IUD/implant insertion/removal if the clinic is recognized as intermediate level. Meanwhile, at the advanced and comprehensive level, FP facilities must have doctors, midwives, nurses, and administrative staff. Since the facility should offer advanced FP services such as tuba ligation and vasectomy, it should have a specialist or trained medical doctor.

Moreover, it is important to note that in the Guidelines of Family Planning Service Management (2014) launched by Directorate General of Maternal and Child Health, MoH does not define or even mention the four categorizations of Family Planning Facility level. In page 14 of the guideline, it states what FP services shall be provided by FKTP and FKRTL as has been discussed in section 2.2.2. But it does not differentiate both FKTP to be Basic and Intermediate FP facility and FKRTL to be Advance and Comprehensive FP facility. Therefore, it can be concluded that MoH may not prioritize the FP facility level defined by BKKBN in order to differentiate what family planning services can be perform by a health facility.

2.2.5. The Implementation of FP Service under JKN Scheme[21]

Any health facility that fits the definition of MoH guidelines can collaborate with BPJS Health. The collaboration is done through a cooperation agreement between the director or the owner of the health facility and BPJS Health. The agreement must be at least one year and can be renewed upon a mutual agreement. However, to cooperate with BPJS-Health, health facilities must meet all BPJS requirements. Then, BPJS Health must determine the adequate number of health facilities and participants to be served. There are several

[21] Guidelines of FP Service Implementation *(Pedoman Penyelenggaraan Pelayanan KB dalam JKN (BKKBN, 2014)) page 16-30.*

requirements* to collaborate with BPJS, including legal supporting documents of the health provider[22]. Additionally, it is crucial that the health facilities have been accredited.

According to Guidelines of Implementation Family Planning Services under JKN Scheme (BKKBN, 2014), there are several important elements to be considered.

1. Advocacy and Counselling (KIE-Communication, Information and Education)

Advocacy and Counselling are integral parts of the implementation of family planning services under JKN scheme. Advocacy activities are intended for policy makers to ensure that all stakeholders related to FP services in JKN system at either central, provincial, or district/city levels should provide policy support and operational/financial commitments to support implementation in terms of regulation, infrastructure, facilities, infrastructure, human resources, technical guidance, monitoring and evaluation, and adequate budgeting support. Counselling (communication, information and education-KIE) in the implementation of family planning services under JKN is carried out in the context of ensuring the increase in knowledge, attitudes, and behavior of families and communities that participate in JKN scheme.

2. Expanding FP Participation

Expanding FP participation in the community is achieved by increasing the awareness of individuals, families, and communities regarding the use and benefits of family planning. The direct participants are defined as married couples that are still not practicing family planning, as well as all current FP users. The indirect participants of this campaign are key people in the community, including religious and political leaders.

3. Family Planning Services
    1. Scope
        1. FP services in the health facility: FP services in the health facility is based on the FP facility classification as mentioned early.
        2. FP services in midwife or nurse practice: if there is no doctor available in a sub-district with the appointment of the head of local Health Office, the midwives and nurses can work together with BPJS Health in providing family planning services. Service scope includes:
            a. The practice of midwives includes family planning services provided in simple KB facilities up to complete (without vasectomy)

[22] The requirements are a collaboration agreement with laboratory, pharmacy, and other networks and a statement of willingness to comply with the relevant provisions under the National Health Insurance.

b. The practice of nurses includes family planning services provided in a simple family planning facility

3. FP services by FP facility network: the scope of family planning services by the FP facility network includes FP services provided in a basic FP facility, until they they have trained health personnel and facilities to support family planning services.

2. Service Procedure

1. FP Service Systems: FP service systems include the following requirements:
   - FP services are carried out in accordance with the Standard Operating Procedure (SOP)
   - The facility shall apply contraceptive choices in 'cafeteria' approach, meaning that the client shall know all the methods available and choose what method they want to use by themselves
   - The client should fill out the informed consent sheet for each injection KB service, IUD/implant, vasectomy, and tubectomy.
   - Family planning services in health facilities are done through a one stop service: it means that every potential client/prospective client that needs family planning services can be served by KIE needs in several related units. After promotion, KIP/counseling, and decision-making process regarding selected contraceptive methods, family planning medical services are carried out at the designated location.
   - Services are carried out in an integrated manner with other reproductive health components, including services for maternal and child health (KIA), sexually transmitted infection prevention and control services (PP-IMS), and adolescent reproductive health services (in this case providing information about family planning).
   - Human resources and infrastructure facilities available must meet the requirements.
   - All actions must be well documented.
   - There must be a monitoring system, evaluation, and feedback from clients to control service quality.
   - There must be monitoring and evaluation after the service.

2. FP Service Referral Systems: Referral systems are created to control quality and costs in an integrated and sustainable manner. Special attention is primarily

intended to support efforts to reduce the incidence of side effects and complications of contraceptive use.

The implementation of Referral Systems

Family planning services are carried out in a structured and level-based manner, according to medical needs. Advanced referral health services can only be provided for referral from primary-level health services and/or other advanced referral health services. Midwives and nurses can only make referrals to primary-level health care providers. The provisions referred to above are excluded from the state of emergency, the specificity of the client's health problems. The referral systems can be done vertically and horizontally:

- **Vertical Reference:** Vertical referral is between different levels of family planning services, from lower levels of service to higher levels of service or vice versa (refer back). Vertical references from lower levels of service to higher levels of service are carried out if:

  i) Clients need specialist or sub-specialist family planning services.

  ii) Referrers cannot provide family planning services according to client needs due to limited facilities, equipment and/or workforce.

  Vertical referral from higher levels of service to lower levels of service are carried out if:

  - Family planning services can be handled by lower levels of health facilities according to their competence and authority;
  - Clients need advanced services that can be handled by lower levels of facility and for convenient reason, efficiency, and long term services, and/or:
  - Referrers cannot provide health services as needed by clients because of limited facilities, infrastructure, equipment, and/or workforce.
- **Horizontal Reference:** Horizontal referral is between health services in one level. Horizontal referrals are carried out if the referrer cannot provide health services in accordance with the needs of the client because of limited temporary or permanent facilities, equipment, and/or workforce.

2.2.6. Family Planning Financing Systems[23]

Contributions

Health insurance contributions are a sum of money paid regularly by participants, employers, and/or the government for the health insurance program. The amount of JKN contributions is determined through a Presidential Regulation and reviewed regularly in accordance with social, economic, and basic needs of a decent life.

How to Pay for FP Services

a. Standard Rates

The amount of payments made by BPJS Health to Health Facilities is based on an agreement between BPJS Health and Association of Health Facilities in the area of the health facility (in each province) and refers to the standard rates set by the Minister of Health.

1. **Primary Level Health Facilities**

FP service at Primary Level Health Facilities is covered by capitation system paid by BPJS Health monthly. Family planning counseling services, condom administration, and pill services are included in the capitation financing component of FKTP. Additionally, injection, IUD/implants insertion, and sterilization services (tubectomy and vasectomy) are provided according to the annex of the regulation of the Minister of Health Number 59 of 2014. All JKN participants will have access to primary health facilities that have collaborated with BPJS Health, and there is no additional payments (regulation of the Minister of Health Number 59, Year 2014, Article 12).

2. **Practice of Midwives in Collaboration with BPJS Health in Sub-districts that Do Not Have Doctors**

Tariff for FP services in midwife practices in a sub-district that do not have a doctor based on the provisions of the District Health Office uses non capitation rates for obstetric and neonatal health services paid by the BPJS Health monthly. (Table 4)

3. **Nurse Practice in Collaboration with BPJS Health in a Sub-district without Any Medical Personnel with the Agreement of Head of the Local Health Service**

Tariff for family planning services at the nurse practice is not yet regulated.

[23] Guidelines of FP Service Implementation *(Pedoman Penyelenggaraan Pelayanan KB dalam JKN (BKKBN, 2014))* page 31-34

4. FP Facility Network

Tariff for family planning services on FP facility network (midwife practice) uses capitation and non-capitation rates available at first-level health facilities. The tariff rate is based on an agreement between the leaders of the first level health facilities and the Association of Indonesian Health Offices (ADINKES).

Table 4 Non-capitation Tariff for Family Planning Services (Regulation of the Minister of Health Number 59 of 2014)[24]

No.	FP Services	Amount of Non-capitation Tariff
1.	IUD/implant insertion/removal	IDR100,000
2.	Injectable FP services	IDR15,000
3.	Treatment for FP complication	IDR125,000
4.	Vasectomy services	IDR350,000

5. Advanced Level Referral Health Facility

For the Advanced Level Referral Health Facility, BPJS Health pays with the system called Indonesian – Case-Based Group Package, referred to as INA-CBG Rates. It is the amount of claim payments by BPJS Health to Advanced Level Referral Health Facilities for service packages based on disease diagnosis. Vasectomy and tubectomy services are family planning services that are paid for by the INA-CBG's system.

b. Claim Procedure

- Procedure for filing a claim in Primary and Advanced Level Health Facilities that collaborated with BPJS (and also midwives practice outside the Primary Level Health Facilities that collaborated with BPJS) and the First Level Health Facilities that have not entered a cooperation with BPJS Health should be in accordance to the following established rules:

  a) Completed general claim administration in the First Level Health Facilities, which include:

  a. Three copies of claim form (FPK);

[24] Guidelines of FP Service Implementation *(Pedoman Penyelenggaraan Pelayanan KB dalam JKN (BKKBN, 2014))* page 32

b. Softcopy of service data for Health Facilities that have used other P-Care/BPJS Health application or manual service recapitulation for health facilities that have not used the P-Care application;
c. Original receipts with stamp;
d. Proof of services that has been signed by participants or family members;
e. Other items required by each claim bill.

b) Completed administration of general claims in Advanced Level Referral Facilities, which includes:

f. Three copies of claim form (FPK);
g. Softcopy of application output;
h. Original receipts with stamp;
i. Proof of service that has been signed by participants or family members.
j. Other items required by each claim bill.

- Procedure for submitting claims for FP Facility Network (practicing midwives and doctors that have not collaborated with BPJS Health) is as followed:

3. Claim for the services provided in the previous month is submitted to the Puskesmas on the third of the following month. The Puskesmas will report to the District Health Office by the seventh of the month.
3. Verification is carried out to ensure JKN membership and suitability of the nominal amount claimed by the number of services.
3. Primary Level Health facilities pay for FP services to networks no later than 25 (twenty-five) days after the submission of a complete claim is received by Primary Level health facility.
3. Submission of claims for family planning services from the network to the first level health facility includes a file of claim liability in forms of:

a) FP service registration form (F/II/KB/14)
b) Photocopy of KB participant card (K/I/KB/14)

Figure 1 Claim Procedure[25]

2.3. Challenges of Family Planning Implementation under JKN Scheme

This section describes different roles and functions of FP for BKKBN and BPJS Health based on the Cooperation Agreement Number 83/KSM/G2/2014 and Number 0199/KTR/0314. Table 5 explains these functions.

Table 5 Duties and Responsibilities of BKKBN and BPJS Based on the Cooperation Agreement Number 83/KSM/G2/2014 and Number 0199/KTR/0314[26]

Tasks of BKKBN	Tasks of BPJS Health
1. Provides information and recommendations to BPJS Health regarding registered health facilities in BPJS systems that have met criteria and requirements to provide family planning services.	a) Provides information to BKKBN about health facilities both public and private that have collaborated with BPJS-Health.
2. Advocates, starting from provincial BKKBN and SKPD in Family Planning district level, to improve cooperation and coordination with the department of health in the provincial and district level also with all *puskesmas* in terms of implementing family planning programs through periodic meetings, technical guidance, and integrated supervision.	b) Provides budget support to cover family planning services at facilities in accordance with the regulations.

[25] Guidelines of FP Service Implementation *(Pedoman Penyelenggaraan Pelayanan KB dalam JKN (BKKBN, 2014))*

[26] Okriyanto, *Implementation of Family Planning Services Under JKN Scheme, 2016, Jurnal Ilmiah Keluarga dan Konstritusi, pp:77-88.*

3. Provides and distributes a. Communication, information, and education materials for the mobilization of family planning and reproductive health services (RH) to service facilities in collaboration with BPJS Health. b. Supporting family planning tools to health facilities that collaborate with BPJS Health c. Contraceptive methods and medicines in accordance with the needs of family planning services to all registered service facilities and in collaboration with BPJS Health.	c) Raises awareness about the health facilities offering family planning services under JKN Scheme
4. Plans mobile Family Planning services for married couple in coordination with local Health Office	d) Carries out technical guidance, monitoring, supervision, and evaluation of family planning programs under JKN Scheme.
5. Conducts medical technical training in family planning services for doctors and midwives and non-technical medical training for officers at service facilities in collaboration with BPJS Health.	
6. Raises awareness of health facilities offering family planning services under JKN Scheme.	
7. Carries out technical guidance, monitoring, supervision, and evaluation of family planning programs under JKN scheme.	

Despite the political will of the government and also the progress of implementing family planning services under JKN scheme, several obstacles remain. Even after almost four years of implementation, gaps in regulations and guidelines for family planning are still yet to be addressed. Among the most important issues to be addressed are credentialing of FP facilities and standardization of services for the quality of FP services. As mentioned above, the credentialing systems that have been used by BKKBN are different from the ones used by BPJS Health. The later one uses the classification of health facilities by the Ministry of Health that divides health facilities into two categories, namely Primary Level Health Facility (FKTP)

and Advanced Level Referral Health Facility (FKRTL). Meanwhile, BKKBN uses four classification of health facilities, namely *Sederhana (*Simple*), Lengkap (*complete*), Sempurna (*Advance*) and Paripurna (*Comprehensive).

This system creates several obstacles to FP at the grassroots level. For instance, health facilities registered by BKKBN but not by BPJS may receive contraceptive stock but may not be reimbursed for the services provided. This can discourage health providers from offering FP services. The other challenge is to ensure that FP services can reach all community groups in all regions in the country. This can only be achieved by improving the coverage and quality of services by strengthening health systems and by strengthening the management and distribution of contraceptive devices and drugs to fulfill sexual and reproductive health and rights.

2.4. WHO Recommendations for Family Planning Services[27]

In 2018, WHO launched an updated handbook called *Family Planning, a Global Handbook for Providers* that can be accessed online. The handbook offers technical information to help health care providers deliver family planning methods appropriately and effectively. It incorporates and reflects Medical Eligibility Criteria and Selected Practice Recommendations as well as other WHO guidance. This third edition brings the global handbook up to date with current WHO guidance on all topics covered. As a thorough reference guide, the handbook provides specific and practical guidance on 21 family planning methods. It also covers health issues that may arise in the context of family planning services. The intended primary audience for this handbook is health care providers that offer family planning in resource-limited settings around the world.

This global handbook is helping health care providers to ensure that every woman receives informed counseling reflective of the latest information on available contraceptive methods. One of its chapters explains who can provide FP services. It states that many different people can learn to inform and advise people about family planning and provide family planning methods. When more types of health workers are authorized and trained to provide family planning methods, more people will have access to them. The types of health care providers that can provide FP services are mentioned in Table 6.

[27] Family Planning, a Global Handbook for Providers, WHO 2018

Table 6 Types of Health Care Providers that Can Do and Provide Family Planning Are as Follows:[28]

Specialist doctor	Gynecologist, obstetrician
Non-specialist doctor	Family doctor, general practitioner
Advanced associate and associate clinician	Assistant medical officer, clinical officer, medical licentiate practitioner, health officer, physician assistant, surgical technician, non-physician clinician, medical assistant, nurse practitioner
Midwife nurse	• Registered midwife, midwife, community midwife, nurse-midwife • Registered nurse, clinical nurse specialist, licensed nurse, BSc nurse
Auxiliary nurse-midwife	Auxiliary midwife
Auxiliary nurse	Auxiliary nurse, nurse assistant, enrolled nurse
Pharmacist	Pharmacist, chemist, clinical pharmacist, community pharmacist
Pharmacy worker	Pharmacy assistant, pharmacy technician dispenser, pharmacist aide
Lay health worker	Community health worker (CHW), village health worker, community health volunteer
User/self	Woman, man, client

In addition, some methods can be offered by health workers but do not *require* health workers. For example, condoms are sold in shops by vendors and through vending machines. Also, community health workers or cadres and experienced/successful users can teach others how to use different methods; such as fertility awareness methods, male and female condoms, LAM, and withdrawal. They can also support and advise new users of many other methods. Users of injectable can learn to give themselves injections with a special formulation of DMPA in the Uniject delivery device. Programs can support self-injection with information and training including strong referral links to health care providers, monitor, and follow-up.

Table 7 summarizes who can provide family planning services. This table was taken from the 2018 edition of *Family Planning Guidelines for Providers*.

[28] Ibid, page 373.

Table 7 Who Can Provide Family Planning Services[29]

CONTRACEPTIVE SERVICE	Lay Health Workers (such as CHWs)	Pharmacy Workers	Pharmacists	Auxiliary Nurses	Auxiliary Nurses-Midwifes	Nurses	Midwifes	Associate/ Advance Associate Clinicians	Non-specialist Doctors	Specialist Doctor
• **Informed Choice Counselling** • **Combined Oral Contraceptives (** • **Progestin-only oral contraceptives** • **Emergency contraceptive pills (ECPs)** • **Standard Days Method and TwoDay Method** • **Lactational amenorrhea method (LAM)** • **Condoms (male & female), diaphragms, caps, spermicides**	●	●	●	●	●	●	●	●	●	●
• **Combined Oral Contaceptives (COCs)**	☑	☑	✓	✓	✓	●	●	●	●	●
• **Implant insertion and removal**	❋	☒	☒	☑	☑	✓	✓	●	●	●
• **Intrauterine devices (IUD)**	☒	☒	☒	❋	✓	✓	✓	●	●	●

[29] Family Planning, a Global Handbook for Providers, WHO 2018, page 375

Vasectomy (male sterilization)	✖	✖	✖	❋	❋	❋	❋	●	●	●
Tubal ligation (female sterilization)	✖	✖	✖	✖	✖	❋	❋	●	●	●

Legend

✓ = Recommended

● = Considered within typical scope of practice; evidence not assessed

☑ = Recommended in specific circumstances

❋ **=** Recommended in the context of rigorous research

☒ = Recommended against

✖ = Considered outside the typical scope of practice, evidence not assessed

All recommendations above assume that assigned health workers will receive task-specific training prior to offering services. Adopting task-sharing also requires functioning mechanisms for monitoring, supervision, and referral. The recommendations are applicable in both high- and low-resource settings. They provide for a range of types of health workers that can perform the task safely and effectively. The options are intended to be inclusive and do not imply either a preference for or an exclusion of any particular type of provider. The choice of the type of health worker for a specific task will depend upon local needs and condition.

In accordance to the newest edition of family planning guidelines for providers, WHO also developed the *Decision-Making Tool*[30]. It translates principles of good counselling and informed decision making into a practical but tailored process that providers and clients can follow. In order to achieve the client-centered care outlined above, the provider must become a counsellor, not just a provider. The client's perception of good quality care is often related to the way the care is provided, the way information is given, and the way the health care provider interacts with her or his client. The tool is based on the following key principles: 1) the client makes the decisions; 2) the provider helps the client consider and make decisions that best suit that client; 3) the client's wishes are respected whenever possible; 4) the provider responds to the client's statements, questions, and needs; and 5) the provider listens to what the client says in order to know what to do next.

WHO emphasizes nine guiding principles for FP services to be followed by all providers. Those principles are: 1) non-discrimination, 2) availability of contraceptive

[30] Decision Making Tool for Family Planning Clients and Providers, WHO 2015

information and services, 3) accessible information and services, 4) acceptable information and services, 5) quality, 6) informed decision-making 7) privacy and confidentiality, 8) participation, and 9) accountability.[31] Elements of quality of care in family planning include choices among a wide range of contraceptive methods; evidence-based information on the effectiveness, risks and benefits of different methods; technically competent, trained health workers; provider–user relationships based on respect for informed choice, privacy and confidentiality; and appropriate constellation of services that are available in the same locality.

To accelerate progress towards attainment of international development goals and targets in sexual and reproductive health, and in particular to contribute to meeting unmet needs for contraceptive information and services, WHO has developed guidelines on ensuring human rights in the provision of contraceptive services and information[32]. The fulfilment of human rights requires that health-care facilities, commodities, and services be scientifically and medically appropriate and of good quality. Quality of care and human rights are therefore two intrinsically connected approaches. Realization of a right-based approach without ensuring quality of care is not possible. Similarly, programs cannot achieve quality of care without guaranteeing human rights of clients.

The quality of care in contraceptive information and services, based on human right standards does not mention specific requirements of the physical building of health facility or instruments needed. It emphasizes on respecting users' privacy and guaranteeing confidentiality. This includes providing physical integrity and private spaces for counselling and examination. The guidelines also emphasize on the choices of contraceptives that providers should ensure a range of contraceptive methods.

[31] *Family Planning: a global Handbook for Providers*, WHO 2018

[32] Quality of care in contraceptive information and services based on human rights standards: A checklist for health care providers, WHO 2014

3. METHODOLOGY

3.1. Types and Design of Research

This study was designed as an indirect observational study that mainly used quantitative methods. Qualitative methods were also used in this study to gain an in-depth understanding of family planning use among the users. It took a cross-sectional approach, capturing at a specific period of time the Family Planning Service under two credentialing systems.

For the purposes of mapping FP facilities, the study used secondary data of all health facilities, public and private that provided FP services at the national and district level in BKKBN and BPJS offices. After acquiring a list of the facilities in both agencies, we reviewed to what extent the lists overlapped. Next, the study validated the quality of services of FP facilities. The aim of the validation process was to assess whether each health facility had provided family planning service based on their level of classification.

3.2. Location and Time of Research

The study was conducted in ten districts in five provinces, with two districts in each province. The research was carried out in November and December 2018. The regions that were included as the research locations are as follows.

a. Nanggroe Aceh Darussalam (NAD)
    i. Banda Aceh
    ii. Aceh Barat
b. South Sumatera
    i. Palembang
    ii. Lahat
c. Special Region of Jakarta
    i. Jakarta Pusat
    ii. Jakarta Barat
d. East Java
    i. Surabaya
    ii. Malang
e. East Nusa Tenggara
    i. Kupang
    ii. Timor Tengah Selatan

Research locations were selected by using purposive sampling and taking into account these considerations:

1. Three out of five provinces chosen were currently running a pilot project for modeling the integrated programming, planning, and budgeting for maternal health and rights-based family planning at the district level implemented by Bappenas with support from UNFPA in collaboration with PKMK UGM. The project was implemented in three districts (one district in each province). To compare family planning health facilities at the district level, we included all capital city of these provinces as the study area as well.
2. The selected provinces might have represented the variety of contraceptive prevalence rate, dropout rate, and unmet need of family planning services.
3. We chose East Nusa Tenggara to represent the Eastern Indonesia. Additionally, East Nusa Tenggara was considered to have a low contraceptive prevalence rate (40%).
4. We chose Jakarta because this province was "assumed" to have better health systems compare to the other areas.

A general characteristic of each district is presented in Chapter IV.

Eligibility Criteria for Validating FP Facilities:

1. The health facility was registered under BKKBN and/or BPJS system in the district level.
2. The providers of the facility were willing to provide required data.

3.3. Sampling Techniques

We used stratified sampling to obtain data for FP facilities. BKKBN websites provided complete information about health facilities that provided FP services including the status of ownership, classification of the clinic, and its collaboration with BPJS. By this statistical unit of analysis, we determined the sample size. We also took into account the provincial number of health facilities for the unit of analysis instead of the district number because the number of facilities in each district varies greatly.

Table 8 The Number of Sample Need with Oversample (CI 80%, Margin of Error 20%)

Province/district	Total Number of Health Facilities Providing FP Services	Sample Size
Nanggroe Aceh Darussalam	589	31
a. Banda Aceh	33	16
b. Aceh Barat	43	15
South Sumatera	660	36
a. Palembang	197	29
b. Lahat	37	7
Jakarta	534	29

a. Jakarta Pusat	94	15
b. Jakarta Barat	96	14
East Java	1869	29
a. Surabaya	153	15
b. Malang	94	14
East Nusa Tenggara	586	30
a. Kupang	52	15
b. TTS	44	15
Total study size in 10 districts	840	155

3.4. Instrument and Data Collection Techniques

Instruments of data collection for health facilities were set according to the analysis points that had been planned containing the following aspects:

1. Brief summary of the health facility including the type of health facility, ownership, accreditation status, and whether or not the health facility collaborated with BPJS.
2. Services related to reproductive health which the health facilities provided.
3. Readiness of heath facility in providing those services including human resources, trained staffs, protocol of each services, and register to capture the service provided.
4. Availability of family planning counselling because family planning counselling had not been a primary focus by the health providers (according to the literature review above).
5. Family planning services available in the health facilities including postpartum family planning readiness, availability of the contraceptive and trained staffs, how the health facility stores the contraceptives, and its stock levels.
6. Logistic and financial aspects related with the family planning services.

Instrument tools using for collecting data:

1. Recording sheets and checklists. Data collectors brought these instruments to obtain FP facility data in BKKBN and BPJS offices, as well as validation of the quality of services at each FP facility. At the end of the day, data collectors input results in a shared folder so that the research team could directly verify the data and examine its completeness and logic.
2. Field notes were used to record useful observations during data collection related to FP services in the facilities that were not captured in the quantitative data.
3. Recording and notes for qualitative interviews.

3.5. Data Collection and Analysis

Summary of the data collection and data analysis processes are described in this section.

3.5.1. Mapping of FP facilities

The data was collected by extracting data from BKKBN sources and BPJS sources. From BKKBN sources, we easily retrieved data by accessing the verified website (http://aplikasi.bkkbn.go.id/sr/Klinik/Laporan/ViewLaporanPELKON.aspx) that contained all information needed. From there, we extracted the data of registered clinics based on types of clinic (Table 2A), number of clinics based on family planning classification (Table 3A), and number of clinics based on the status and ownership of clinic (Table 4A). In the data provided, we could also access provincial, district, and sub-district level. In the sub-district level, we could also view the name of all clinics provided family planning services. The data were complete and systematic, providing all detailed information we needed in terms of family planning services across the country. However, as the data was updated once a year, when we verified BKKBN at the district level, quite few of clinics were not implementing family planning services. The challenges will be explained later in the discussion section. We also verified data by getting the data from BKKBN office in the district. To get the data from BPJS we sent our study proposal to BPJS Health in the national level by email and waited for their approval to send the data that is required. However, the time to get the data was considerably long. By the time this report was written, we still had not received BPJS data.

Descriptive analysis was conducted to quantitative secondary data for the following information:

- The number of health facilities providing family planning services based on the ownership and type of health facilities.
- The number of health facilities providing family planning services in accordance with its collaboration with BPJS systems.

3.5.2. Facility Assessment

Ten data collectors were placed in ten districts where the study was conducted. Before data collection begun, we started by training the data collectors using a webinar system. All data collectors attended the training. Also, to ensure that everybody was on the same page, the supervisors from the main team at UGM visited all data collectors in the ten districts at the beginning of the data collection to conduct monitoring of data collection as well as to gain study permission.

Obtaining permission from stakeholders in each district was not as simple as we predicted. Ideally, as the study was conducted in five provinces, we should get the permission from the Ministry of Home Affairs (MOHA) and then we should bring the letter from MOHA to

the related stakeholders. However, it took more than three weeks to get the permission letter from the MOHA. Therefore, we processed permission by visiting *Kesbangpol* (*Kesatuan Bangsa dan Politik Dalam Negeri*) at the provincial level instead to get a recommendation letter to go to *Kesbangpol* in the district. In three provinces, we could easily get the letter from *Kesbangpol* within two days. In those six districts we obtained data by almost 90% of the targeted samples. However, in the other two provinces, they still required he letter of recommendation from MOHA or *Kesbangpol* Yogyakarta. Even though we had obtained the required letter from *Kesbangpol* in their own Provinces, it was still not easy to get into some health facilities. We were rejected by some private health facilities. Due to the difficulties to get permission from provincial health office in these provinces, we could not interview a number of health facilities. However, it was important to note that we still reached 80% of the target facilities, so the objective of the study was still represented. Also, after we did sampling of the health facilities by using the simple random sampling technique, the results showed similar findings in terms of the standardization of family planning service. Hence, the completed interviews sample could answer the research question.

After collecting the data in the health facilities, the data collectors input the data in Excel and placed the files in dropbox. Our dropbox had been set privately to restrict viewing to authorized personnel. After that, data verification was completed by the study supervisors. Data were analyzed manually using Microsoft Excel with some help of STATA when thematic analysis was needed as mentioned in the instruments section. The analysis schema is shown in Figure 2.

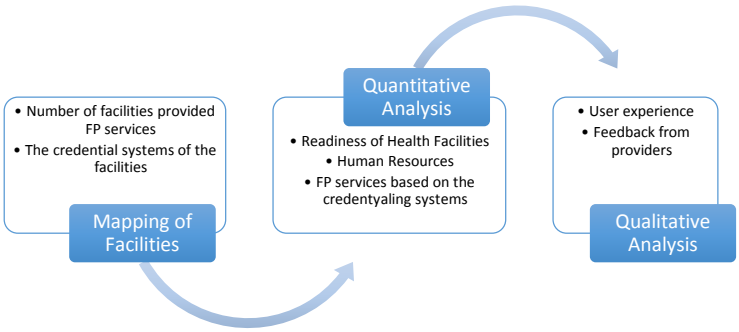

Figure 2 Data Analysis Scheme

4. GENERAL DESCRIPTION of RESEARCH LOCATION

The study used purposive sample to determine the study sites. There were several family planning indicators used to determine the study site, namely Contraceptive Prevalence Rate (CPR) and Total Fertility Rate (TFR). Additionally, we took into account the maternal mortality ratio and infant deaths as one of the indicators showing the success of FP program. Research locations were Jakarta Pusat, Jakarta Barat, Banda Aceh, Aceh Barat, Palembang, Lahat, Surabaya, Malang, Kupang, and Timor Tengah Selatan (TTS).

Looking at the population aspect, Surabaya, Malang, and Jakarta Barat were the top three populated area, with each having more than two million citizens. The least populated areas were Aceh Barat, Lahat, and TTS. In terms of maternal and child health, the highest MMR was in TTS, that was 290/100000 (according to the district's health profile 2016), followed by Kupang and Surabaya whose MMRs were quite the same, 141 and 154 per 100 thousand live birth respectively. The other districts had MMR less than 100 per 100 thousand live birth. The lowest MMR went to Banda Aceh, that was 37/100000 live births. These facts aligned with Total Fertility Rate (TFR) in each district. As TTS had the highest MMR, its TFR was also the highest that was 4.2. In contrast, there were four districts with TFR below 2.0, that were Jakarta Pusat, Jakarta Barat, Surabaya, and Malang. If we compared to their MMR, three of them had MMR below 100 per 100 thousand live birth. This finding could strengthen the argument that family planning gave a positive impact to maternal health.

Table 9 Characteristics of Study Sites*

Indicators	Jakarta Pusat	Jakarta Barat	Banda Aceh	Aceh Barat	Palembang	Lahat	Surabaya	Malang	Kupang	TTS
Populations	1,139,285	2,326,721	254,904	189,119	1,623,099	401,494	2,862,406	2,576,596	412,708	461,681
Total area (km^2)	52	124	61.36	2,927.95	369.22	4.362	350.54	3.238	26.18	3.947
Population density (person/km^2)	23,671	17,961	4,154	65	4,052	92	8,770	875,96	2,289	117
Maternal Mortality Rate (MMR)	95/100000	96/100000	37/100000	43/100000	79/100000	38/100000	154/100000	98/100000	141/100000	290/100000
Number of maternal death in 2017	13	24	2	6	23	13	34	17	12	27
Population growth rate	0.034	1.830	1.96	2.130	1.010	1.049	0.52	0.63	2.59	0.50
Number of women in reproductive age (15-49 year-old)	135,626	744,233	80,307	57,051	459,229	103,365	854,285	253,558	125,916	112,869
Number of live births in a year	13,738	51,423	5,781	3,502	29,011	9,741	42,822	38,279	8,499	9,303
Number of infant deaths in a year	125	331	39	57	12	?-	21	114	42	51
Number of couples in reproductive age	180,051	523,922	43,334	34,057	288,412	79,861	518,226	519,379	55,034	73,089

*Data source: Central Bureau of Statistics, district or city health profile, 2016

Active family planning acceptors	111,003	317,425	32,380	23,215	204,989	58,295	512,531	393,878	49,438	44,166
TFR	1.93	1.70	2.74	3.17	2.30	2.59	1.73	1.83	2.61	4.27
ASFR of adolescents (15-19 years)	0.0183	0.0187	0.0098	0.0426	0.0207	0.0494	0.0205	0.0173	0.0166	0.0674
CPR in all methods (%)	81 ,8	42.6	74.72	40.7	48.2	56.3	78.94	74.16	39.2	39.1
Number of long-term contraceptive acceptors	26,070	76,976			30,355	-	8,751	103,793	5,435	6,385
Proportion of long-term contraceptives (%)	23.10	24.25	3.00	9.00	13.71	-	16.50	33.40	19.70	17.70

Indonesia's Contraceptive Prevalence Rate (CPR) was around 60%. In our study sites, there were four regions that had CPR around 75%, i.e. Jakarta Pusat, Banda Aceh, Surabaya, and Malang. Meanwhile, three districts that were in the bottom were Aceh Barat, Kupang, and TTS, each of that had only 40% CPR.

Even though socio-cultural and economic issues were recognized to be some determinants of universal access to family planning, national policies, strategies, and guidelines were also very crucial for the implementation of family planning programs that could accommodate individual and family rights. Low CPR in some areas as listed in Table 9 was an indication that communities (especially women in reproductive age) might find it difficult to obtain their rights to access FP programs. Such conditions might lead to a high rate of unwanted pregnancy in the community and to a high maternal mortality rate. High maternal mortality rates in some regions indicated high rates of high-risk pregnancy; this was associated with another indicator, i.e. ASFR for 15-19 years. Teenage pregnancy, as one factor that contributed to maternal mortality indicated failure to fulfill adolescent rights to access sexual and reproductive health information, an important indicator for FP programs.

Next, we were interested to see the number of FP facilities based on the status of the facilities: Basic (*Sederhana*), Intermediate (*Lengkap*), Advanced (*Sempurna*), or Comprehensive (*Paripurna*). The data in Table 10 were extracted from BKKBN's website.

Table 10 Health Facilities Providing FP Services in 2017 Based on Types of FP Facilities[33]

District	Basic FP Facility (*Sederhana*)	Intermediate FP Facility (*Lengkap*)	Advanced FP Facility (*Sempurna*)	Comprehensive FP Fac (*Paripurna*)	Total	Public Facility	Private Facility	Total
Jakarta Pusat	72	15	3	4	94	76	18	94
Jakarta Barat	91	4	0	1	96	81	15	96
Banda Aceh	32	1	0	0	33	18	15	33
Aceh Barat	40	3	0	0	43	18	25	43
Kota Palembang	161	30	1	5	197	58	139	197

[33] source: http://aplikasi.bkkbn.go.id/sr/Klinik/Laporan2013/ViewLaporanPELKON.aspx

Lahat	36	2	0	0	38	34	4	38
Surabaya	148	4	0	2	154	90	64	154
Kab. Malang	92	3	0	0	95	45	50	95
Kota Kupang	49	3	0	0	52	25	27	52
Timor Tengah Selatan (TTS)	40	4	0	0	44	40	4	44
TOTAL	761	69	4	12	846	485	361	846

As seen in Table 10, in eight districts, more than 90% of health facilities providing FP services were classified as Basic FP facilities (*Sederhana*). According to BKKBN definition of basic FP facility, in these eight districts, 90% of the facilities only provided basic FP services; such as counselling, condoms, pills, and injections. If a woman wanted to get an IUD/implant she had to seek an intermediate clinic that was rarely found in these districts, leading to discontinuation of contraceptive services and making it difficult to increase FP coverage due to limited services. Only two districts – Jakarta Pusat and Palembang – had a range of intermediate, advanced, and comprehensive FP facilities. Also, according to Table 10, there were six districts that did not have either advanced or comprehensive FP facilities: Banda Aceh, Aceh Barat, Lahat, Malang, Kupang, and TTS. This situation led to the assumption that in these places there were no permanent contraceptive services both for tubectomy and vasectomy services. This study also gave evidence of FP facilities we identified in the validation process.

Ownership status varied in each district. Five districts were dominated by public facilities, namely Jakarta Pusat, Jakarta Barat, Surabaya, Lahat, and TTS. Three districts had quite the same number of public and private facilities, namely Banda Aceh, Malang, and Kupang. The other three districts had a significant number of private facilities that were Palembang and Aceh Barat.

Moreover, it is important to see the average monthly contraceptive services as shown in Table 11:

Table 11 Average Monthly Contraceptive Services in 2018

	Average Monthly Contraceptive Services in 2018									
District	**IUD**	**%**	**Implant**	**%**	**Condom**	**%**	**Injection**	**%**	**Pills**	**%**
Jakarta Pusat	246	43.9%	17	3.0%	47	8.4%	177	31.6%	74	13.2%
Jakarta Barat	177	9.9%	55	3.1%	147	8.2%	1073	60.1%	332	18.6%
Banda Aceh	160	4.9%	40	1.2%	236	7.2%	1392	42.7%	1431	43.9%
Aceh Barat	42	2.6%	51	3.2%	159	9.9%	908	56.4%	449	27.9%
Palembang	41	2.7%	53	3.5%	277	18.1%	566	37.1%	590	38.6%
Lahat	55	0.7%	410	5.0%	493	6.0%	4411	53.7%	2838	34.6%
Surabaya	699	9.7%	474	6.6%	722	10.1%	4028	56.2%	1249	17.4%
Kab. Malang	324	7.0%	322	6.9%	210	4.5%	2824	60.9%	960	20.7%
Kota Kupang	114	5.1%	116	5.2%	124	5.6%	1181	53.1%	689	31.0%
TTS	19	0.4%	252	5.1%	70	1.4%	4183	84.0%	457	9.2%
INDONESIA	40935	4.1%	58870	5.9%	58249	5.9%	491769	49.7%	339369	34.3%

Source: http://aplikasi.bkkbn.go.id/sr/Klinik/Laporan2013/ViewLaporanPELKON.aspx

As seen in Table 11, the most preferable method was short-acting hormonal methods that were pills and injectable. Nine out of ten districts had more than 75% of users that used either contraceptive pills or injections, the same as the national figure. Seven districts had more than 50% of injection users, with the highest in TTS with 84% of users of injections. Only Jakarta Pusat had a different proportion of contraceptive preference. There, nearly half of the users were using a long-term contraceptive method, namely IUD (43%) and followed by implant 3%. Four districts with more than 10% of u long-term methods users (IUD plus implant) were Jakarta Barat, Surabaya, Malang, and Kupang. This figure was also similar to the national level that had 4.1% of IUD users and 5.9% of implant users. The other five districts had only around 5% of long-acting users. Meanwhile, the use of condoms (presumably male condoms) was varied in those districts. Palembang had the highest rate of condom users that was 18% followed by Aceh Barat, Surabaya, Jakarta Pusat, Jakarta Barat, and Banda Aceh with 7-10%. The others were below that figure, with the lowest being in TTS with only 1.4% of condom users.

Table 12 presents the number of FP facilities based on types of the facilities and their collaboration status with BPJS Health.

Table 12 Number of FP Facility Based on Types of Facilities and Collaboration Status with BPJS Health

District/city	Hospitals with SK PKBRS* (1)			Hospitals without SK PKBRS (2)			Delivery Hospitals *RS Bersalin* (3)			*Puskemas* (4)		
	Collab. with BPJS			Collab. with BPJS			Collab. with BPJS			Collab. with BPJS		
	Yes	No	Total	Yes	No	Total	Yes	No	Total	Yes	No	Total
Jakarta Pusat	7	1	8	0	0	0	0	1	1	8	42	50
Jakarta Barat	1	11	12	1	0	1	0	3	3	0	75	75
Banda Aceh	6	1	7	1	0	1	2	10	12	11	0	11
Aceh Barat	4	2	6	0	2	2	2	1	3	8	5	13
Palembang	17	0	17	0	0	0	7	0	7	41	0	41
Lahat	2	0	2	0	0	0	0	0	0	32	0	32
Surabaya	8	8	16	3	12	15	4	3	7	56	7	63
Malang	5	13	18	5	3	8	1	4	5	35	4	39
Kupang	5	11	16	2	0	2	0	4	4	5	5	10
TTS	1	1	2	0	0	0	0	1	1	22	13	35
TOTAL	**56**	**48**	**104**	**12**	**17**	**29**	**16**	**27**	**43**	**218**	**151**	**369**

District/City	Practice of GP (5)			Others (6)			Total Facility		
	Collab. with BPJS			Collab. with BPJS			Collab. with BPJS		
	Yes	No	Total	Yes	No	Total	Yes	No	Total
Jakarta Pusat	0	0	0	2	28	30	17	72	89
Jakarta Barat	0	0	0	0	14	14	2	103	105
Banda Aceh	0	0	0	1	1	2	21	12	33
Aceh Barat	2	0	2	5	19	24	21	29	50
Palembang	38	5	43	77	8	85	180	13	193
Lahat	2	0	2	1	0	1	37	0	37
Surabaya	0	0	0	26	24	50	97	54	151
Malang	1	1	2	11	12	23	58	37	95

Kupang	0	1	1	0	19	19	12	40	52
TTS	0	0	0	1	4	5	24	19	43
TOTAL	**43**	**7**	**50**	**124**	**129**	**253**	**469**	**379**	**848**

*SK = *Surat Keputusan* or Decision Letter

PKBRS = *Pelayanan Keluarga Berencana Rumah Sakit* or Hospital Family Planning Services

Table 12 concluded that more than half of total facilities in these ten districts had collaborated with BPJS Health. The number varied within the districts. Palembang and Lahat had more than 90% of facilities that had collaborated with BPJS. Surabaya, Malang, Banda Aceh, and TTS had more facilities with BPJS collaboration than and less facilities that had not collaborated with BPJS-Health. Meanwhile, Jakarta Pusat, Jakarta Barat, Aceh Barat, and Kupang had less FP facilities that had collaborated with BPJS-Health. These data were from 2017, and it might have not been updated yet.

5. RESULTS and ANALYSIS

We interviewed 119 health facilities in ten districts of 160 target samples. We did not succeed to collect data in 36 health facilities because in some provinces, such as DKI Jakarta and East Java, it was difficult to get permission in either public or private facilities. Due to the limited time that we had to conduct the study by the end of 2018, it was difficult to get all permission needed from related stakeholders.

5.1. FP Facility Validation Result compared to BKKBN's 2017 Classification

Table 13 conveys the comparison of BKKBN's 2017 classification of health facilities and results of facility assessment.

Table 13 Validation Results of FP Facilities Status

District	n	BKKBN's Classification				FP Facility Validation Result				
		B	Int	Adv	Comp	B	Int	Adv	Comp	Not*
Jakarta Pusat	3	2	1	0	0	0	3	0	0	0
Jakarta Barat	8	7	1	0	0	0	6	2	0	0
Banda Aceh	10	10	0	0	0	2	3	4	0	1
Aceh Barat	17	14	3	0	0	1	15	0	0	1
Palembang	28	17	6	1	4	6	17	3	1	1
Lahat	7	5	2	0	0	0	5	2	0	0
Surabaya	8	8	0	0	0	0	5	2	0	1
Malang	9	7	2	0	0	0	8	1	0	0
Kupang	14	11	3	0	0	3	6	4	0	1
TTS	15	13	3	0	0	1	12	1	0	1
TOTAL	**119**	**94**	**21**	**1**	**4**	**13**	**80**	**19**	**1**	**6**
Total in %	**100**	**79.0**	**17.5**	**0.8**	**3.3**	**10.8**	**68.1**	**16**	**0.8**	**5.0**

*****n = total sample

B = Basic FP facility (*Klinik KB status Sederhana*)

Int = Intermediate FP facility (*Klinik KB status Lengkap*)

Adv = Advanced FP facility (*Klinik KB status Sempurna*)

Comp = Comprehensive FP facility (*Klinik KB status Paripurna*)

Not = Not FP clinic, since the clinic did not give any FP services anymore.

Table 14 Family Planning Services Provided by Facilities in Total

No.	Service Coverage	% FP Facilities Providing Services		
		Public n = 63	Private n = 56	Total n = 119
1	Counseling	100.0%	92.9%	95.8%
2	Provision of Condom	82.5%	69.6%	75.8%
3	Pills	85.7%	92.9%	88.3%
4	Injectables	95.2%	83.9%	89.2%
5	IUD	90.5%	73.2%	81.7%
6	Implants	85.7%	69.6%	77.5%
7	Vasectomy	17.5%	28.6%	22.5%
8	Tuba Ligation	14.3%	37.5%	25.0%

From 119 facilities that we interviewed, based on BKKBN classification we found on the website, there were 94 Basic FP facilities, 21 Intermediate FP facilities, one advanced FP facility, and four comprehensive FP facilities. This composition was similar to Table 10 displaying the total reporting of FP facilities in these ten districts. Basic FP facility was dominant compared to other types of FP facilities. However, based on our findings after the validation, the result was significantly different. It showed that only 11% (13) of health facilities we visited were basic FP facilities. There was a significant number of intermediate FP facilities that was 68% (80) of all facilities. This result was a positive finding, demonstrating that FP service coverage was increasing in these districts as a result of the expanding services of IUD/implants as LARC methods.

Intermediate FP facility (*Lengkap*) was classified as a facility able to give basic FP services and provide IUD/implants insertion and removal and/or vasectomy services. Most intermediate FP facilities provided basic FP services as well as IUD/implant insertion/removal but not the vasectomy services. However, it as a good indication that IUD/implant insertion could be found relatively easy in these districts.

The other noticeable figure was in Advanced FP facility. Referring the classification based on BKKBN's list, we interviewed only one advanced FP. However, after we did validation to the entire targeted sample, it turned out that 16.8% (20 facilities) were advanced FP facilities. These 20 facilities were located in all ten districts. There were two districts that had only one Advanced FP facility that were Timor Tengah Selatan and Malang. In Timor Tengah Selatan, we interviewed all the targeted sample but not in Malang, so the result may not represent the whole areas there. Other districts had at least two Advanced FP facilities.

However, not all Advanced FP facilities provided all FP services based on its requirement to be an Advanced FP facility in BKKBN's guideline. Only half of them performed all Advanced FP services, including counselling, short acting methods, IUD/implant insertion/removal, vasectomy, and also tuba ligation. 40% of the Advanced FP facilities did not perform vasectomies. Based on our direct observation, the health providers in that facility said that they did not provide vasectomy because the facility did not have a surgeon or urologist. There were also two facilities that did not perform any FP services. If the client wanted to get the services, the facilities would refer them to primary health care.

Our questionnaire did not ask about recanalization and infertility treatment, so we could not determine whether or not the facility was a Comprehensive FP facility. Based on BKKBN's 2017 classification, we interviewed four Comprehensive FP facilities, all located in Palembang. One of them after the validation was reclassified as an Intermediate FP facility, because the facility did not provide tuba ligation and vasectomy. The others were classified as Advanced FP facilities. After cross-checking with the official website of the facility, only one facility, Rumah Sakit Mohammad Hoesin provided infertility services, so it could be considered as a comprehensive FP facility.

There were also six facilities listed as Basic FP facilities according to BKKBN's 2017 classification, but validation revealed that these facilities did not perform FP services anymore. All six facilities were private. Some stated that the reason why they did not provide FP services due difficulty to get contraceptives from BKKBN and to claim the services from BPJS because they did not have MoU with the health center. Other facilities stated that they did not have doctors or midwives that could provide FP services.

Table 15 defines health facilities based on MoH classification and after the validation process of family planning services.

Table 15 Health Facilities Based on MoH Classification and after the Validation Process of Family Planning Services

				FKTP				FKRTL		
Dictrict	**n**	**FKTP**	**FKRTL**	**Not FP Clinic**	**Bas**	**Int**	**Adv**	**Bas**	**Int**	**Adv**
Jakarta Pusat	3	2	1	0	0	2	0	0	1	0
Jakarta Barat	8	6	2	0	0	6	0	0	0	2
Banda Aceh	10	7	3	2	1	3	1	0	0	3
Aceh Barat	17	16	1	1	1	14	0	0	1	0
Palembang	28	20	8	1	6	13	0	0	4	4

Lahat	7	5	2	0	0	5	0	0	0	2
Surabaya	8	7	1	0	1	5	1	0	0	1
Malang	9	8	1	0	0	8	0	0	0	1
Kupang	14	8	6	1	2	5	0	1	0	5
TTS	15	13	2	1	1	11	0	0	1	1
TOTAL	119	92	27	6	12	72	2	1	7	19

We interviewed 92 FKTP or Primary Health Care Facilities and 27 Advanced Health Care Facilities. Of the 92 primary health care facilities, 72 were intermediate FP facilities that provided basic family planning services and also IUD/Implant insertion/removal services. There were two facilities in FKTP that provided advanced family planning services. One of them was PKBI's clinic and one of them was a maternal and child clinic providing also services for tuba ligation. Six facilities were not providing FP services anymore (as described in the previous paragraph). Of the 27 advanced health care facilities, 19 were advance FP facilities that provided tubal ligation and vasectomy services. Still there were seven facilities that went to intermediate FP services, because these facilities did not have Obs/Gyn specialist that could perform tuba ligation. There was a hospital in Kupang that only gave basic family planning services.

5.2. Collaboration with BPJS Health

One important aspect explored in this study was whether or not the FP facility had collaborated with BPJS Health. As mentioned in the desk review section, family planning fitted into integrated services, one of the JKN scheme priorities. Table 6 shows the number of health facilities that collaborated with BPJS Health and funding of FP services in the facilities. The funding may come from BPJS Health, BKKBN at the district level, Jamkesda (*Jaminan Kesehatan Daerah*/Regional Health Insurance), Jampersal (*Jaminan Persalinan* - Delivery Insurance), Private Insurance, or from the client themselves. Family Planning offices at the district level through the decentralization system might also provide reimbursement for family planning services by providing a statement letter of financial incapability if the clients did not have a BPJS card.

Table 16 Sources of FP Services Funding

		Public (n=63)			Private (n=56)			
District	**n**	**BPJS**	**BKKBN**	**Jamkesda**	**BPJS**	**BKKBN**	**Jamkesda**	**Priv. Insc**
Jakarta Pusat	3	100%	100%	0%	0%	100%	0%	0%
Jakarta Barat	8	100%	0%	67	0%	100%	0%	50%
Banda Aceh	10	100%	33%	0%	50%	25%	25%	0%
Aceh Barat	17	100%	0%	14%	90%	10%	0%	0%
Palembang	28	100%	14%	57%	71%	0%	28%	42%
Lahat	7	100%	0%	80%	100%	0%	100%	100%
Surabaya	8	100%	0%	33%	60%	0%	20%	40%
Malang	9	100%	0%	33%	33%	67%	0%	0%
Kupang	14	100%	67%	33%	75%	37.5%	25%	25%
TTS	15	92%	67%	18%	33%	67%	0%	33%
TOTAL	119	98%	24%	35%	63%	25%	18%	25%

Table 16 shows that all public facilities had collaborated with BPJS-Health with the exception of one facility in TTS. The facility was a BKKBN clinic, so the supply and also the service fee were provided by BKKBN. Of the private facilities, 63% had collaborated with BPJS Health. Some clinics that had not collaborated with BPJS were clinics run by midwives. Based on the guidelines of FP implementation under JKN Scheme that had been mentioned above, private midwife clinics could collaborate directly with BPJS Health under the supervision of the local health department if its sub-district did not have a medical doctor. Otherwise, they might collaborate with BPJS Health through their main network that could be a *Puskesmas* or doctor's practice.

As for public facilities, while even almost 100% collaborating with BPJS, there were still 24% of facilities that claimed their FP services from BKKBN at the district level. This occurred regularly in TTS and Kupang. There was also one facility in Jakarta Pusat and two facilities in Banda Aceh that reported the same. This scheme was not mentioned in the guidelines. In the guidelines, it was clear that BKKBN should provide the supply stock, while BPJS provided the service fee. However, based on our anecdotal evidence in the field – talking informally with staff at BKKBN district level and with the health providers – local BKKBN still reimbursed the service fee because some facilities found it too difficult to follow the claims

procedure of JKN scheme. Moreover, there were still a range of citizens that did not participate in free BPJS system funded by the government but were still unable to afford health services. In these cases, local government produced a statement letter to show financial incapability. The health provider, either in public or in private facility, use this letter to claim the family planning service fee from BKKBN.

On the other hand, several local governments also still allocated their budget of health services through *Jamkesda* (*Jaminan Kesehatan Daerah*-Regional Health Insurance) and *Jampersal* (*Jaminan Persalinan*-Delivery Insurance). FP services could be claimed as well through these two schemes. These situations undoubtedly would lead to several problems. First, health providers would try to get reimbursement from the agency that had the easiest claims process. For instance, if they thought that getting a reimbursement from BKKBN at the district level or from *Jamkesda* scheme was easier than from BPJS, they would go for the easier route even if they had to ask the client to provide some requirements to get the reimbursement. Second, it was also possible that double claims occurred (claims made to two different agencies). Therefore, attention needed by relevant stakeholders to overcome these problems.

5.3. Human Resources Perform FP Services

In this section, we would like to see whether FP facilities had met the requirement of human resources based on its level of classification. The classification we used here was based on the result of our validation displayed in Table 17.

Table 17 Health Providers Performing FP Services

Classification of Facility Providing FP Services		% FP Fac. Providing Staffs			% FP Fac. Had Trained Staff in Less Than a Year		
	n	Doctors	Midwives	Nurses	Doctors	Midwives	Nurses
Basic	13	84.6%	84.6%	92.3%	23,3 %	7.7%	0%
Intermediate	80	95.0%	100%	86.3%	13.8%	42.5%	0%
Advanced (+ Compr.)	20	100%	100%	100%	15%	55 %	0%
Not FP Clinic	6	50%	50%	16.7%	0%	0%	0%
TOTAL	119	82.5%	83.8%	73.8%	18.8%	26.5%	0%

Classification of Facility Providing FP Services		% FP Fac. Whose Staff Performed IUD/implant Services		
	n	Doctors	Midwives	Nurses
Basic	13	0%	0%	0%
Intermediate	80	22.5%	48.8%	0%
Advance (+Compr)	20	15%	55%	0%
TOTAL	119	13%	35%	0%

Referring to Table 3 (Classification of FP Facility Based on the Minimal Requirement of Human Resources)**,** it was clear that a Basic FP facility should have either doctors, midwives, or nurses. From the 13 basic FP facility above, all facilities had at least one health provider needed to be a basic clinic. Almost 80% of these facilities had doctors, midwives, and nurses. Only 23% of doctors and 7% of midwives in all basic FP facilities had been trained for FP in the past year. One limitation of this study was that we did not specify what type of training was given. It could possibly be that they had been given counselling training, IUD/implant removal/insertion, or other trainings. There were no staff members that performed IUD/Implant services in a Basic FP facility, aligning with the definition that basic FP services should only give basic FP services such as counselling, condoms, pills, and injectable. However, looking at potential human resources the basic FP facilities had, it was possible that many of these facilities could be classified as Intermediate FP facilities if the staff would have been trained in IUD/Implant services.

Similarly, the requirement of human resources needed by an Intermediate FP facility was the same as the requirement of a Basic FP facility. From Table 17, it can be seen that 100% of the facilities had midwives, 95% had doctors, and 86% had nurses. Furthermore, 13% of doctors and 42% of midwives had FP trainings in the past year. Also, 20% of doctors and almost half of the midwives performed IUD/implant services. Those that performed these service had been trained, but not limited to the past year. It can be concluded that in half of the Intermediate facilities, IUD/implant services were done by midwives.

These figures are similar to those in Advanced and Comprehensive FP facilities. All facilities in this category had doctors, midwives, and nurses. 15% of the doctors and 55% of the midwives had been trained in the past year, and almost all of them performed the required skills. As we mentioned earlier in this section, we did not ask about recanalization and infertility treatment in our questionnaire; accordingly, we could not determine whether a facility was a comprehensive facility or only an advanced. Therefore, we had merged both of them into one group for the analysis of human resources. Based on Table 3, either Advanced or

Comprehensive FP facilities had the same minimal requirements in terms of requirements of human resources needed.

It is important to note that Table 17 shows that less than 100% of FP facilities that had either midwives or doctors performed IUD/implants. However, this did not mean that they did not provide the services. This data suggests that staff might not have been trained to provide this service or they might have been trained more than one year ago.

5.4. Stock Out Experience

FP facility experiencing stock out of any contraceptive choice in the last three months had always become the issue. This study analyzed whether the statement was still relevant or not during the implementation of JKN scheme.

Table 18 Stock Out Experience Based on the Classification of Facilities and Ownership

Facility Classification	Ownership	n	Stock-Out Experience Based on FP Method				
			Injectable	Pill	Condom	IUD	Implant
Primary (FKTP)	Public	51	1.9%	9.8%	7.8%	3.9%	1.9%
	Private	41	4.8%	0	2.4%	0	0
Advance Referral (FKRTL)	Public	12	1.6%	0.8%	0.8%	0	0
	Private	15	0	0.6%	0	0	0.6%
	TOTAL	119	4.4%	5.4%	5.0%	1.6%	1.6%

It is interesting to see that in general, stock-out experience was not a big problem. If we were looking at the long acting reversible contraceptive, only few facilities (less than 5%) in public FKTP ever had a period that they did not have any IUD or implants. The other categories (private FKTP and almost all FKRTL) never experienced this. Looking at the short acting contraceptives, it appeared that pill and condom more likely to experience stock-out for public FKTP (9.8% and 7.8% respectively). Meanwhile the same problems were not a big deal for FKRTL. Less than 5% of FKTP both public and private ever experienced injectable stock-out.

In total, only 5% or less of the facilities ever experienced any contraceptive method, with some attentions to the availability of pills and condoms in public FKTP. We could conclude that, if we compared to the last study about the stock out experience mentioned in Chapter 1, there were some improvements in terms of how the FP service systems ensured that health facility was not lacking for contraceptive choices.

5.5. Availability of Services Related to Family Planning

Besides assessing whether a facility had provided family planning services based on its classification, we were also interested to see other maternal health services related to family planning services. These services were potential to give counselling of FP, recruit new FP users, and also maintain current users.

Table 19 Number of Facilities Provided Services Related to Family Planning

		Services Related to Family Planning*					
FP Facility Status	**N**	**ANC**	**Delivery**	**ARH**	**FP**	**PPFP**	**PAC**
Basic	13	92%	46%	53%	100%	38%	30%
Intermediate	80	99%	65%	75%	100%	88%	44%
Advance (+compr)	20	95%	95%	45%	100%	95%	95%
Not FP Facility	6	50%	50%	50%	33%	0%	0%
Total	119	95%	67%	66%	97%	79%	49%

*****ANC = Ante Natal Care

ARH = Adolescent Reproductive Health or KRR (*Kesehatan Reproduksi Remaja)*

FP = Family Planning Services

PPFP = Postpartum Family Planning

PAC = Post-abortion Care

Table 20 Number of Facilities Providing Services Related to Family Planning Based on the Classification of the Facilities and the Ownership

		n	ANC	Delivery	ARH	FP	PPFP	PAC
Primary (FKTP)	Public	51	98%	51%	73%	100%	86%	37%
	Private	41	90%	66%	61%	90%	63%	37%
Advance Referral (FKRTL)	Public	12	100%	100%	67%	100%	100%	92%
	Private	15	93%	100%	47%	100%	80%	87%
	TOTAL	119	95%	67%	65%	97%	79%	49%

From Table 19 and 20, we can see that 95% of the facilities provided ANC services. There were only six facilities that did not provide ANC services. Two of them were specialized only in family planning services, and did not give any other services. One hospital in advanced facility category did not provide ANC services. Three others were not FP facilities that also did not provide ANC services. 80 facilities provided delivery services, six in basic facilities, 52 in

intermediate facilities, 19 in advance facilities, and three others were in not FP facilities. One advanced facility that did not provide delivery service was a PKBI (*Perkumpulan Keluarga Berencana Indonesia* - Indonesian Planned Parenthood Association) clinic. Looking at the level of facility and ownership, we got quite similar percentage. All facilities in the Advance Referral Health facility (FKRTL) provided delivery services, half of the primary public health facility (FKTP) provided delivery services, and two out of three primary private provided the services.

More than half of the facilities stated that they provide ARH services, 55% both in FKTP and in FKRTL. This is a good point to consider, since adolescents also have the rights to have quality information on reproductive health. However, in this study, we did not look closely at this issue to see whether the ARH services have met the standard or not.

Three quarter of the facilities said that they also provided PPFP (Post-partum Family Planning) services, 73% in FKTP and 89% in FKRTL. In this study, we did not separate PPFP services into immediate PPFP or PPFP within 6-weeks period postpartum. These findings were still positive, meaning that the chance to recruit new users after delivery was high. Unfortunately, we did not specifically ask about the PPFP methods proportion. Also, we did not ask about the PPFP training and the counselling training for PPFP.

Half of the facilities mentioned that they provided PAC (Post-abortion Care) service. Almost all facilities with advanced status provided the services. Less than half of intermediate facilities and small portion of basic facilities provide PAC service. These should became attention that PAC services could not be found easily. Meanwhile, using contraceptive after lost pregnancy was considered important to ensure that the woman is ready for another pregnancy.

5.6. User Experiences

Understanding how contraceptive users thought of family planning services they received in the facility was crucial to improve the services. We used an in-depth qualitative approach with semi-structured questions to examine how users felt about the family planning services. We interviewed 16 women in five districts. They were clients who were at the facility we did the validation process.

There were several themes arising from the analysis of the qualitative data. Firstly, positive experience on the FP services they received and secondly comments regarding the payment of the services.

1. Comments on the FP Services They Received

The reasons why a user chose a FP facility to get a contraceptive method were firstly because of the regulation. Two women in Kupang said that they chose the facility because of the close distance between their home and the facility.

“I first came here when I did ANC visits. Now I come here to get injectable method. I chose this facility *because it is close to home. If the midwife comes, she will serve us based on the queue.” A client in Kupang*

"I chose this clinic because of the place is close to my home. The service is also good and affordable. Actually I have a BPJS Health card. But here, they do not take BPJS card. If I want to get free services, I shall walk quite far. Meanwhile, my house is only in the back of this building so I prefer going here.” (A woman in Lahat that came to the facility for getting injectable method)

Meanwhile, a woman in Banda Aceh said that she wanted to remove her IUD after six years of using it in *Puskesmas* because the procedure should be like that.

“We just followed the rule. It said that we should go to Puskesmas *to get health services, so here we are. Later, if they cannot handle it here, we will be referred to the hospital. It’s based on the standard (procedure).”*

All five women we interviewed in Banda Aceh were satisfied with the family planning services, including how the health providers treated them. They would like to recommend the facility to other people as well.

“So far, I feel comfortable. They (the health providers) are also good in serving us as the patients.” (A client in Banda Aceh)

"First of all, the services are OK. I also got accurate information of family planning services and all things related. The people are kind, too.”. (A client in Banda Aceh)

We also got the similar response from seven women we interviewed in TTS and Kupang. They were also pretty satisfied with the family planning service they received. However, we were unsure what aspects of the services from the health provider that they were satisfied with. We could not conclude whether it was because of the comprehensive counselling they received or because of the midwife that was just happy to serve any method, without giving a proper counselling first.

“The midwife was kind. She did not force me or did not forbid me to use injectable method.”

There was one exception. A woman preferred to use IUD method, however, *Puskesmas* did not provide the method. Therefore, she really hoped that the variety of contraceptive methods should become a consideration in the clinic.

"I need (to use) IUD because I am not young anymore. If I use IUD, I do not have to come back every three years to remove and replace the implant. But unfortunately, this Puskesmas *does not provide IUD services.” (A client in TTS)*

Our study limitation was that we did not confirm back to the health provider about the comment of the interviewee. After cross-checking our quantitative data, it appeared that the woman visited a *Puskesmas* that, based on our interview, provided IUD services and could show IUD stocks. But, the woman did not get the preferred services perhaps because the trained staff was absent.

2. Comments about Payment Systems of FP Services

In terms of payment method, all women in Banda Aceh used BPJS Health, so they paid nothing for the health services including family planning services. One woman in TTS did not have any health insurance so she had to pay for the admission fee to get into the health facilities (IDR2,500), but she did not pay for the implant insertion. Two women in Kupang also came to the facility (*Puskesmas*) for injectable methods. They also only had to pay for the admission fee that was IDR5,000. Our assumption here was that the health provider would claim it to BKKBN for the reimbursement of the family planning services. This also aligns with the result of the funding source of FP services in Table 10, that most public FP clinics in TTS (all of them were *Puskesmas*) still got the reimbursement of family planning services from BKKBN.

A woman linked the good services she received with the free services because of BPJS Health. This might reflect that the availability of payment mechanism is an important factor when clients considering a decent health service.

“I think some clinics in Banda Aceh are good in doing the services. Furthermore, there is also BPJS Health that makes all services free.” (Woman in Banda Aceh)

A woman preferred to pay in the FP facility because the facility was near to her house. Even though she had BPJS card but she did not mind not using it and paid out of pocket.

> *"I have no complaints. But I do not say that this is not a burden at all. I have no problems with it (the payment). However, I will recommend people to go to* Puskesmas *if they want a cheap or free services."*

A woman that came to a hospital and used BPJS Health in Palembang said that she was satisfied with the services because the providers were helpful and kind in giving the information. She had a complaint of the long procedure to get FP services.

> *"There are so many counters that we have to visit to get a service. We also have to queue so long, it is inefficient at all."*

In conclusion, all clients we interviewed gave positive feedback of the family planning services they received. The clients emphasized on the good communication of the providers, providers that respected their choice, the close distance of the facility from their home, and the variation of contraceptive choices the facility offered. An important note here is regarding the range of contraceptive choices. There was a client that preferred to use IUD method, but unfortunately the method was not available at the facility, that was in *Puskesmas*. This case should become the priority of related stake holders to make all services available and accessible to all potential users.

In terms of payment methods, almost all clients were happy in the payment method they used. Most of them were using BPJS card. Some that did not use BPJS only paid for the admission fee, and not for the services. There is a need to investigate more of how the providers and the facility get the reimbursement of the services they give to those that do not use BPJS Health or other insurance scheme. Because based on our direct observation below, some providers stated that they freed the FP services to the client.

5.7. Comments from Health Providers

Even though this study did not specify to do an in-depth interview to health providers in the family planning facility, but at the end, to answer the quantitative questionnaire, we asked them about their comments and also recommendation regarding the family planning services and its procedure. These comments can be important for stakeholders to take into account when developing regulations regarding the family planning services. Their comments were:

- A number of health providers in FP facilities in TTS, Palembang, Aceh Barat, and Lahat stated that almost all FP services they gave to the clients were free, except for the stock that they bought themselves, such as 1-month injectable method. Most of them that stated the similar statement were *Puskesmas*. They said that they ever claimed to BPJS Health for reimbursement of the services but they found many difficulties regarding the administration process and bureaucracy. Therefore, they then gave FP services for free. This finding aligns with the user experience above, stating that some users that did not use BPJS Health cards did not have to pay for FP services. If the providers did not get paid for services rendered, it may lead to demotivation of the providers to give FP counselling and thus lead to discontinuation of FP use.
- Some other health providers complained about the duration of submitting the claim documents and the free service fee from BPJS took long period of time to get, even until one year of waiting. They said that BPJS had so many requirements and even after that, the money they got was less than what they proposed before.
- Many health providers also asked to get training updates. They realized the importance of getting refreshing training related to family planning services to improve the services.
- A health provider in a private facility commented that it was better that BPJS did not take care of family planning services, so all facilities that had not collaborated with BPJS could still perform the services. The providers mentioned that her clinic had collaborated with BKKBN in the district level for years. In addition to that, she never found any difficulties to claim the FP services, it was easy and on time.
- Some mentioned about the networking of *Puskesmas* and practice of midwifes to be improved. For example, for any activities related to family planning, such as training updates, *Puskesmas* shall invite the midwives in the networking systems to attend the training as well.
- Some private facilities also mentioned that they did not have targeted area in the community. Hence, they could not do FP counselling in the community. They emphasized in the importance of them to collaborate with *Puskesmas* to improve FP services in the grassroots level.

6. STUDY LIMITATIONS, SUMMARY and RECOMMENDATIONS

6.1. Limitations of the Study

We are aware that this study has a number of limitations that are listed below:

1. The study was purposively conducted in only ten districts in Indonesia. Meanwhile, Indonesia has more than 500 districts. The results of the study may not be used to represent Indonesia in general. The study can only depict situations of family planning services under JKN scheme that happens in some places. However, after data analysis, the similar situations repeated in these districts. So, even this study was only in ten districts, it can potentially give a big picture of what happens in the other areas.
2. During the data collection, we found some obstacles to get study permissions from the provincial to district level in some places. This led to unfinished data collection in some districts, because it took a long time to get the permission. Furthermore, the study was conducted in a short period of time, making it more difficult to stay on track to the proposed timeline. However, we can reach almost 80% of the sample size, so it still fits in the confidence intervals range.
3. We admit that the questionnaire of the study also had several limitations, including the scope of the questions and the respondents. Further study is needed to examine closely about the funding systems of FP services under JKN scheme as well as the health providers' perspective on the family planning management systems.

6.2. Overall Findings of the Study

1. After the validation process, a noticeable percentage of basic family planning facilities in BKKBN's 2017 list should go to intermediate facilities, because they provided IUD and implant services. It is important for BKKBN to update the list, so readers do not underestimate family planning services given in districts in Indonesia. If BKKBN's list states that most FP facilities in the district level are dominated by basic FP facility, people will assume that it is difficult to get IUD/implant services. It is also important to have similar definitions and understandings of family planning facility status, as we still found some differences in how BKKBN and MoH defined Basic family planning facility. As in our recommendation below, to avoid some confusion in defining types of FP facilities, BKKBN can consider to omit the classification systems and to use only systems by MoH that are FKTP and FKRTL.

2. We also found that a big proportion of health facilities could not perform vasectomy. In all intermediate FP facility, only very few of them could provide vasectomy. Even though it is true that tuba ligation is more popular than vasectomy, but providing many long term or permanent choices is very important to ensure the continuation of family planning services as well as to improve men's participation in family planning services. Therefore, ensuring that all male methods available should become a priority as well.
3. Two out of three of all facilities we interviewed were intermediate FP facility. It means that IUD and implants services are available and shall be easy to find. However, if we compare to Table 10, we can see that IUD and implants only account for around 10% of contraceptive used in almost all districts, except in Jakarta Pusat where its LARC use accounts for 50% of the users. Therefore, besides the availability of the services, it is important to ensure that the community also uses available services.
4. We also found a few number of private primary health facilities that previously gave family planning services but now were no longer giving family planning services because of various reasons. For instance, they did not have trained health staffs or found it difficult to collaborate with BKKBN or to network systems regarding the report and reimbursement of the services.
5. The next important thing to be considered is the funding of family planning services. After the validation, we found that almost all public facilities and three quarter of private facilities had collaborated with BPJS Health in overall health services. However, for the family planning services, a noticeable figure of the facilities still also depended on BKKBN in the district level to do the reimbursement of the services. Many facilities argued that they found it difficult to get the reimbursement of the services from BPJS Health. Meanwhile, the Guidelines of Family Planning Services Implementation under JKN Scheme mentions that facilities that have collaborated with BPJS Health should claim the services to BPJS-Health. BKKBN should only provide the contraceptive stocks. Therefore, it is urgently crucial to synchronize the systems in the district level.
6. There is still a need to do more training updates and monitoring of the training results to the health providers regarding family planning services.
7. Another noticeable finding is the counselling documentation that was still not done in many district, even though the health staffs reported that they had done the family planning counselling during Ante Natal Care or during delivery. But, we were not sure with the counselling method and the quality that might influence the low uptake of long term method.

6.3. Recommendations

1) We suggest BKKBN to simplify its credentialing systems. Instead of using the four classifications to refer FP facility, namely Basic (*Sederhana*), Intermediate (*Lengkap*), Advanced (*Sempurna*), and Comprehensive (*Paripurna*), BKKBN can use MoH classification that is Primary Level of Health Facility (FKTP) and Advanced Referral Level of Health Facility (FKRTL). On BKKBN's website[34], we can see that BKKBN provides data for these two credential systems (Table 2A and Table 3A). Using these two classifications may be good to recognize the level of an FP facility, but it can be confusing for some extent. There are several reasons underlying this recommendation.
   a) First, our study found that from 79% of Basic FP facility based on BKKBN's website, only 10% of them provided FP services to be classified as basic (*Sederhana)* FP facility. The other noticeable percentages went to Advanced (*Lengkap)* FP facility, meaning that they provided IUD and implants insertion and removal if we referred to the definition of Advance FP Facility based on BKKBN's guideline. That finding could be interpreted that BKKBN might not be consistent using the classification to determine the class of an FP facility. On the other hand, the study also found that FP facilities were categorized as 'Basic/*Sederhana'* although they provided IUD or implant insertion/removal. They did not find it difficult to get stocks from BKKBN. It could be interpreted that the classification system did not hinder them from getting stocks. One could question the importance of using the four classification system.
   b) Second, based on our desk review from WHO journals and handbooks, we did not find any recommendation to use classification for FP facilities. WHO emphasized 'a lot at who could provide the services?' A case in point, for IUD/Implant insertion/removal should be performed by trained doctors/midwives. Therefore, rather than focusing on classified the FP facilities and then being not consistent in using the classification, it is arguably better to strengthen human resources providing FP services. Moreover, based on the result of the study, not all doctors and midwives providing FP services had been getting a training or an update training.
   c) Third, in terms of the reimbursement of FP services, unfortunately BPJS did not recognize the classification system by BKKBN. The flow of getting reimbursement from BPJS is clearly said in the guidelines as quoted on Figure 1, that FKTP and FKRTL shall follow the procedure to claim the services. There were still problems as our study found that many private or even public primary health cares find it difficult to get

[34] see more http://aplikasi.bkkbn.go.id/sr/Klinik/Laporan2013/ViewLaporanPELKON.aspx

reimbursement from BPJS, but in terms of BKKBN classification types, BPJS did not take it into consideration at all.

d) Lastly, we argued that BKKBN's classification could be deregulated. We based this argument from the users' point of view. When we did in-depth interviews, the reasons of why users come to an FP facility were not because of the level of the FP facility. Clients were hardly aware or even gave any attention to whether that the facility was Basic and not intermediate level. The reason why they choose a facility was because they knew that the facility and/or the provider could provide the services they wanted. It confirms that upgrading health providers' competencies shall be the priority because clients choose a facility mainly because of the providers' performance.

2) However, we are fully aware that the classification of health facilities by MoH does not mentioned a lot about family planning service. Guidelines of Family Planning Management under JKN Scheme by MoH, as mentioned in the literature section, states what FP services shall be given by either Primary Level of Health Facility (FKTP) or Advanced Referral Level of Health Facility (FKRTL). However, it does not describe in details of what type of family planning service that they are authorized to provide, credibility of health providers, etc. In addition, in the accreditation system, MoH regulation of FKTP also does not include family planning service specifically as a part of the assessment. If we want to use the classification of health facility providing family planning services by MoH, MoH needs to look back at their guidelines of FP services and also to include family planning in the accreditation components. The accreditation system could potentially be used to also ensure the quality of available FP services. Therefore, there shall be a clear mechanism to maintain that the FP services is accredited and meet the standards. Continuous technical assistance to facilities is fully needed as a part of capacity building to the health providers in the facility.
3) We recommend MoH to use the standard of Intermediate FP Facility services based on BKKBN's credential systems to be conducted by FKTP and Advanced FP services to be conducted by FKRTL. It means that the health facility registered as FKTP shall provide counselling, pills, injectable, condoms, IUD/implant insertion and removal, until vasectomy if there is a trained doctor. The health facility registered as FKRTL shall perform all FKTP services plus tuba ligation. For comprehensive FP facility (*Paripurna*), which is infertility treatment can be performed by only selected facilities.
4) BKKBN should monitor the payment systems of FP services in the district level. The study found that a number of public facilities still claimed FP services from BKKBN even they had collaborated with BPJS Health. They did not claim the services to BPJS, as they found its procedure was complicated. It is important to ensure that health providers can get their

right after giving FP services. Monitoring activities are important to make sure that FP facilities do not claim to both BPJS and to BKKBN.

5) Regarding the point above, it is important for the Ministry of Health and BPJS Health to review again regulations regarding the payment of family planning services. The study found that intermediate FP facilities that shall provide IUD/implant services can be easily found in the study areas. However, if compared to average monthly contraceptive use, IUD/Implant was not the preferable methods. This might be resulted from the demotivation of health providers to do proper counselling as they found it difficult to claim the services. From the qualitative study, we found that there was a potential client said she could not get IUD insertion service, as the provider said there was no IUD service. But, when we confirmed to our quantitative study, the facility should be able to give the service as they had the IUD stock. It might be because the trained provider was not there at the time. But they did not suggest this client to come back to get the services or to suggest another FP choice to the client as they did not see any benefits for them to provide the services. Eventually, we may lose potential numbers of FP users if we continue the claim procedure systems.
6) In terms of expanding the use of LARC methods in the community, the delivery service strategy should be consistent with the Guidelines of Family Planning Management. For instance, it is said that vasectomy can be done in primary health care facilities if there is a trained doctor. But the study found that no intermediate FP facilities in the primary health care facilities performed vasectomy, since there was no trained medical doctor. Even, in advanced referral level of health facilities (FKRTL), only few numbers of the facility could perform vasectomy, based on the availability of a surgeon or an urologist. Therefore, MoH and BKKBN should make an effort to expand and scale up training to medical doctors in all FP facilities to ensure that the competency to deliver vasectomy service is available.

LIST OF ACRONYMS

ADINKES	: *Asosiasi Dinas Kesehatan*/Department of Health Association
ANC	: Antenatal Care
ARH	: Adolescent Reproductive Health
ASFR	: Age Specific Fertility Rate
BKKBN	: *Badan Kependudukan dan Keluarga Berencana Nasional*/ National Board of Population and Family Planning
BKKBD	: *Badan Kependudukan dan Keluarga Berencana Daerah*/ Regional Board of Population and Family Planning
BPJS	: Badan Penyedia Jaminan Sosial/Board of Social Insurance Providers
BPS	: *Bidan Praktek Swasta*/Private Midwife Practice
CPR	: Contraceptive Prevalance Rate
DP3AKB	: *Dinas Pemberdayaan Perempuan, Perlindungan Anak, Keluarga Berencana*/Department of Women Empowering, Child Protection and Family Planning
FP	: Family Planning
FKTP	: *Fasilitas Kesehatan Tingkat Pertama*/ Primary Level of Health Facility
FKRTL	: *Fasilitas Kesehatan Rujukan Tingkat Lanjutan/* Advance Level of *Health Facility*
IUD	: Intra Uterine Device
JKN	: *Jaminan Kesehatan Nasional*/National Health Insurance
Jamkesda	: *Jaminan Kesehatan Daerah*/Regional Health Insurance
Jampersal	: *Jaminan Persalinan/* Delivery Insurance
KARS	: *Komite Akreditasi Rumah Sakit*/Commite Hospital Accreditation
Kemenkes/MoH	: *Kementrian Kesehatan*/Ministry of Health
KIE	: *Komunikasi, Informasi dan Edukasi*/ Communication, Information and Education
KRR	: *Kesehatan Reproduksi Remaja*/Adolescent Reproductive Health
LARC	: Long Acting Reversible Contraceptive
MMR	: Maternal Mortality Rate
PAC	: Post abortion care
Permenkes	: *Peraturan Menteri Kesehatan*/Ministry of Health Regulation
PKBRS	: *Pelayanan Keluarga Berencana Rumah Sakit*/Family Planning Service in Hospital

PNC	: Post Natal Care
PPFP	: Post Partum Family Planning
Polindes	: *Pondok Bersalin Desa*/Delivery House in the Village
Poskesdes	: *Pos Kesehatan Desa*/Village Health Services
Puskesmas	: *Pusat Kesehatan Masyarakat*/ Primary Public Health Center
iPustu	: *Puskesmas Pembantu*/Sub-Ordinate of Primary Public Health Center
PUS	: Pasangan Usia Subur/Married Couple
RS	: Rumah Sakit/Hospital
SDG	: Sustainable Development Goal
SKN	: *Sistem Kesehatan Nasional*/National Health Systems
TFR	: Total Fertility Rate
TPM	: *Tempat Praktik Mandiri*/Private Independent Practice
UHC	: Universal health Coverage

ACTIVITY PICTURES

Figure 1 Communication with BKKBN Sumatera Selatan Province

Figure 2 Data Collection in Palembang with MoH and BKKBN team supervision

Figure 3 Data Collection in Puskesmas Oesapa Kupang with MoH and BKKBN Central team

Figure 4 Data Collection in Timor Tengah Selatan with MoH and BKKBN Central team

Figure 5 COmmunication with local BKKBN in Timor Tengah Selatan

Figure 6 Data Collection in Klinik Stela Melania, Surabaya

Figure 7 Data Collection in RS Bhayangkara Banda Aceh

Figure 8 Data Collection in Kabupaten Malang

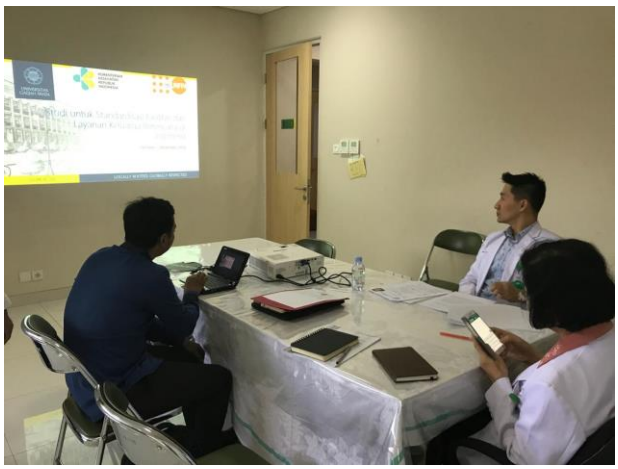

Figure 9 Study Presentation in a hospital in Jakarta Barat. However, even after this presentation we got rejection by the hospital.