Sexual and Reproductive Health Services in Indonesia: An Analysis of Equality, Quality and Accountability

RIZNAWATY IMMA ARYANTY
NINUK WIDYANTORO
November, 2019

DAWN Discussion Paper #16

Development Alternatives with Women for a New Era

This paper is part of an international research effort by feminist authors from the Global South.

The DAWN Discussion Papers are intended to generate wide-ranging debate and discussion of ongoing analysis under different themes on which DAWN works. The papers are made available prior to finalisation as part of our mission to inform, network and mobilise.

Feedback and comments are welcome and may be sent to info@dawnnet.org

Riznawaty Imma Aryanty, Ninuk Widyantoro. 2019. Sexual and Reproductive Health Services in Indonesia: An Analysis of Equality, Quality and Accountability. DAWN. Suva (Fiji).

Sexual and Reproductive Health Services in Indonesia: An Analysis of Equality, Quality and Accountability

1. Introduction

It has been nearly 25 years since the United Nations International Conference on Population and Development (ICPD) with its Programme of Action (PoA) that was agreed by consensus in Cairo in 1994. ICPD set key goals to be achieved by 2015, including reduction of infant, child and maternal mortality; provision of universal access to education, particularly for girls; and provision of universal access to a full range of reproductive health services, including family planning (UNFPA, 1994). Following the ICPD in 1994, there have been advances in various aspects of sexual and reproductive health services in Indonesia.

In the four years after Cairo, Indonesia went through significant political changes. The fall of the New Order in 1998 (ending Suharto's 30-year regime) brought a dramatic transformation to Indonesian society. Two years later, in 2000, Indonesia implemented a decentralisation policy and the law on local government was enacted to establish financial balance between central and local governments. Decentralization added more complexity to the institutional arrangements of program deliveries and brought about a dramatic change in the administration arrangement in districts, whereby authority for planning and development was transferred to district government. Decentralisation to district level gives significant authority to district administrations in program funding and implementation, while at the same time districts have limited capacity and experience in managing programs.

The fall of the New Order in 1998 also witnessed an increase in the influence of conservative Islamic values in the community (Rinaldo 2008). A growing trend to root ideas for change in religious discourse and making Islam a more central aspect of life in Indonesia was observed. This in many ways posed new challenges to sensitive issues such as promotion of a sexual and reproductive health program. The rise of conservatism was accompanied by the emergence of symbols representing Islamic piety, appearing in the form of increasing use of veiling among Muslim women and the practice of polygamy that usually involves Siri marriage. This form of informal marriage is not usually registered, which increases vulnerability of both women and children in this situation. A rise of conservative forces has also led to a call for "strengthening of family values" to make the country more "civilized". One of these groups has requested a judicial review to outlaw any consensual sexual relationship outside marriage, including same-sex relationships. To what extent conservative groups influence decisions on the number of children and, therefore, family planning is currently not documented.

The two main Sexual and Reproductive Health and Rights (SRHR) programs implemented by the government in Indonesia are family planning and maternal health. The maternal health program was introduced during the pre-independence period (early 1940s) as a key community health program, at a time in Indonesia when high maternal deaths were identified as a pressing community health problem. After independence in 1945, maternal and child health got special

attention, with the establishment of centres for Mother-and-Child Welfare (Balai Kesejahteraan Ibu dan Anak, BKIA) at district level from 1952. These centres were then merged with polyclinics at community health centres and became the health centres (Puskesmas), the precursors of the primary health care system in Indonesia (Cholil, Iskandar & Sciortino, 1998). In successive decades there was a rapid expansion of health care facilities that significantly increased access to care.

The family planning program was introduced later, with some reservation at first (Hull, 2007). In the late 1950s a group of doctors established Perkumpulan Keluarga Berencana Indonesia/PKBI (Indonesian affiliation of the International Planned Parenthood Federation/IPPF). The family planning program was later promoted mainly as a response to internal and external concerns of rapid population growth, especially in major cities (Hull, 2006). The National Institute for Family Planning (Lembaga Keluarga Berencana Nasional/LKBN) was established in 1968 and then transformed into the National Family Planning Coordinating Board (Badan Koordinasi Keluarga Berencana Nasional/BKKBN) in 1970. The family planning program has since expanded, increasing contraceptive use from 0 to more than 60 per cent within four decades. The program is internationally renowned for rapidly expanding access to and use of modern contraceptives, and BKKBN got credit for much of this success.

A major recent advance in provision of health services in Indonesia is the enactment of the National Health Insurance Scheme (Jaminan Kesehatan Nasional/JKN[6]) since 2014. The JKN aims to achieve universal health coverage for all by the end of 2019. At the end of the first-year implementation of JKN, 133.4 million people were covered. By mid-2019, 222 million people were covered by JKN, equal to 84.1 per cent of the population. With JKN, the cost for health services, including SRHR such as family planning services, antenatal care, delivery, post-partum and treatment of sexually transmitted diseases, can be obtained free of charge or at a minimal cost. In the other words, implementation of JKN offers a great opportunity to address the continuing problem of high maternal mortality as it removes the user fee. Financial constraints are dominant factors causing maternal deaths in Indonesia (D'ambruso, Byass, & Qomariyah, 2010).

This case study aims to describe the progress in achieving ICPD PoA goals in Indonesia. It describes the law and policy context of SRHR development in Indonesia and progress to date, emphasising the two main components of SRHR, maternal health and family planning programs. Data and information were gathered from the latest survey reports, focused group discussions and interviews with key informants. The case study applies a framework of quality, equality and accountability to assess laws, policies and programs towards respecting, protecting and fulfilling the human rights of the most disadvantaged women (Sen, 2013).

2. Laws and Policies on Maternal Health and Family Planning

We argue in this and the next section of the case study that, regardless of a number of new laws that were enacted in Indonesia bringing new perspectives to maternal and family planning

[6] JKN: Jaminan Kesehatan nasional (Public Health Insurance) is a national-based insurance that covers all communities and is applied nation-wide.

programs, there are various barriers and challenges affecting equality, quality and accountability of the programs.

The first law that explicitly concerned maternal health is the Health Law introduced in 1992. The law focuses on family health and refers to a period before, during and after pregnancy and other periods outside pregnancy and delivery. The law is also the first regulation on abortion in Indonesia, although the word abortion itself is not used in this law, indicating continuing sensitivity towards the issue. "A certain medical procedure" is used to replace the word 'abortion'. While the law was expected to provide better protection to reproductive rights, according to women's rights activists inconsistency within its articles and their differing explanations led to more controversy rather than clarifying debates (Djohan, Indrawasih, Adenan, Yudomustopo & Tan, 1993; Hull, Sarsanto & Widyantoro, 1993), particularly on statements related to abortion.

Parallel to the amendment process of the Health Law, an amendment of the Population Law was also on-going in the Parliament. Both laws have articles on Family Planning. During the process there was an effort to pull all family planning articles into the Health Law. Towards the end of the amendment process, however, family planning articles were stated in both laws. The old Law on Population and Family Development stated only that family planning services were for married couples. This excludes unmarried adolescents and young people from government family planning programs.[7]

After a long amendment process that covered two legislative cycles, the two important laws related to SRHR were passed. The Health Law and Population Law were both enacted in October 2009. The Health Law uses the terminology of Reproductive Health for the first time and has nine articles on the topic, including provision of abortion for medical indications of effects on women's health, and congenital defects. While the Population Law brings up family planning as a means of population control, there is no significant change in the new population law regarding the family planning program's beneficiaries, and unmarried people are still excluded. Five years after enactment of the Health Law, a Government Regulation on Reproductive Health was enacted in 2014 followed by a ministerial decree on training and implementation of abortion services when medically indicated and rape cases in 2016. The process of development of the ministerial decree was heavily influenced by the interests of various stakeholders. However, implementation of the law is far below expectations.

The Health Law and the Government Regulation state that abortion should be conducted with pre- and post-abortion counselling by competent and authorised counsellors. The law further states that abortion should be performed before the pregnancy is six weeks from the first day of the last menstrual period and provided by health personnel with the skills and authority as certified by the Minister. The Government Regulation in 2014 and Ministerial Decree in 2016 following the Health Law give further explanation on how abortion should be provided and highlight the dominant role of doctors in abortion. The requirement that pre- and post-abortion

[7] This limits access for the unmarried (particularly young adolescents) to the services. People in general and health personnel tend to be judgmental about young persons trying to get contraceptives, although it is true that condoms are widely available at many stores.

counselling should be provided by competent and authorized counsellors does not, however, define who these counsellors should be.

The law on Local Government governs the structure of district institutions and offices. The law states that health is a compulsory basic service that should be provided at the district level. This means each district should have a dedicated office for health. Meanwhile family planning is categorised as a compulsory function but is not related to basic services. Consequently, the law strengthens the importance of health institutions at the district level, but it does not have implications for the maternal health program that has been running in a decentralised manner for more than a decade. However, the arrangement of the family planning program, which tends to be centralised, is affected. The new law requires that a family planning district office should be established, but since family planning is not categorised as a basic service, the office is often combined with other programs. The most common structure for family planning found in the districts is where they are jointly run with child protection and women's empowerment programs. Consequently, the amount of resources allocated for the family planning program tends to be limited, as it is spread thinly among the other divisions in the office.

3. Equality, Quality & Accountability for Maternal Health and Family Planning

Indonesia is among the countries with considerable experience in expanding the family planning program as signified by the improvement of contraceptive use from non-existent in the early 1970s to 63 per cent in 2017; and a reduction in the average number of children per woman during the same period, from 5.6 in the early 1970s to 2.4. Since the early 1990s, Indonesia has invested tremendously in creating a cadre of midwives to increase coverage of delivery by skilled birth attendants (SBAs). A significant reduction in infant and child mortality has occurred since then. However, the maternal death problem in Indonesia shows a paradox. Despite a high proportion of deliveries by SBAs (91 per cent - IDHS 2017), the MMR continues to be high (305 per 100,000 live births according to the most recent estimates).

Disparities within geographic and socio-economic areas remain challenging. Comprehensive sexual and reproductive health services and unsafe abortion practices remain neglected. Most of the program has also experienced a slowing down and reduction in intensity, particularly after the decentralization system was introduced in 2000. Nevertheless, the maternal and child health program continues to gain more attention following the declaration of the Millennium Development Goals (MDGs) in 2000 with a projected target of achieving an 'MMR of 102 per 100,000 by 2015 (Bappenas, 2010). A health-focused strategy called 'Making Pregnancy Safer' was launched in 2000 (Departemen Kesehatan R.I., 2001) followed by various maternal health-focused projects supported by different donors.

3.1. Maternal Health Program

In the late 1980s, maternal health problems started to become a major concern and were highlighted in the international discourse as the global burden of maternal mortality became more evident. The world gained an understanding of high maternal deaths due to pregnancy and delivery-related causes. Indonesia participated in several conferences from the late 1980s

into the 1990s that influenced program direction in the country. The Safe Motherhood Conference in Nairobi in 1987 led to the Safe Motherhood Initiatives of 1988.

The International Conference on Population and Development (ICPD) in Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995 also influenced program direction as well. After the conferences, the ICPD Program of Action (PoA) commitment was translated into action mainly to promote maternal health and family planning programs in the country. The data of the Indonesian Demographic and Health Survey that reported a high level of maternal mortality ratio, estimated at 390 maternal deaths per 100,000 live births during the period 1990-1994 and 334 per 100,000 live births during the period 1993-1997, provided a ground for the focus (Statistics Indonesia, National Family Planning Coordination Board, Ministry of Health Indonesia, & ORC Macro, 2003) on the Mother Friendly Movement in 1998.

One of the most important programs during this period focused on the deployment of midwives at village level in 1990s by the Ministry of Health, aimed at bringing maternal health closer to women in the community. This effort was initiated in a move to ensure equity in accessing the family planning program.

The maternal health program relies heavily on the community health centre (Pusat Kesehatan Masyarakat/Puskesmas), the cornerstone of the public health system in Indonesia, and remains one of the program priorities of Puskesmas since its inception. Early initiatives in maternal and child health focused on the provision of care. However, a significant change was Puskesmas substituting the extensive network of TBAs, Traditional Birth Attendants (dukun) with a 'Community Midwives' program. With a local area monitoring concept, a Puskesmas is responsible for various programs provided in its catchment area, usually at the sub-district level. The service of Puskesmas can be provided either at the Puskesmas facilities, by Puskesmas pembantu (sub-health centres), at a village maternity post by the midwives in the community, or through an outreach program.

The community midwives' program deployed midwives at village level as part of the effort to reduce maternal deaths. This was a strategic step to reduce the domination of traditional birth attendants close to the community in providing delivery assistance at the village level (Widayatun, Hull, Raharto, & Setiawan, 1999). The community midwives programme was dramatically successful in increasing the coverage of maternal health care, particularly antenatal care and skilled birth attendance. The coverage of home delivery was around 80 percent in the early 1990s. It dramatically decreased in the following years with implementation of the community midwives programme and introduction of delivery at the Puskesmas facilities.

However, after running for several years, there were various concerns about the quality of the midwives training program. The short period crash course for midwives without follow-up training did not provide adequate knowledge and skills to perform standardised care. Several studies have indicated that many village and Puskesmas-based midwives, who are intended to provide delivery care, do not qualify as Skilled Birth Attendants as per the international definition. Thus, increasing the number of midwives at the community level did not impact on

the incidence of maternal deaths, which remains high in Indonesia. This contrasts to the situation in other countries where skilled birth attendance is a good predictor of quality of maternal health care and contributes to reduction of the maternal mortality ratio. However, deployment of the community midwives reduced home deliveries. By 2017, the percentage of home deliveries was 20.5 as people shifted to deliveries at facilities (BKKBN, BPS, Kemenkes R.I. & USAID, 2018).

Table 1 shows the progress of selected maternal and family planning indicators. It shows that during the past decades, the level of maternal deaths remains high at 200-300 per 100,000 live births. Similarly, family planning programs have stagnated, with modern contraceptive use remaining steady at around 57 per cent in the past two decades. Indonesia was not successful in achieving the MDG 5 on reduction of maternal deaths or 5b to achieve universal access to reproductive health.

Table 1: Selected Indicators on MMR and Family Planning

Selected Indicators	1994	1997	2002	2007	2012	2017
Total Fertility Rate (TFR)	2.9	2.8	2.6	2.6	2.6	2.4
Maternal Mortality Ratio (MMR): maternal deaths per 100,000 live births	390	334	307	228	359	305*
Delivery by skilled health personnel (%)	36.5	43.2	66.3	79.4	83.1	90.9
Delivery in health facilities (%)	17.5	20.7	40.1	46.6	63.2	79.0
Contraceptive use (all methods)	52.1	54.7	56.7	57.4	57.9	57.2
Unmet needs for contraception	15.3	13.6	13.2	13.1	11.4	10.6

Source: Indonesian Demographic and Health Survey 1994, 1997, 2002, 2007, 2012
***** Based on Intercensal Population Survey since IDHS 2017 does not calculate MMR

Measurement of maternal mortality could not be easily done in Indonesia where vital statistics and civil registration are not fully in place. Therefore, the MMR measurement relies mostly on

survey data where calculations of MMR are often based on a very small number of cases and the validity of the MMR levels were often questioned and debated. After 2000, the government of Indonesia has recommended using census or intercensal data for calculating MMR and special questions to investigate maternal deaths were added to the Census questionnaire. The Census of 2010 reported a maternal mortality ratio of 278 per 100,000 livebirths, although this number was not widely quoted. Table 2 shows the results of a Census 2010 follow up study on causes of maternal mortality and level of maternal mortality by region.

Table 2: Level and Causes of Maternal Deaths by Region in Indonesia in 2010

Selected indicators	**Region**					**Indonesia**
	Sumatera	**Java-Bali**	**Kalimantan**	**Sulawesi**	**Eastern Indonesia**	
Maternal mortality ratio	262	227	340	459	434	278
Postpartum hemorrhage	16.4	16.8	28.1	26.3	29.8	20.3
Hypertensive disorders	33.3	33.1	34.9	32.6	25.8	32.4
Placenta previa, premature separation of placenta and Antepartum hemorrhage	4.4	2.7	4.3	2.3	3.6	3.3
Other maternal care related to fetus and amniotic cavity and possible delivery problems	3.0	1.7	0.0	0.8	0.1	1.6
Pregnancy with abortive outcome	3.7	4.2	2.7	5.6	4.2	4.1
Obstructed labor	0.5	1.1	0.0	0.6	1.0	0.8
Others	38.7	40.3	30.0	31.8	35.6	37.4

Source: Review of Maternal Mortality in 5 Regions in Indonesia, 2012

As indicated above, there is regional variation. The main causes of maternal death are dominated by direct obstetric reasons with hypertensive disorders as the leading causes, followed by postpartum haemorrhage. This indicates that there has been a shift in the main cause of maternal deaths in the past decades from haemorrhage to hypertensive disorders. The indirect causes of maternal deaths as indicated in the other cases are varied among the regions.

In Java and Bali, the main indirect causes are cardiovascular and cardiomyopathy diseases, whereas in Eastern Indonesia the indirect causes are non-puerperal infections such as malaria and tuberculosis.

The maternal death phenomenon in Indonesia continues to be a paradox where, despite a high proportion of deliveries by SBAs (91% in IDHS 2017), the MMR continues to be high according to the most recent estimates. The disparities in MMR occur across regions, sub-groups and socio-demographic variables. Various problems underlying under-performance in the health system may be the reason behind this situation. Many projects were implemented vertically, focusing on a disease or health problems-specific approach that often overlooked the systemic health factors that determine quality of care. Hospitals are the main facilities where maternal complications are treated. However, the median scores of compliance to standards for complications treatments are below 80 per cent as shown in Table 3.

Table 3: Compliance to Standards for Management of Maternal Complications

Components for management of complications*	Hospital			
	Median	Min - Max		
Postpartum hemorrhage	74.2	25.0	-	93.0
Preeclampsia/eclampsia	69.5	21.8	-	92.7
Postpartum infection	71.7	13.0	-	93.5
Early pregnancy hemorrhage (before 20 weeks gestation)	66.4	17.2	-	91.4
Preterm labor	67.0	22.7	-	93.2
Prolonged labor	68.6	13.6	-	90.0

Source: Ministry of Health, Pelayanan Kesehatan Ibu di 100 Fasilitas Kesehatan dan 10 Provinsi di Indonesia tahun 2012.
*Scores on compliance in percentage shows in median with minimum and maximum scores

There are also disparities between coverage of maternal health indicators. Figure 1 shows the disparity of selected maternal health indicators, antenatal care by health providers, percentage delivery in health facilities and percentage delivery by Caesarean section by wealth quintile. In general, all indicators show increasing trends from 2007 to 2012 and 2017. Antenatal care has the highest coverage among the three indicators by wealth quintile, while delivery in health facilities and delivery by Caesarean Section show an increasing trend, but also wider gaps among the wealth quintile categories.

The Jaminan Kesehatan Nasional (JKN/national health insurance) is supposed to eliminate financial barriers and was expected to cover all citizens by 2019. The three indicators reflect the conditions in which barriers remain for poor people accessing care, despite introduction of JKN. One critique regarding JKN is that the scheme seems to benefit people who are living in urban areas or areas where health facilities' availability is high. In remote areas or areas with

geographic challenges where health facilities are dispersed over a wide geographical area, the scheme cannot be used by the poor who cannot afford the cost of transport to access health services.

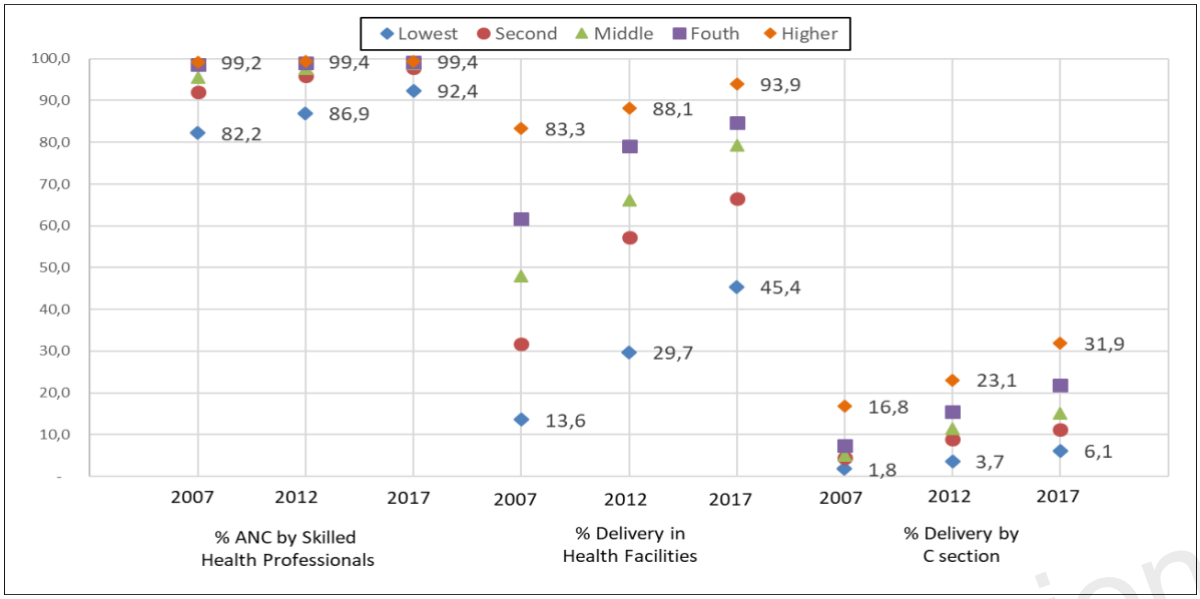

Figure 1. Distribution of selected maternal health indicators by wealth quintile
Source: Indonesian Demographic and Health Survey 2007,2012 and 2017.

3.2. Family Planning Program

Despite the globally acknowledged success in expanding family planning, the program has its adverse side. The family planning program was initiated in a highly centralised system with a strong program aiming to recruit many women as family planning acceptors. The word "acceptors" for family planning users that was used for a lengthy period very much represents the nature of the program, in which women were considered passive recipients. Problems such as poor service quality and limited choice of contraceptives, with emphasis on those that are provider-dependent and long-acting such as IUDs and implants, were reported. Clients are rarely provided with full and accurate information about contraceptives, especially side effects, nor have they been encouraged to switch contraceptive methods if they do not like the one they have. Often, services have been delivered in ways that do not protect privacy and may also impose inappropriate social pressure to accept a particular method. Implementation and service delivery of the program does not seem to provide women with the means of regulating their fertility autonomously through access to freely chosen contraceptives. Therefore, the program's principles and practices do not focus on safeguarding women's reproductive health (Smyth, 1991).

Deployment of midwives at village level is expected to increase family planning uptake, as there are more providers for contraceptives. However, the program only slightly affects overall prevalence of contraceptive use although it did affect method choice. In early 1990s when the community midwives' program was introduced, the level of contraceptive use reached 50 per cent. The family planning agency was very strong then, with huge campaigns promoting 'two children is enough' and long-term contraceptives being encouraged through mobile clinics. In

the decades afterward contraceptive use only slightly increased. The presence of midwives at community level was associated with increased use of injectable contraceptives and decreased use of IUDs and implants. The women's "switching behaviour" indicates that the program succeeded in providing additional outlets for promoting the use of injectable contraceptives and data shows an increased uptake of short-term contraceptive methods. With deployment of midwives at village level, there are more providers for contraceptives. However, the midwives gain benefit from promoting injectables (with a regular need to retake the injectable, thus requiring payment of a fee for services) rather than the long-term methods.

The contraceptive prevalence rate for all contraceptive methods was 63.6 per cent in 2017, with an increase in the use of traditional methods but a slight decrease in modern contraceptive methods in the previous five years, from 57.9 per cent to 57.2 per cent. Overall, most provinces experienced a decrease in the use of modern contraception. The disparity in the use of modern contraception between provinces is also considerable. The highest use is found in Central Kalimantan at 69.4 per cent while the lowest is in Papua at 35.9 per cent (Figure 2).

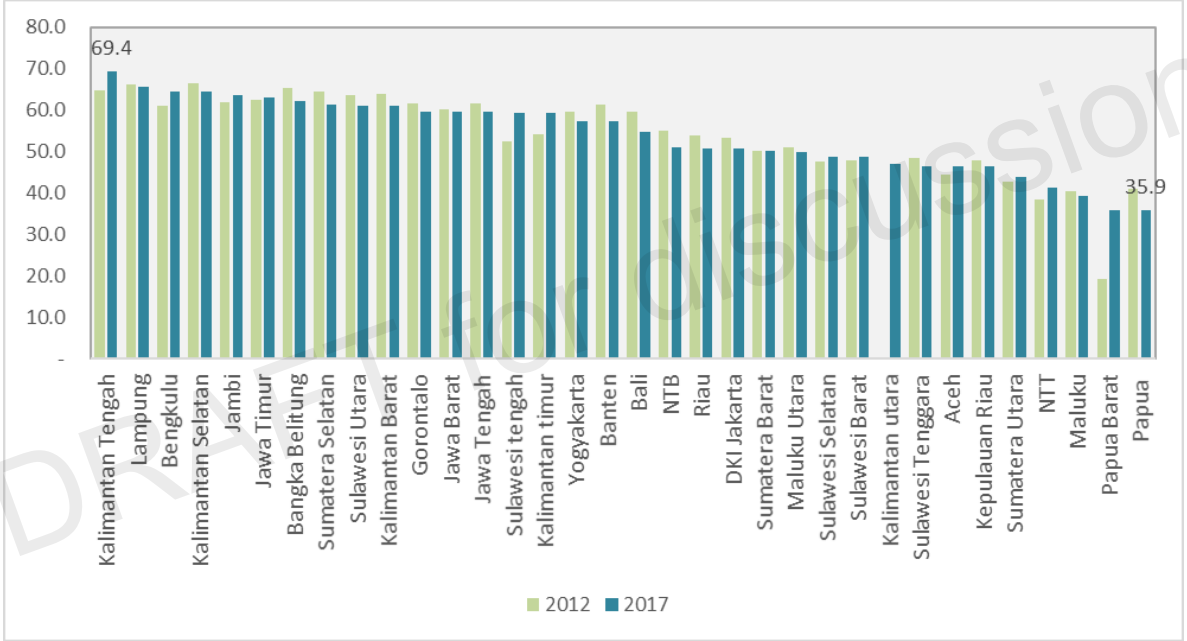

Figure 2: Modern Contraceptive Use by Province, 2012 and 2017
Source: Indonesia Demographic and Health Survey 2012 and 2017

As discussed above, contraceptive use in Indonesia has experienced a major shift over the decades, from long-term contraceptive methods to the short-term as can be seen in Figure 3. The proportion of women using injectables has dramatically increased, while the use of the long-term contraception method of IUDs has declined. The different methods of contraception have different effectiveness. The use of short-term methods has a higher risk of family planning failures. It is also important to note that the shift in contraceptive use has been argued to be health-provider-driven as described above.

Male contraception (male sterilisation and condom) use in Indonesia is very low, less than 3 per cent. This level is lower than the use of traditional methods. In the past three decades, male

sterilisation is stable at 0.2 per cent, while male condom use has increased from 1.3 per cent (1997) to 2.5 per cent (2017). The family planning program in Indonesia has always been focused on women since its introduction, and education programs for men are extremely limited. In many communities, men play important roles in decision making, including those related to reproductive health such as using contraceptive. Therefore, serious efforts are needed to educate men on reproductive health issues.

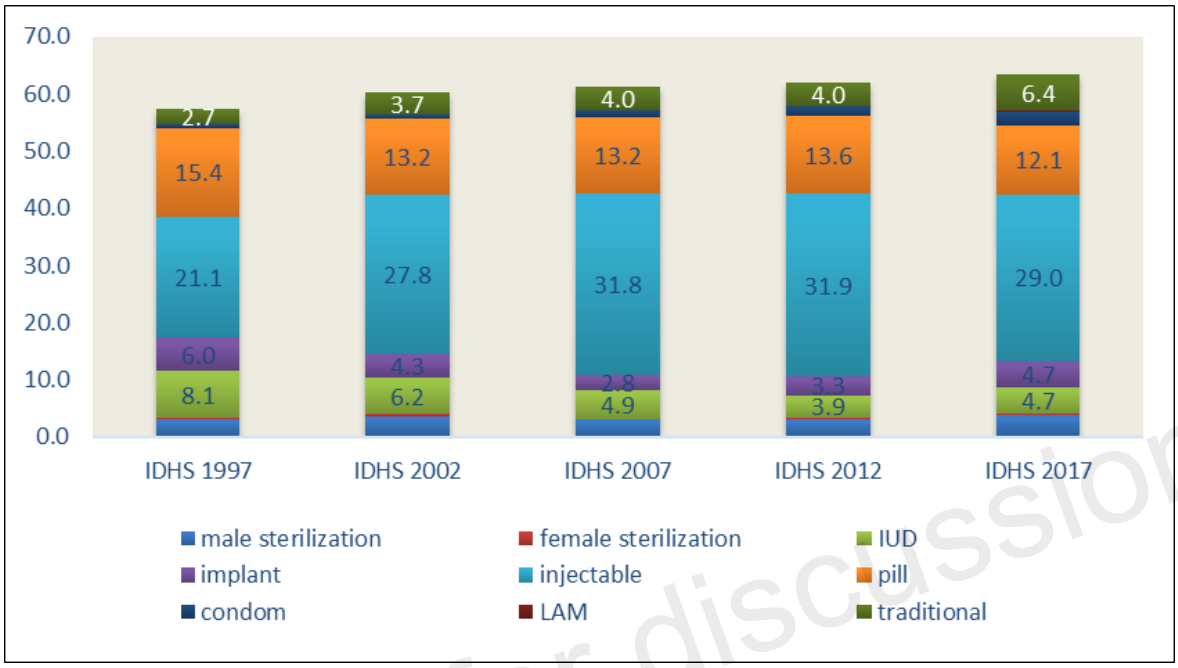

Figure 3: Chart on the shift of contraceptive methods mix
Source: Indonesian Demographic and Health Survey 1994, 1997, 2002, 2007, 2012

Figure 3 shows the shift of contraceptive methods in the past three decades. In the 1990s, the use of long-term methods (IUD, implant and sterilisation) was the highest. There were reported issues of violating rights, for instance women being forced to use methods such as IUDs. Gradually there was a switch to short term methods. But other issues of rights emerged since women were not well informed and educated about the choices of contraceptive methods. Even older women who did not want any more children still used short term injectables. So, there are issues of rights and inadequate information on the choices in both situations that raise concerns on equality, quality and accountability.

Contraceptive use does not vary significantly by socio-economic group. Unmet needs for contraceptives remain high over the years with past decades showing unmet needs of around 11 per cent. The unmet needs are particularly high among the lowest wealth quintile. The discontinuation rate is also high at 29 per cent, with the most common reason for discontinuation being fear of side effects (BKKBN, BPS, Kemenkes R.I., et al., 2018). High discontinuation rates reflect the problem in quality that affects the sustainability of the program, and lack of attention to educating and counselling on reproductive health. Despite understanding the need to respect women's reproductive rights, the program still applies a conventional approach to achieve demographic targets.

Table 3: Contraceptive Use and Unmet Needs by Wealth Quintile

Wealth Quintile	% Modern Contraceptive Use		% Unmet Needs	
	2012	2017	2012	2017
Lowest	53.0	56.3	13.5	11.0
Second	61.4	61.4	10.2	10.2
Middle	60.2	59.6	10.3	10.0
Fourth	58.7	56.3	10.9	10.2
Higher	55.4	52.3	12.3	11.7
Total	57.9	57.2	11,4	10.6

Source: Indonesian Demographic and Health Survey 2012 and 2017.

Efforts to revitalise the family planning program have been discussed since the realisation that the program achievements were stagnating. There were efforts to strengthen the program to return to the era of family planning's glory days, but they have not been successful in bringing the program up to the expected level. The lack of attention and low priority given to the family planning program, particularly at the sub-national level, has become one of the major challenges.

In July 2012, the Summit for Family Planning was held in London where the FP2020 program was launched. It called for voluntary family planning services to reach an additional 120 million women and girls in the world's poorest countries by 2020. An Indonesian delegation attended the summit led by the Coordinating Minister of People's Welfare. Following the commitment at the summit, BKKBN, UNFPA, USAID and Canada established a FP2020 country committee forum that held regular meetings. It is expected that the forum could be used to share experiences and lessons learned as well as discussing and addressing various challenges in family planning programs. A rights-based family planning strategy that aims to provide a guide for all family planning stakeholders has been developed through the FP2020 committee. Several other programs were supported and implemented by the main stakeholders of family planning in Indonesia following the FP2020 commitments. In January 2016, BKKBN hosted the fourth International Conference on Family Planning that gathered over 3100 participants from more than 80 countries. The conference was officially opened by the President of the Republic of Indonesia. The commitment to revitalise the family planning program currently seems to be reaching a new high and the FP2020 initiative provides a platform and momentum to promote the program.

However there seems to be limited visible improvement in the family planning program on the ground. Unclear roles and responsibilities between the Ministry of Health that is responsible for family planning service providers and BKKBN as the main institution responsible for family planning demand continue to exist. The Law on Local Government added more

DAWN Discussion Paper #16

www.dawnnet.org