INDONESIA

PAC-FP COUNTRY BRIEF

Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Republic of Indonesia's investment in providing PAC and FP services to women in need.

POLICIES, LEADERSHIP, AND GOVERNANCE

The Republic of Indonesia's national policy on family planning (FP) and reproductive health (RH) is outlined in a number of documents, including the Reproductive Health Policy (2014), the National Action Plan for Family Planning Services 2014–2015 (2014), and the third National Medium-Term Development Plan 2015–2019 (2015). The latter document serves as a detailed plan to expand access to FP services. While Indonesia does not have a policy or roadmap for postabortion care (PAC), the Indonesian Ministry of Health and the National Family Planning Coordinating Board (locally known as Badan Kependudukan dan Keluarga Berencana Nasional, or BKKBN) collaborated with Jhpiego to develop postpartum FP materials as part of a broader learning resource package.

Legal Status on Abortion

According to Indonesia's 1992 Health Law, abortion is permitted to save the life of the woman in the case of rape or incest, but only within the first six weeks of pregnancy (Sedgh and Ball, 2015).

PAC TRAINING AND STANDARDS

Since 2002, Indonesia's National Clinical Training Network (Jaringan Nasional Pelatihan Klinis, or JNPK) has provided PAC training materials through the Clinical Training Package for Postabortion Care. The curriculum, developed in collaboration with Jhpiego and EngenderHealth, is limited to specific zones and institutions. The training focuses primarily on interpersonal communications skills, PAC, FP (including short-acting and long-acting methods), pain management, manual vacuum aspiration, infection prevention, and quality of care. While the curriculum is designed for training doctors and midwives, clinical PAC is only available through doctors who provide manual vacuum aspiration and dilatation and curettage; misoprostol is not yet available for the treatment of incomplete abortion.

STRENGTHENING SERVICE DELIVERY

In partnership with BKKBN, a consortium of international nongovernmental organizations launched Pilihanku ("My Choice"), which aims to contribute to Indonesia's FP goal

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients

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to achieve a national modern contraceptive prevalence rate of 62.2% by 2020 (JSI Research and Training Institute, Inc., 2016). Implemented in 11 districts, Pilihanku aims to increase knowledge around contraceptive choice, including postpartum and postabortion FP, and to empower women to make decisions that align with their RH needs.

Indonesia has furthermore committed to strengthening its health infrastructure to increase access to health services by planning the construction of 23,500 FP clinics, including mobile FP services to reach rural and remote areas (FP2020, 2016). The country similarly aims to improve supply chain and service delivery by developing parallel supply chain models that address challenges specific to districts and remote areas (FP2020, 2016).

In 2017, Ipas started working in Indonesia to strengthen the country's PAC policies and services.

BARRIERS TO PAC

Women in Indonesia face multiple barriers to accessing PAC and FP services. One key barrier women face is provider stigma. Women fear provider harassment at the facility when seeking PAC, often influenced by the legal status of abortion in Indonesia. Providers are reportedly less welcoming to young women who seek PAC, which may be a result of Indonesia's legal distinction between married and unmarried women with respect to accessing RH information and services (Amnesty International, 2010).

Stigma within the community is also a barrier to PAC. Despite this, there are no programs aimed at destigmatizing PAC and other services for clients who have experienced a pregnancy loss.

FINANCING MECHANISMS

Launched in 2014, Indonesia's National Health Insurance Program aims to achieve universal health coverage (FP2020, 2014). While the program covers PAC, it does not include FP for postabortion or postpartum women. Yet, since 2016, the universal health coverage scheme (locally known as Jaminan Kesehatan Nasional, or JKN) has included all contraceptive methods (FP2010, 2016). Under this plan, public district hospitals and facilities provide services for free to the lowest socioeconomic group.

Indonesia has maintained its commitment to invest in FP services and commodities by increasing its yearly budget allocations to FP programs: the country allocated IDR 2.6 trillion (approximately USD 178,402,000) to FP in 2012 and increased this investment to IDR 3.56 trillion (approximately USD 244,273,000) in 2016 (FP2020, 2016). An additional commitment by multi-stakeholder partnerships dedicated USD 28 million for FP in 2015 (FP2020, 2015).

INDONESIA		Year	Source
Demographic/background indicators			
Country population	264,000,000	2017	World Bank[1]
Total fertility rate	2.4	2016	
Age at first birth	22.0	2012	Demographic and Health Survey, 2012
Maternal mortality per 100,000 live births	359		
Newborn mortality per 1,000 live births	19		
Infant mortality per 1,000 live births	32		
Under-five child mortality per 1,000 live births	40		
Facility-based deliveries	63.0%		
Proportion of women who attended at least one antenatal visit in the past five years	96.0%		
Proportion of women who received a postnatal check within two days of delivery	80.0%		
Abortion and FP-related indicators			
Number of abortions	2,000,000	2001	Guttmacher Institute, 2008
Abortions per 1,000 women	37		
Number of unintended pregnancies	2,088,000	2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Number of unintended pregnancies averted due to use of modern contraceptive methods	12,140,000		
Number of unsafe abortions averted due to use of modern contraceptive methods	2,865,000		
Number of maternal deaths averted due to use of modern contraceptive methods	16,000		
Modern contraceptive prevalence rate, all women of reproductive age	45.5 %		
Knowledge of FP, all WRA	98.0%	2012	Demographic and Health Survey, 2012
Contraceptive use by type		2017–2018	FP2020 Core Indicator 2017–18 Summary Sheet
Long-acting and permanent methods			
Sterilization (female)	6.7%		
Sterilization (male)	0.4%		
Intrauterine device	8.2%		
Implant	8.2%		
Short-acting methods		2017–18	
Injection (intramuscular and subcutaneous)	50.8%		
Pill	21.2%		
Condom (male)	4.4%		
Condom (female)	0.0%		
Other modern methods (e.g., cycle beads, and lactational amenorrhea method)	0.2%		
Unmet need for FP[2]	11.0%	2012	Demographic and Health Survey, 2012
Unmet need for spacing	4.0%		
Unmet need for limiting	7.0%		
Percentage of all women who received FP information during their last visit with a health service provider	24.4%	2016	FP2020 Core Indicator 2017–18 Summary Sheet

[1] https://data.worldbank.org/indicator/SP.DYN.TFRT.IN

[2] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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