Quality of Health Services in the Family Planning Program in Donggala Regency, Indonesia

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ABSTRACT

This research is policy research aimed at evaluating the family planning program in Donggala Regency. This study's population is fertile age couples (PUS) who have had family planning with certain contraceptives. Descriptive analysis in the form of frequency distribution and cross-tabulation analysis. It shows that the majority of the population of more than 70 percent follow the family planning program involving contraceptive service officers in all education groups. The largest number of underprivileged people who use family planning and visit contraceptive service officers have graduated from elementary school. However, in this group, only 73 percent of the PUS visited the officers. This group of people who graduated from elementary school is also the most massive underprivileged person who does not see officers. Poor people who are aware of health will always come to health services in contraception services or general health services.

INTRODUCTION

The main objective of national development is to create social welfare from various dimensions to produce quality, healthy, intelligent, and productive people. Action is directed explicitly towards achieving a degree of life, which can be measured by the Human Development Index (HDI) [1].

Based on HDI in 2006, Indonesia is still classified as low, ranked 112 out of 174 countries, and lower than its neighboring countries [2]. The low HDI is strongly influenced by the inadequate nutritional status and health status of mothers and children; this can be seen, among others, from the high infant mortality rate of 35 per thousand live births and under-five mortality rate of 58 per thousand live births and the maternal mortality rate of 307 per hundred. Thousand live births. More than half of infant and child mortality is caused by children's low nutritional status under five. So this causes the health status of the Indonesian public, especially the maternal and infant mortality rates, which are relatively high compared to neighboring countries such as Singapore, Malaysia, and others [3].

Various HDI indicators, namely the purchasing power index, the health index, and the education index, are still low due to multiple factors. Various programs launched by the government are not automatically able to raise the standard of living in the short term. A large number of supporters with a high growth rate is still the biggest challenge [4,5].

The inability of government investment to increase economic access and public education in the short term causes a large population to remain an obstacle to development and has not yet become a development asset. The high poverty rate with almost even distribution in every province illustrates that access to the economy is still difficult for some Indonesians.

For this reason, the process of increasing development financing must also be balanced with efforts to reduce the rate of population growth so that the quality of Indonesian people is gradually more able to be realized. The family planning program, which has shown maximum results in the past, needs to be continuously improved, considering Indonesia's current high population growth [4].

Various efforts must be made to reduce population growth through policy changes that lead to an increase in human resources. Controlling population growth and population growth has implications for improving the quality of human resources and the economy. With controlled population growth, development financing can be directed at productive sectors capable of providing leverage on national income and per capita income, which are measures of a nation's prosperity. On the other hand, many people with low education tend to have low productivity and low competitiveness, especially compared to foreign workers, whose trend continues to increase [6].

The effort to evaluate the family planning program can not only be seen from the outcome aspect, namely the controlled population size, it can also be seen from the extent to which the financing made finds the planned targets. This is where the benefit-cost analysis is needed in the implementation of the family planning program [7]. Efforts to design a good family planning program cannot be separated from the accuracy of the relevant agencies' plans, especially the BKKBN. This is because the program carried out must have the maximum impact on the community as the family planning program's ultimate target.

The results of this benefit-cost analysis will give us an idea of whether a program has the right goals or not. If a program is right on target and has better benefits from the number of inputs used, the program can continue in the future [8]. On the other hand, plans with low benefits need to be evaluated as to why this is happening and can lead to revision or termination of the program concerned and replacing it with other, better plans.

METHODOLOGY

This research is policy research aimed at evaluating the family planning program in Donggala Regency. This study's population is fertile age couples (PUS) who have had family planning with certain contraceptives. Sampling using a cluster sampling technique which is carried out in stages as follows: 1). Phase I conducted sampling based on the regional cluster in Donggala Regency. The areas selected in this study were 5 (five) sub-districts based on

geographical characteristics, namely mountainous regions, coastal areas, and urban areas. 2). Phase II: determine the sample size of the rural area from the sample sub-districts of 2 villages, which are also allocated based on geographical characteristics. 3). Stage III: determine the sample size of fertile age couples (PUS) who have received family planning or are currently on family planning. Each village was taken as many as 30 respondents. Overall respondents can be counted (5 x 2 x 30) = 300 respondents. To provide a clear direction for this research, the research variables must be measurable and operational. For this reason, it is clearly explained the variables of this study as follows. To see the benefit-cost of the family planning program, it will be elaborated based on the aspects of the benefits and social costs of WUS participation in the family planning program.

The analytical tool used to answer the problems posed will be used descriptive analysis tools in frequency distribution and cross-tabulation analysis.

RESULTS AND DISCUSSION

Table 1: Crosstabulation of education level by visiting contraceptive service officers if PUS wants to have family planning

Education When visiting the officer	Education When visiting the officer					Total
	Without information	Yes	%	No	%	
No school	786	745	0.876	105	0.124	1636
Not completed in primary school	247	459	0.762	143	0.238	849
Graduated from elementary school	1362	1844	0.735	664	0.265	3870
Did not finish junior high school	259	573	0.758	183	0.242	1015
Completed junior high school	561	1297	0.86	212	0.14	2070
Did not finish high school	15	35	0.972	1	0.028	51
Graduated from high school	110	190	0.772	56	0.228	356
Didn't Finish the Academy	5	4	0.8	1	0.2	10
Graduated from the Academy	61	116	0.921	10	0.079	187
Graduated S1	100	63	0.759	20	0.241	183

It shows that the majority of the population of more than 70 percent follow the family planning program involving contraceptive service officers in all education groups. This shows a high level of awareness of contraceptive service personnel's importance in helping couples of childbearing ages have KB.

The data above shows that the most underprivileged people who have KB and visit contraceptive service officers are the largest with primary school education. However, in this group, only 73 percent of the PUS saw the officers. This group of people who graduated from SD is also the largest underprivileged community who do not visit contraceptive service personnel.

Contraceptive officer services are provided by the government to provide information and education for the public regarding contraceptive use. It is hoped that officers' reports to couples of childbearing age who are about to go to KB will increase the success of the family planning program launched by the government and the couple's wishes.

The task for the government, in this case, the BKKBN, is to focus more on contraceptive services by providing direct counseling to underprivileged members of the community through their cadres in each village, especially those with primary school education, because this community group does not involve contraception officers the most in the KB

Table 2: Crostab Use of Hospital Facilities With PUS Visits To Officers Who Want Family Planning

If KB goes to the officer	When sick, go to the puskesmas			Total
	No Information	Yes	No	
No Information	1632	1375	499	3506
Yes	158	4391	777	5326
%	0.03	0.82	0.15	0.52
No	75	619	701	1395
%	0.05	0.44	0.50	0.14

The data above shows that most people who have a KB through officers will come to the puskesmas if they experience illness. This trend is also seen in the community who do not visit contraceptive service personnel, and most of them do not visit the puskesmas when they are sick.

This condition shows that poor people who are aware of health will always come to health services in contraception services or general health services. This was possible because of the health information and understanding of the importance of health provided by the contraceptive service cadres in the village.

The data above shows that most of the couples of childbearing age in Donggala tend to care about their health, as demonstrated by 52 percent of them visiting contraceptive service officers when they want to be KB. Based on these conditions, the government must reinforce contraceptive service cadres in each village to also play a role in providing health information and health facilities for families

Table 3: Crosstab Between Use of Health Facilities When KB Ber and Children 7-15 Years Old School

If KB goes to the officer	Children 7-15 years of age attend school			Total
	No Information	Yes	No	
No Information	3115	269	122	3506
Yes	681	4167	478	5326
%	*0.13*	*0.78*	*0.09*	*52.08*
No	64	164	1167	1395
%	*0.05*	*0.12*	*0.84*	*13.64*

The data above shows a tendency that poor people who are aware of health with indicators of visiting contraceptive service personnel are more successful in sending their children to school until 15. On the other hand, underprivileged people who do not visit contraceptive service officers tend to be less successful in sending their children to school until they are 15 years old. This can be seen from the 84 percent of underprivileged people who do not visit contraceptive service personnel at the time of birth and cannot send their children to school until they are 15 years old.

This condition shows that people who follow the family planning program with health workers' help have demonstrated success in delaying and regulating birth patterns. With the planned birth pattern and the number of children, it is more capable of improving family life quality. This can be seen from the indication of pre-prosperous families' ability to send their children to school until they are 15 years old.

Based on this phenomenon, the function of family planning extension workers in each village turns out to be not only for the success of the family planning program but also on the ability and willingness of family planning participants to improve their children's education.

Growth of Fertile Age Couples in Donnggala Regency
The number of child-age couples in Donggala since 2008 and 2009 has decreased in several community groups based on the level of their welfare, as seen in the graph below:
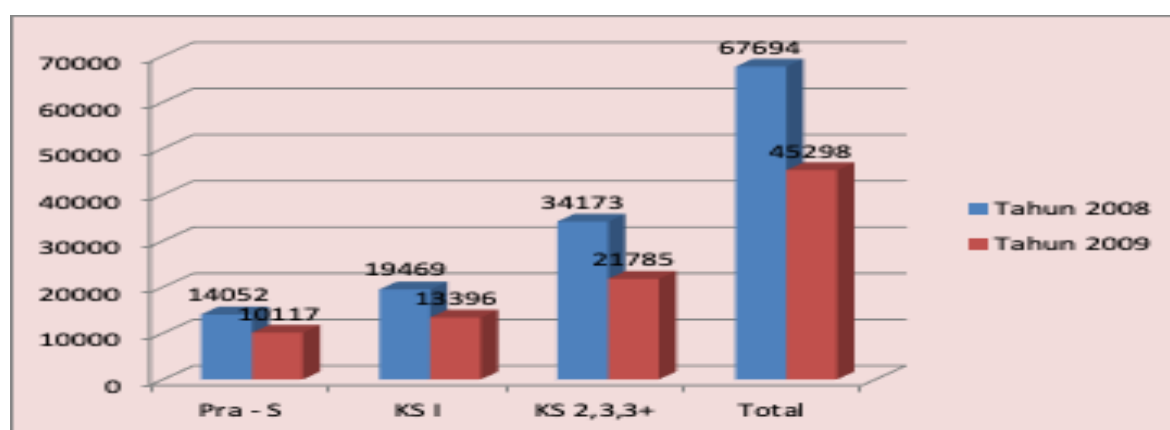
The data above shows that the fertile age couples of the pre-prosperous community in 2009 experienced a decrease of 28 percent. The people of the KS1 group in 2009 also experienced a more significant decline than those of the pre-prosperous group, namely 31.19 percent. The largest decrease in the number of EFA in 2009 was in the KS2,3,3 + group, namely 36.25. Overall, the couples of childbearing age in Donggala Regency experienced a decrease of 33.08 percent.
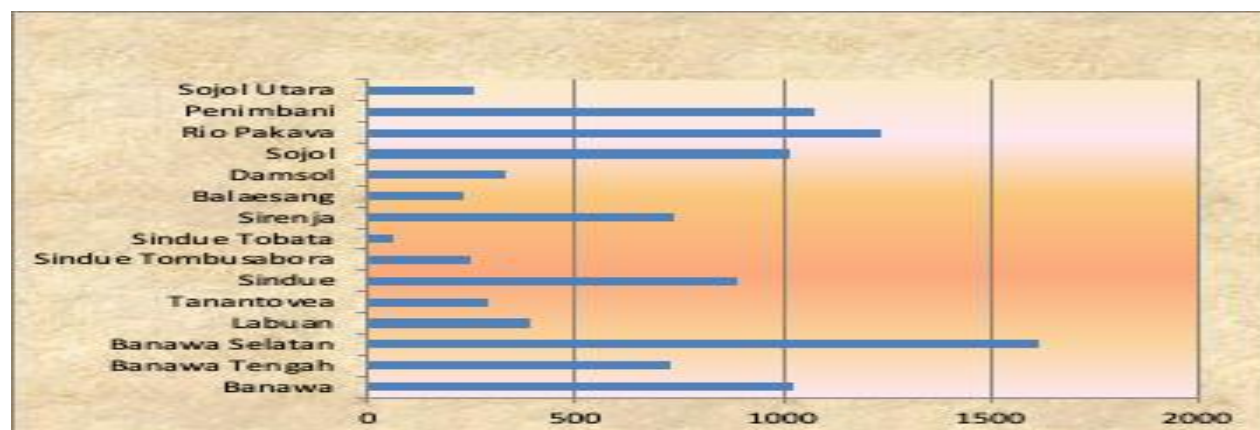
The decline in the number of fertile aged couples in Donggala Regency in 2009 was quite significant. When viewed from the total population of the age group 15 to 49 years since 2008, it has increased, but this has not been accompanied by an increase in the number of reproductive-age couples. This condition may be explained that the decrease in the number of childbearing age teams in 2009 in the Donggala Regency was caused by a reduction in the desire to get married or postpone marriage in 2009.

Postponement of marriage can also be made possible by considering family economic readiness and awareness of

postponing young marriages. It is hoped that the decrease in EFA in 2009 will also reduce the birth rate in 2010.

Number of Fertile Age Couples in the Pre-Prosperous Group in Each District in Donggala Regency

The distribution of the number of couples of reproductive age in pre-prosperous groups in Donggala Regency in 15 Districts can be seen in the chart below:

The couples of reproductive age in the largest pre-prosperous group are in the South Banawa District, Rio Pakava District, and the Penimbani District. The least fertile age couples in pre-prosperous communities are in Sindue Tobata and Balaesang and Sindue Tombusabora Districts.

This condition gives a signal for the government, especially the BKKBN, to pay more attention to several districts with the largest PUS in Donggala Regency. Poor people focus on meeting their basic needs; their understanding and desire for health are not their top priority. Based on this, the government is more pro-active in providing counseling and assistance for easy access to health.

Health improvement through counseling and easy access assistance can break the cycle of poverty through good family planning. Planning in the family will reduce the economic burden that must be borne by the family so that they can take advantage of income for things that have higher priority.

Number of Fertile Age Couples in the Prosperous Group 1 in Each District in Donggala Regency

The distribution of the number of couples of reproductive age in the Prosperous Group 1 in Donggala Regency in 15 Districts can be seen in the chart below:
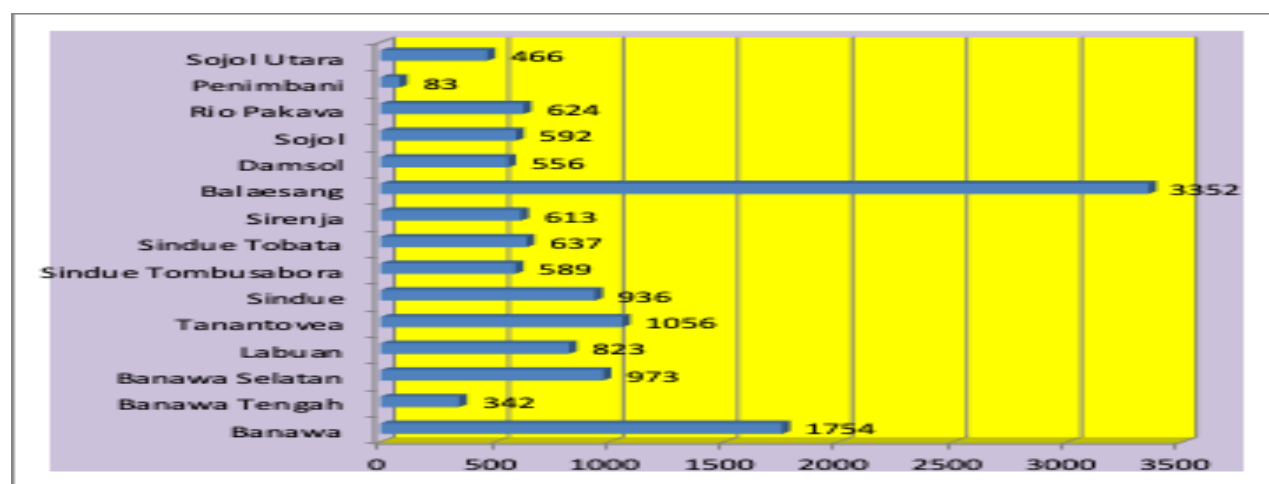

Balancing and Banawa Subdistricts have the largest fertile age pairs compared to the other 14 Districts. When compared with the number of couples of childbearing ages in the pre-prosperous group in the two sub-districts, it can be seen that Balaesang and Banawa are the sub-districts that have more fertile age couples in the thriving group 1. In several other districts, such as hoarding more fertile couples in their pre-prosperous group, this condition also has something in common with several other sub-districts. Of course, in this case, the BKKBN needs to strengthen health programs related to reproduction in several sub-districts with the most considerable fertile age in Donggala Regency; this means that it will focus more on the target to be addressed.

Distribution of EFA from group KS2,3, 3+ based on sub-districts in 2009

KS3 and 3+ are groups of relatively well-off people, so that although they are still in the low category, they are not as bad as KS1 or Pra Sejahtera. In terms of economic capacity, these PUS Ks3 and KS3 + groups can finance family planning activities so that they can be directed towards achieving independent family planning. However, because, in general, the public perceives that the KS3 group is also low, they tend to use government funds in using contraceptives.

Overall, the number of EFA in the KS3 and KS3 + groups was 21785 and was the largest group compared to KS 1 and KS2. The distribution of EFA in the KS3 and KS3 + groups by the district is as follows.
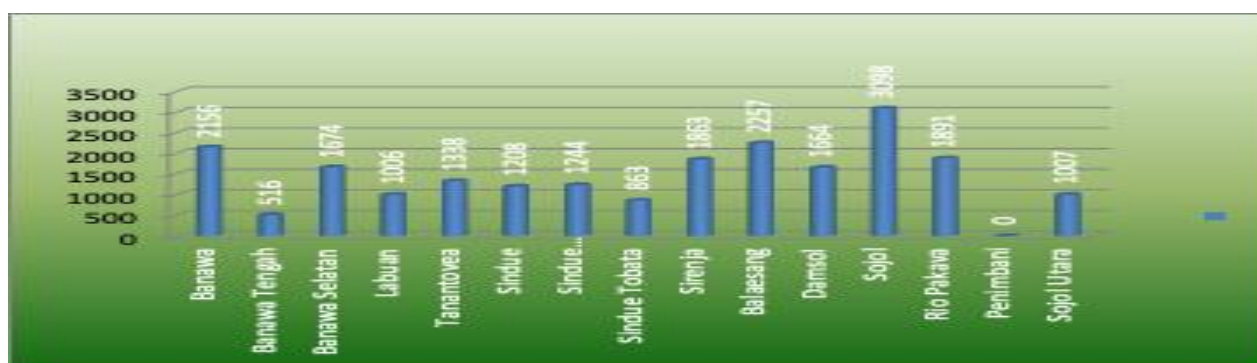
Number of EFA in the KS3, KS3 + groups in Donggala Regency by District.

Age Composition of Fertile Couples

The fertile age couple (PUS) is the main target of the family planning program because it has a high level of versatility. The EFA group from underprivileged families usually tends to have a relatively large number of children because mothers in the disadvantaged group usually have low education, so their knowledge of family planning is shallow. This is the importance of intensive counseling to increase the understanding of mothers from underprivileged groups. Insufficient knowledge plus a low level of education causes poor people to be unable to send their children to school; they do not have the concept of family development, so that poverty will be hereditary. The composition of the number of PUS in Donggala district in 2009 is:
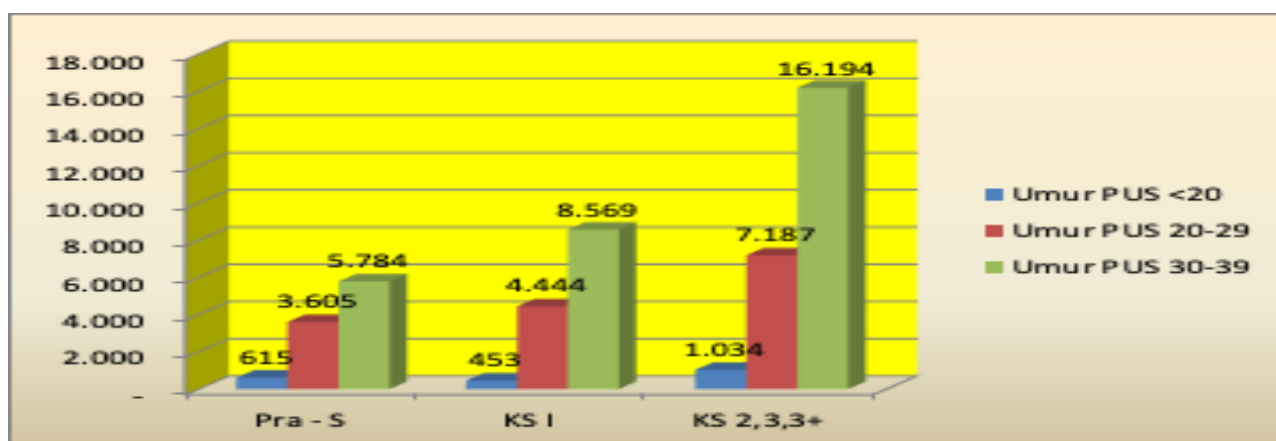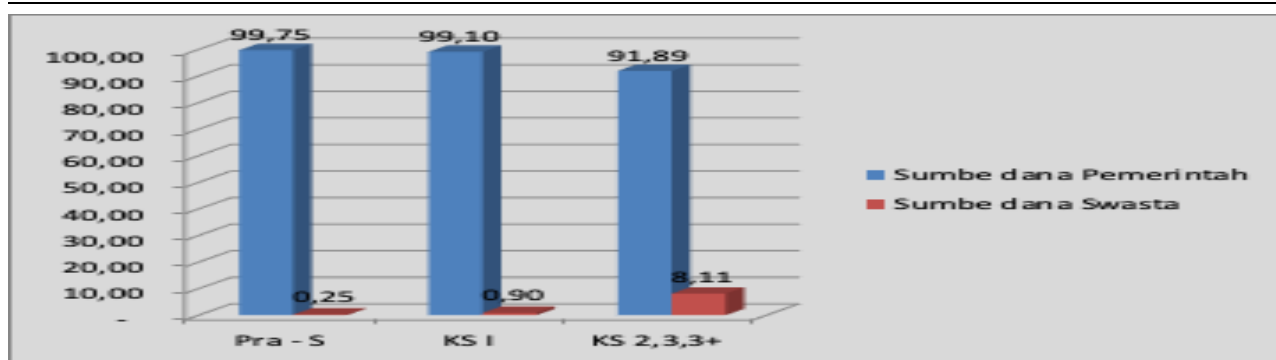

From the graph above, it can be seen that in 2009, the PUS group at the age of 30-39 was the largest, both in Pra-prosperous families, KS1 and Ks2,3, and 3+. Seeing this condition, it is necessary to observe whether the 30-39 age group generally has one child or two children. If typically, two children already have, then the target of counseling is how the PUS in this group will not add more children if no one is economically supported. The extension can focus on empowering PUS 30-39 age to be more productive in the family economy, for example, through various family economic training, which can help the family economy so that it has an impact on poverty alleviation.

The presence of PUS aged <20 years indicates that their education level is also low. This means that PUS with age <20 years is almost sure that they have not graduated from high school or have just graduated from high school. Psychologically, they are generally not ready to marry, especially if the economic conditions are also shallow. This psychologically vulnerable condition typically triggers divorce for young couples because they are not mentally prepared to cross the ladder and are exacerbated by the household's economic situation.

PUS, at the age of 35 and over, generally has a risk in the delivery process. Therefore, in the 35-year age group, an adequate understanding of the concept of safe delivery is needed. Knowledge of safe childbirth is expected to provide PUS provision to develop their psychology so that they will not give birth to another child at the age of 35 years or older. Thus, on the one hand, it will reduce the occurrence of complications of childbirth, and the second is the awareness to not give birth again at the age of 35 years, which means it will also help reduce the birth rate.

Source of family planning funds

In general, contraceptives are easily found in various places, from health centers, drug stores, pharmacies, and practicing doctors. However, in economically vulnerable groups, these multiple places' availability does not fully motivate them to use calculators to regulate the pregnancy process or terminate the pregnancy. The poor generally still depend on their family planning behavior on contraceptives provided by the government. Based on the 2008 data, it can be seen graphically as follows:

From the graph above, it can be seen that a tiny proportion of family planning participants use their funds. This means that both groups KS1, KS2,3, and 3+ are still dependent on the government about their family planning participation. Seeing this phenomenon, there are not many options for the government to promote family planning among the poor apart from intensive counseling, coupled with the provision of free contraceptives. In the low group of KS2,2 and 3+, only 8% use their funds (independent family planning), and in the poorer (Pra Sejahtera and KS1), the proportion is getting smaller.

The intensity of counseling for the poor must always be sought and must be the most critical indicator because failure to reduce the birth rate of the poor will cause a negative multiplier effect, such as an increased state burden, an increase in unemployment for unskilled workers, the emergence of social problems, the limitations of educational subsidies. And the difficulty of managing the poor in various aspects. Low community groups are also prone to exploitation, which creates a high social burden for the government.

PUS is not a family planning participant

PUS non-KB consists of several reasons. In general, there are four reasons why PUS does not have family planning, namely, being pregnant, wanting to have children immediately, delaying pregnancy, and not wanting any more children. The last two reasons are the most prone to an increase in a less controlled population and less planned. PUS who wish to postpone pregnancy does not use contraceptives to use scientific methods, and women who do not want children anymore. However, natural ways of delaying pregnancy are generally risky because pregnancy can occur only because of 1 sperm cell that fertilizes the ovum.

The PUS group's ignorance and unwillingness in using the contraceptive while the underlying reasons are wanting to postpone pregnancy and not wanting any more children should be the focus of family planning extension workers in the field. There need to be intensive efforts to increase awareness of EFA in this group. The proportion of women who do not have family planning because they do not want more children and postpone pregnancy in 2008 and 2009 is stated as follows:

Table 4. The number of women who do not want more children and postpone pregnancy in Donggala district

Years	Postpone Pregnancy	Don't Want Children	Total PUS
2008	6166	5958	47,949
2009	5951	5773	45,298

From the table above, it can be seen that there were 6,166 PUS who did not have family planning because they wanted to postpone pregnancy, while PUS who did not have family planning in 2008 totaled 5,958.

The proportion of women who do not have family planning in 2008 and 2009 on the grounds of delaying pregnancy and not wanting more children is presented in the following graphic:
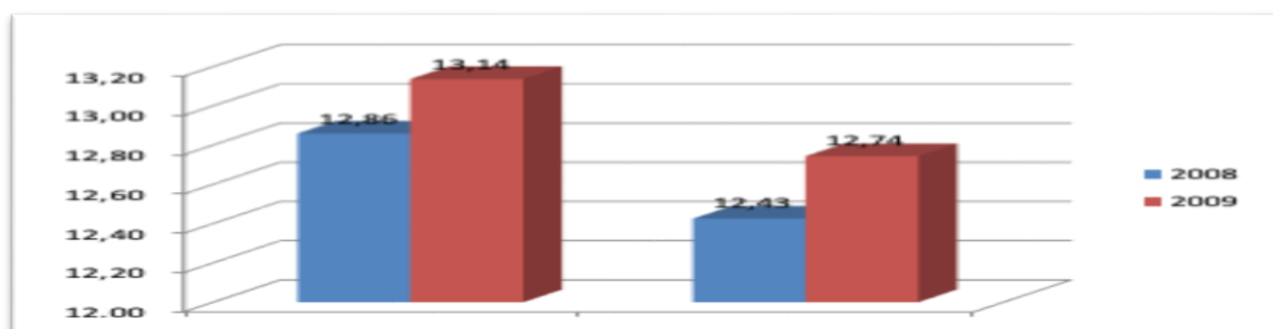
From the graphic above, it can be seen that, in 2008 and 2009, the proportion of PUS who did not have family planning because they did not want any more children were around 12% more than the total population of EFA in

that year. In 2009, the proportion of PUS who did not take family planning on the grounds of wanting to delay pregnancy the balance was more significant, namely 13.14%, while in 2008 it was 13.14%. In the graph, it can

be seen that in 2009, the population of EFA was more significant than in 2008, so that although the proportion is not too different, it looks different graphically.

The simplicity in providing family planning services is assessed from two things: the ease of fulfilling the requirements to become new family planning participants and the stages of organizing family planning services itself. As far as observations have been made in the field, level simplicity to meet the requirements needed for new family planning participants is arguably uncomplicated and straightforward. The same applies to the stages of family planning services. To receive family planning services, especially participants under 45 are encouraged to take counseling, then choose which family planning product to use [9,10].

So, it can be concluded that the level of simplicity of family planning services implemented in the Donggala Regency area is quite simple and does not make it difficult for the community both in terms of requirements and stages.

The family planning program service process begins with the community as a potential family planning participant by coming directly to the nearest family planning clinic, be it a midwife, doctor, or community health center. After arriving at the community clinic, they will be given guidance in counseling; at this stage, the community will explain the family planning program in more detail. After conducting counseling, the organization will have their health checked if they want to participate in family planning, then determine what products they want to use [11]. After finding the option that feels right, then install the equipment and become a new active participant.

CONCLUSION

This study concludes that there is a high level of awareness of contraceptive service personnel's importance in helping reproductive-aged couples have birth control. The largest number of underprivileged people who visit the contraceptive service officer have graduated from elementary school. However, in this group, only 73 percent of the PUS called the officers. This group of people who graduated from SD is also the largest underprivileged community who do not visit officers. Pre-prosperous people who are aware of health will always come to health services in contraception services or general health services.

Therefore, the research recommends that local governments provide reinforcement for contraceptive service cadres in each village to also play a role in providing health information and health facilities for families.

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