SJIF Impact Factor: 5.464

WORLD JOURNAL OF ADVANCE HEALTHCARE RESEARCH

ISSN: 2457-0400
Volume: 4.
Issue: 2.
Page N. 27-33
Year: 2020

Original Article www.wjahr.com

UTILIZATION AND ALLOCATION FOR VILLAGE FUND IN THE PROMOTION OF FAMILY PLANNING VIA UPTAKE LONG ACTING AND PERMANENT METHOD (LAPM) IN WEST NUSA TENGGARA PROVINCE, INDONESIA

Surotul Ilmiyah*[1,4], Rita Damayanti[1], Ede Surya Darmawan[1], Iwan Ariawan[1], Hoirun Nisa[2], Hendri Hartati[3], Ousman Bajinka[4]

[1]Faculty of Public Health, Universitas Indonesia.
[2]Department of Public Health, Faculty of Health Sciences, Syarif Hidayatullah State Islamic University (UIN), Jakarta, Indonesia.
[3]Centre of Health Research Universitas Indonesia.
[4]Xiangya School of Medicine and Public Health, Central South University, Changsa, China.

Received date: 05 January 2020 **Revised date:** 26 January 2020 **Accepted date:** 16 February 2020

***Corresponding author: Surotul Ilmiyah**

Xiangya School of Public Health, Central South University, Changsa, China.

ABSTRACT

Background: Indonesia has succeeded in driving population growth rates through family planning programs, however, the number of Total Fertility Rate (TFR) is still stagnant, even higher than ASEAN countries. Long Acting and Permanent Method (LAPM) is a very effective method to delay, space pregnancy. West Nusa Tenggara is a province with a high TFR rate, a low contraceptive prevalence rate (CPR) and a low use of LAPM. Decentralization should strenghten institutional support for family planning at the village level. Johns Hopkins University through the Universitas Indonesia (UI) Health Research Center and Cipta Cara Padu Foundation (YCCP) has made an advocacy initiative on Village Law No. 6/2014 for the benefit of family planning programs. **Aim**: This study aims to look at utilization of village funds allocation for family planning promotion with long acting and permanent method (LAPM) uptake in West Nusa Tenggara Province, Indonesia. **Methods**:This study was conducted with a cross-sectional design using bivariate chi-square analysis and multivariate analysis using multilevel with individuals as level 1 and villages as level two file, with the secondary data endline survey (YCCP) and UI Health Research Center in 2016. **Results:**The results showed that village funds increased the use of LAPM with *p* value of 0.041, and Multilevel Odd Ratio (MOR) 1,162 showed that villages funding for LAPM promotion was 1,162 times greater in increasing uptake of LAPM acceptors compared to villages that did not have village funds for LAPM promotions. In addition, other variables that were very influential; family planning policy in the village, village family planning institutions, and knowledge after controlling for education, time, economic, cost of family planning services, and transportation costs. **Conclusion**: the study concluded that, there should be advocacy for village health levels in various regions by allocating village funds above Rp.7,500,000 to strengthen family planning programs to support LAPM. Access barriers in LAPM can be overcome by using funds in addition to management activities, counseling, can also be used for transportation, and cadre transportation that allows acceptors to access health services.

KEYWORDS: Village development, village funds, advocacy, LAPM, Family Planning.

INTRODUCTION

Indonesia had successfully attracted global attention in controlling population growth rate through the Family Planning program. However, Indonesia's TFR is relatively high compared to ASEAN countries' TFR (WPDS, 2013 in Ministry of Health 2013). World Population Data Sheet 2013, Indonesia is the 5th country with the largest population, 249 million with a population rate of 1.49% (BKKBN, 2013). This means that every year the Indonesian population increases by 4.5 million people (almost the same as Singapore's population). The population increase, and a high maternal mortality rate, greatly affected high rate of TFR. Indonesia tends to stagnate for 10 years from 2002-2012, which is 2.6 children every woman of childbearing age, far from the 2014 RPJMN target (2.36) (IDHS, 2012). While the trend of contraceptive use (Contraceptive Prevalence Rate / CPR) only experienced

a 1% increase for 5 years, 61% in 2007 to 62% in 2012 (SDKI, 2012).
Population and Family Planning Department (BKKBN) said that more than half of childbirth are dominated by women of childbearing age (WUS). As much as 46-50 percent of the total maternal mortality rate (AKI) due to pregnancy and childbirth, according to the Ministry of Health, was contributed by young age groups. AKI has touched 228 per 100,000 live births.However, based on SDKI 2012, the number actually increased, even more, to 359 per 100,000 live births (SDKI, 2012).

LAPM are effective methods for delaying and spacing pregnancy as well as stopping fertility. Therefore, the government tries to increase the uptake of LAPM, but in reality, the use of non-LAPM is more than LAPM. BKKBN data contained 8,500,247 new fertile age couples (PUS), more than half of them used non-LAPM at 81.25% i.e. 48.56% injections, 26.60% pills, condoms 6.09%, but only 18.75% who use LAPM especially 7.75% IUD, implant 9.23%, MOW 1.52%, and MOP 0.25% (BKKBN, 2013). While West Nusa Tenggara, a province with a high TFR number, 2.82 in 2012 (SDKI, 2012) is higher than national TFR 2.6 (BKKBN, 2014). New family planning acceptors in 2015 used 26.84% LAPM (IUD, MOP, MOW and implants) and 73.16% non LAPM (injections, pills, condoms) while active acceptors in 2015 used LAPM contraception (IUD, MOP, MOW and implants) as much as 31.15% and non-LAPM (injections, pills, condoms) as much as 68.85% (NTB Health Office, 2015).

Factors that influence the low uptake of contraception in NTB are the high rate of drop out and lack of family planning workers in the field called PLKB (BKKBN, 2015). The ratio of PLKB to a village is 1: 4 while the ideal ratio is 1: 2. The number of NTB PLKB in 2014 was 20,056 (BKKBN, 2014). The low PLKB was caused since after regional autonomy called decentralization, many PLKB were transferred, promoted and retired, while there were no new formations due to a moratorium. As a result, the socialization of the Population, Family Planning and Family Development programs (KKBPK) has become very media-dependent, while the existence of the PLKB is very much needed (BKKBN, 2015).

Since decentralization era and the Village Law No. 6 of 2014, the government launched a development centered in villages. Village funds allocation is suggested that 10% to be used for health (Ministry of Health, 2016). However, with limited health experts at the village level, it will be very difficult to advocate for family planning programs at the village (Budisuari & Rachmawati, 2011). Although the Village Law has regulated the proportion of funds used for community empowerment by 25%, and empowerment for health by 10%, including family planning programs. Advocacy efforts are needed to influence the local government and village level government to allocate part of the village funds to support the family planning strenghtening program through the village PLKB team. NTB as one of the provinces with the highest number of underdeveloped districts based on Perpres 131/2015, almost 100%, that is to say 9 out of 10 needs attention in educating the use of village funds for health, one of them is for family planning. To support this, Center for Communication Program of Johns Hopkins University (JHU-CCP) collaborated with Cipta Cara Padu Foundation, Universitas Indonesia Health Research Center (PPK-UI), Ministry of Health of the Republic of Indonesia, and BKKBN through the Improving Contraceptive Methode Mix program (ICMM) initiated village fund advocacy for family planning in West and East Java in 2013 (JHU, 2013). Key success indicators are the increased in budget supports family planning programs and the increased uptake family planning programs, especially LAPM (Herwanto, 2016).

This advocacy process has raised some of the Regent's commitments regarding Mandatory Program that must be funded, one of which is village fund for health program including the LAPM Program, such as East Lombok (Perbup No. 36 of 2014 concerning Guidelines for Village Financial Management. Article 17, Paragraph 4, k. Supporting LAPM Program); West Lombok (Perbup No. 10 of 2015,); Sumbawa (Perbup No. 11 of 2015 for transport of LAPM acceptors and referring cadre incentives) (YCCP: 2015). Another achievement achieved by Sumbawa is the existence of family planning villages called Kampung KB, one of which is in the Mapin Kebak Village. As much as 70.07% of the total number of PUS in June 2015 has been recorded as family planning acceptors (YCCP: 2015). This study aims to look at the utilization of village funds allocation for family planning promotion with LAPM uptake in West Nusa Tenggara.

METHODS

This study was a cross sectional survey design, quantitative method, using a secondary data analysis of endline data of Improving Contraceptive Methode Mix (ICMM) survey, conducted by Center for Communication Program of John Hopkins University (JHU-CCP) in collaboration with Yayasan Cipta Cara Padu, Health Research Center Universitas Indonesia, Ministry of Health, and BKKBN in 3 Districts of West Nusa Tenggara Province in 2016. LAPM data source was ICMM research data in 3 districts of WNT, i.e. West Lombok, East Lombok, and Sumbawa, while the data allocation of village fund for FP were obtained from advocacy of YCCP in 3 districts. The population in ICMM research was married women aged 15-49 years who lived in the area of West Lombok, East Lombok, and Sumbawa. The selected sample for West Nusa Tenggara was 7281 married women in 121 villages.

The 2016 ICMM data was collected by four stages of the cluster sampling method. Bivariate analysis using chi-

square test was used. The dependent variable was the use of LAPM and the independent variables were level 2 variables, i.e. Village Funds Allocation for LAPM promotion (a regulatory factor), institutional/family planning team at the village level (an organizational factor), as well as policy factors embodied in the village decree Priority of Village Fund Use for family planning. Level 1 variable was knowledge. Control variables were education, age, cost of family planning services, transportation costs, and economic status.

Operationally, village funds were defined on the basis of percentiles 5, 25%, 50%, 75%, where the classification was: 0. No Allocation; 1. Rp.1,000,000- <Rp.4,000,000; 2. Rp.4,000,000 - <Rp. 7,000,000, 3. Rp. 7,000,000-p Rp. 7,500,000; and 4. > Rp. 7,500,000. To see the achievement of LAPM targets in each village, the researchers used the 2011 LAPM target definition of BKKBN i.e. LAPM (IUD, implant, MOW, MOP). (BKKBN, 2011).

RESULTS

The result of univariate analysis showed that from 7235 women, 5971 women (82,5%) used non LAPM and 1264 people (17,5%) used LAPM. Detail results were shown in Table 1.There were 97 from 121 villages in three NTB districts in 2016 that allocated village fund for family planning health promotion at the village level with a variety of rupiah allocations. There were 34 villages (28.1%) that allocated Rp. 7,000,000 -7,500,000 for family planning promotion, while 33 villages (27.3%) allocated Rp.4,000,000- <Rp.7,000,000 for family planning promotion, and 24 villages (19.8%) allocated funds for family planning programs.

Table 1: Village Funds Allocation for Family Planning Promotion at the Village Level of NTB Province in 2016.

Village Funds Allocation for Family Planning Promotion	West Lombok n=37	East Lombok n=45	Sumbawa n=39	n	%
No allocation	59.5	0	5.1	24	19.8
1,000,000 - < 4,000,000	16.2	0	0	6	5.0
4,000,000 - <7,000,000	16.2	40	23.1	33	27.3
7,000,000 - ≤7,500,000	2.7	22.2	59	34	28.1
>7,500,000	5.4	37.8	12.8	24	19.8

Based on the proportion of village fund allocation in each district of the study area in West Nusa Tenggara, 59% villages in Sumbawa allocated Rp.7,000,000-Rp.7,500,000 for family planning promotion, only 5.1% villages that did not allocate fund for family planning. In East Lombok 40% villages allocate Rp.4,000,000-<Rp.7,000,000. Whereas in West Lombok, 59.5% villages still did not allocate fund for family planning. There were 16.2% villages allocated Rp.1,000,000-<Rp.4,000,000 and 16.2% villages allocated Rp.4,000,000- <Rp.7,000,000 for family planning (Table 1).

Table 2 showed that there was a relationship between village funds allocation for family planning with the uptake of LAPM (p = 0.002). Women in villages that allocated > Rp. 7,500,000 for family planning promotion were 1.3 times more likely to use LAPM than those in villages with a low allocation of village funds for family planning programs or even no allocations (Table 2). There were 750 women (20.2%) from the villages that had family planning policies in the village had a tendency to use LAPM. There was a relationship between family planning policy in the respondent's village with LAPM uptake (p< 0.001). Women in villages that had family planning policies in the village were 1.48 times more likely to use LAPM than those in villages without family planning policies (Table 2).

There were 818 women (19.4%) from the villages who had institutional/village family planning teams had a tendency to use LAPM. While 446 women (14.7%) from villages that did not have institutions/village family planning teams had a tendency to use LAPM. There was a relationship between institutional/village family planning team with the uptake of LAPM (p < 0.001). Women in villages that had institutions/village family planning teams were 1.4 times more likely to use LAPM than those who did not have an institution/village family planning team (Table 2). There was a significant relationship between knowledge and LAPM uptake (p< 0.001). From 4284 women with high knowledge, 887 women (20.7%) chose to use LAPM. Women with high knowledge were 1.78 times more likely to use LAPM than those with low knowledge as in Table 2.

Table 2: Distribution of Respondents According to Determinants Related to Uptake of LAPM in NTB Province in 2016.

Variables	Contraception Status				n	OR (95% CI)	*p*
	Non LAPM		LAPM				
	n	%	n	%			
Village Funds Allocation for Family Planning Promotion							

- No Allocation	1215	82.4	260	17.6	1475		0.002
- 1,000,000-<4,000,000	354	83.3	71	16.7	425	1.134 (0.9-1.3)	
- 4,000,000-<7,000,000	1569	84.4	290	15.6	1859	1.063 (0.8-1.4)	
- 7,000,000-≤7,500,000	1757	80	440	20	2197	0.980 (0.8-1.2)	
- >7,500,000	1076	84.1	203	15.9	1279	1.327 (1.1-1.6)	
Village Family planning Policy							
- No	3008	85.4	514	14.6	3522	1.48 (1.31-1.68)	<0.001
- Yes	2963	79.8	750	20.2	3713		
Institutional/Village family planning team							
- No	2581	85.3	446	14.7	3027	1.4 (1.23-1.58)	<0.001
- Yes	3390	80.6	818	19.4	4208		
Knowledge							
- Low	2574	87.2	377	12.8	2951	1.78 (1.56-2.03)	<0.001
- High	3397	79.3	887	20.7	4284		
Education*							
- Low	4398	84.8	789	15.2	5187		<0.001
- Middle	1184	80.0	296	20.0	1480	0.39 (0.32-0.47)	
- High	389	68.5	179	31.5	568	0.54 (0.44-0.68)	
Age*							
- <20 years old	325	93.1	24	6.9	349		<0.001
- 20-35 years old	3402	85.1	598	15.0	4000	0.26 (0.17-0.40)	
- >35 years old	2244	77.8	642	22.2	2886	0.61 (0.54-0.7)	
Cost of family planning services*							
- Expensive, ≥20,000	1139	68.7	519	31.3	1658		<0.001
- Cheap, <20,000	3751	99.2	31	0.8	3782	0.69 (0.6-0.79)	
- Free	1081	60.2	714	39.8	1795	0.01(0.00-0.018)	
Cost of Transportation*							
- No cost	795	100	0	0	795		<0.001
- Cheap, <10,000	4889	82.9	1006	17.1	5895	0.00(0.00-0.00)	
- Expensive, ≥10,000	287	52.7	258	47.3	545	0.23 (0.19-0.27)	
Economic Status*							
- Low	3034	85.5	516	14.5	3550		<0.001
- Middle	1418	83.0	291	17.0	1709	0.565 (0.5-0.65)	
- High	1519	76.9	457	23.1	1976	0.68 (0.58-0.8)	

***Control Variable**

Table 3 showed the result of Multilevel Logistic Regression Modeling Multivariate Variables Level 2 (Village Level Factors) and Level 1 (Individuals) associated with the uptake of LAPM in NTB Province in 2016. It showed all significant variables, i.e. Village Funds Allocation for family planning promotion, family planning policy which is stated in the priority letter of village funds for family planning, and family planning institutions/teams at the village level. The village fund allocation for LAPM promotion is related to the increase in LAPM uptake (p = 0.041). The village that allocated funds for family planning promotion was 1,162 times more likely to increase the number of LAPM acceptors in the village compared to the villages that did not allocate funds for family planning promotion (Table 3). Likewise, the family planning policy stated in the village fund priority decree for family planning at the village level (p< 0.001).

The family planning policy stated in the village letter in priority budget for family planning at the village level had a significant relationship with the uptake of LAPM in the village. The village that had a family planning policy stated in the village fund priority decree for family planning was 2.335 times more likely to increase LAPM use in the village compared to villages that did not have a family planning policy in the village decree (Table 3). The Institution/Village family planning team had a significant relationship with the uptake of LAPM (p< 0.001). The village that has Institution/Village family planning Team was 3.005 times more likely to increase the uptake of LAPM in the village compared to villages that did not have Institutional/Village family planning teams. Thus, the contribution of variables at the village level is very significant in boosting uptake achievement of LAPM target in the village. The existence of village policies contained in the decree, the allocation of village funds for the promotion of family planning, supported by the existence of active village family planning teams will trigger the success of family planning programs, especially LAPM in the village.

Table 3: Multilevel Logistic Regression Multivariate Modeling Level 1 and 2 Variables Related to the Uptake LAPM in NTB Province in 2016.

Village Level Variables	**Coef**	***p***	**MOR**	**95% CI**
- Village Funds Allocation for Family planning Promotion	0.150	0.041	1.162	1.006-1.342
- Family planning policy	0.848	<0.001	2.335	1.627-3.352
- Institutional/village family planning team	1.100	<0.001	3.005	1.667-5.416
Individual Level Variables				
- Knowledge	0.388	<0.001	1.474	1.265-1.717
- Education*	0.416	<0.001	1.516	1.348-1.705
- Age*	0.345	<0.001	1.412	1.236-1.614
- Economic*	0.095	0.048	1.099	1.001-1.208
- Cost of family planning services*	0.802	<0.001	2.229	2.006-2.477
- Cost of transportation*	2.369	<0.001	10.684	8.758-13.034

***Control Variable**

In Level 1 (Individual Factors) variable showed that knowledge of LAPM in young women in NTB had a significant effect in increasing LAPM acceptors in NTB ($p< 0.001$) after controlling for other five variables, such as education, age, family planning services, transportation costs, and economic status. Respondents who had increased/high knowledge were 1.474 times more likely to use LAPM than those with low level of knowlede after controlling for other factors such as high education (1.516 times), age> 35 years (1.412 times), high economic status (1.099 times), the cost of cheap family planning services (2.229 times), and transportation costs (10.684 times) (Table 3).

DISCUSSION

Based on the results of the study, it is known that three independent levels of village were associated with the increased uptake of LAPM in NTB. Village funds variables for family planning at the village level increased the uptake of LAPM in West Nusa Tenggara. The higher the allocation of village funds for family planning programs, the higher the use of LAPM. The most significant association was shown in villages with village funds allocation for family planning above Rp. 7,500,000 with the opportunity to use LAPM was 1.3 times. The results of the multilevel analysis showed that village opportunities that had village fund allocation for family planning promotion were 1,162 times more likely to increase LAPM use. This is in consistent with a previous research at the community level in Kenya using multi-level logit models that reproductive health fund programs were 1.4 times more likely to use LAPM (Obare, 2012).

Although when compared, village funds have a smaller effect because vouchers are more exposed to individuals in the community, so the leverage is greater. Villages have a very strong impact on promoting social change, facilitating access to services, and improving health (Graham, 2014). The villages that had family planning policies stated in a letter were 2,335 times more likely to increase LAPM use in villages. The family planning program was successful in Indonesia because of the family planning network at the village level (Shiffman, 2002).

Institution / Family Planning Team Opportunities were 3,005 times more likely to increase LAPM uptake in the village. One research in Ghana showed that policies, institutions implementing family planning partners and support for service providers are factors related to uptake of LAPM (Emmart, 2010). Utomo (2006) stated that the family planning program at the village level was very effective through cadre strengthening. Bratt (2002) also explained that costs are a barrier in family planning services. In this study, village funds were also allocated for activating acceptor transport, and transport cadres who drove acceptors to health facilities, meaning that there were steps to reduce the acceptor's costs in accessing LAPM.

Knowledge is also significantly related to the increased uptake of LAPM in NTB after controlling for the other five variables, i.e. education, age, family planning costs, transportation costs, and economic status. Respondents with increased/high knowledge were 2.89 times more likely to use LAPM. Through good knowledge about contraception, it can certainly provide an opportunity to choose contraception properly and correctly in accordance with the purpose of family planning (Asih and Hadriah, 2009). This finding is in consistent with several previous research (Beekle, 2006; Karen, 2002; Wakjera, 2010; Charlie 2011; Josep, 2002; Arief, et al, 2013; Nasution, 2011) with the tendency of 1.5 times more likely to use LAPM contraception. The village's leverage is greater.

CONCLUSION

The study concluded that, there should be advocacy for village health levels in various regions by allocating village funds above Rp.7,500,000 to strengthen family planning programs to support LAPM. Access barriers in LAPM can be overcome by using funds in addition to management activities, counseling, can also be used for

transportation, and cadre transportation that allows acceptors to access health services.

Conflicts of Interest

The authors declare that this work is a study using secondary data from Centre of Health Research Universitas Indonesia, Improving Contraceptive Method Mix (ICMM) project. Also from Cipta Cara Padu Foundation for providing data on the use of village funds for family planning in NTB. No funding from any company has been granted to the researchers.

ACKNOWLEDGMENT

We are grateful to staff from the Center for Communication Program of Johns Hopkins University (JHU-CCP) who was willing to provide secondary data on Improving Contraceptive Method Mix (ICMM) for our research, Cipta Cara Padu Foundation for providing data on the use of village funds for family planning in NTB, University of Indonesia Health Research Center, the Indonesian Ministry of Health, and the BKKBN to conduct the 2016 ICMM survey endline research.

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