1 Aims of the Report

The International Conference on Population and Development (ICPD) in 1994 adopted a *Programme of Action* with an ambitious goal:

All countries should take steps to meet family-planning needs of their populations as soon as possible and should, *in all cases by the year 2015*, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law (UN 1994: para 7.16; emphasis added).

Today there is widespread a view that neither the international community nor the majority of national governments have pursued the Cairo Programme with the level of commitment it requires and deserves. Many national family planning programmes appear to have lost focus and momentum.

Against this background the International Council on Management of Population Programmes (ICOMP) and the Asia and Pacific Regional Office of the United Nations Population Fund (UNFPA) are undertaking a review of the status of family planning in selected countries of Asia and the Pacific. The present country report is one component of this broader undertaking.

The aims of this report are to:

- provide a succinct review of the overall status of family planning (FP) and related reproductive health programmes in Indonesia today;
- identify key issues and obstacles which may be limiting universal access to quality FP services; and
- make recommendations (where appropriate) regarding how the provision of services and practice of FP can be improved by “repositioning,” “revitalizing,” or otherwise adjusting the national FP programme.
Past Achievements in FP/RH

President Suharto introduced a national family planning program in 1968 and established the National Family Planning Program – well known around the world by its Indonesian acronym, BKKBN – in 1970. BKKBN was charged with developing a national FP program and with managing foreign aid provided for this purpose. The program was a great success and fertility levels dropped dramatically (Figure 1). According to the latest UN estimates the total fertility rate (TFR) declined from 5.6 live births per woman per lifetime in 1965-70 to 3.4 in 1985-90 (UN 2009). President Suharto was presented the UN Population Award in 1989 in recognition of this success. The Indonesian FP program was “widely recognized as one of the most successful in the world” (Piet 2003: 83). The latest UN estimate for TFR today (2005-10) is 2.2 (see also Hartanto and Hull 2009).

Figure 1. TFR, Indonesia, 1950-2010

If the current status of FP is to be assessed accurately it is important to understand the factors underlying this early success. Those working in the FP program committed to solving the country’s “population problem” often spoke (and wrote) at the time as if success derived exclusively from “program effort.” It is true the program enjoyed inspired leadership during most of its first quarter century and that BKKBN was able to recruit many of the best new entrants into the civil service to produce an impressive and effective “can-do” organization (Hull 2007). On top of this the program had the strong enthusiastic support of President Suharto which guaranteed generous resources (including foreign assistance) and political leverage.

But there were other important non-program factors at work too. Suharto’s authoritarian New Order government established a highly centralized state apparatus which reached down into villages and tolerated no organized opposition; without this broader political-administrative system in place it is difficult to believe BKKBN could have expanded and coordinated the FP
The New Order government maintained political stability and impressive economic growth during most of 1970-95 and these factors too contributed to many people wanting smaller families. The dramatic decline in fertility was in fact due to a combination of many factors, although no one denies the program contributed significantly to the timing and quick pace of the fertility decline and that the rapid expansion in FP services led to improved health and well-being for millions of Indonesians. It is important to acknowledge the role of non-program factors in the early success of the program because when we examine the change in status of the FP program in Indonesia today we find it is has a lot to do with changes in non-program contextual factors.

By the early 1990s the FP program was at its zenith. The Indonesia Demographic and Health Survey (IDHS) showed that the contraceptive prevalence rate (CPR) for currently married women aged 15-49 had reached 50 percent. \(^2\) (There were no national surveys to measure CPR in the 1960s but it is estimated the rate was significantly below 10 percent in 1970.) However by the end of the decade it was obvious to many observers the program was beginning to lose steam. The apparent “plateauing” of the CPR at around 60 percent was often taken as a clear signal of this (Figure 2). The steady increase in CPR for modern

According to the Hulls (1997: 392, 384), “the most dramatic achievement of the New Order government of the period 1966-90 was the major construction of state and civil institutional structures in ways that enhanced central government control while promoting decentralized responsibilities.” It was, they argue, the government’s unique way of using the instruments of social control made available by this political-administrative system which, in combination with a highly patrimonial state ideology committed to political stability, was responsible for the success of “a wide variety of popular government programmes including primary schooling, health service delivery, and family planning.” For further elaboration of this point see also Hull (2003) and Piet (2003).

\(^2\) DHS data were collected in Indonesia in 1987, 1991, 1994, 1997, 2002/03, and 2007. The 1987 DHS was actually a National Contraceptive Prevalence Survey; it covered 20 of the country’s 27 provinces at the time, and so was representative of 93.7 percent of the national population. The surveys in 1991, 1994, and 1997 were “complete” DHS and are representative of the national population as a whole. The DHS in 2002/03 covered 26 of the 33 provinces in Indonesia at that time: Nangroe Aceh Darussalam, Maluku, North Maluku, and Papua were not included for security reasons (and East Timor was dropped because no longer part of Indonesia). The last IDHS, conducted in 2007, covered the whole country.
methods during the 1990s was at a slower pace at the end of the decade than at the beginning of the decade, and during the most recent period 2002 to 2007 it was increasing at an average of only one fifth of one percentage point per year (Table 1). In fact the challenges facing the FP program since the mid-1990s are much more complex than any single indicator can suggest, as we discuss in the following two sections.

3 Current Issues in the National Program

There is a long litany of unresolved issues and challenges facing the Indonesian FP planning program today. For convenience we discuss them under four major headings: changing demographics, political decentralization, the changing international agenda, and the growing demand for “good governance” (Figure 3).

3a Changing demographics

As a country goes through its demographic transition the demographic profile of its population changes. This in turn results in changes in the demand for FP and RH services, and successful programs need to be responsive to this.

Demand for services

We have already noted the apparent recent plateauing of CPR. This does not pose a major problem for future population growth since the balance of evidence suggests the TFR is already quite close to replacement level. A more urgent concern is that such plateauing around 60 percent is associated with continuing unmet need. Unmet need for FP is defined by the DHS as “the percentage of currently married women who either do not want any more
children or who want to wait before their next birth, but who are not using any method of family planning” (BPS & ORC Macro 2003: 85).³

Table 1. CPR (currently married women 15-49), Indonesia, 1987-2007

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<td>61.4</td>
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<td>CPR modern methods</td>
<td>44.0</td>
<td>47.0</td>
<td>52.0</td>
<td>54.7</td>
<td>56.7</td>
<td>57.4</td>
</tr>
<tr>
<td>Average annual increase in CPR for modern methods since previous survey (percentage points per year)</td>
<td>--</td>
<td>0.8</td>
<td>1.5</td>
<td>0.9</td>
<td>0.4</td>
<td>0.2</td>
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</table>

Source: IDHS.

Unmet need for FP (expressed as percent of CMW 15-49) continued to decline during the 1990s even as total demand continued to rise, but remains around 9 percent during 1997-2007 (Table 2). In absolute terms the number of CMW 15-49 with unmet need continued to increase. In short, a plateauing of CPR around 60 percent is not consistent with the Government’s stated policy objective of ensuring FP services are available to all married couples who need them.⁴

Table 2. Need and total demand for FP (currently married women 15-49), 1987-2007

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<td>For spacing</td>
<td>18.7</td>
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<td>24.2</td>
<td>25.1</td>
<td></td>
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<tr>
<td>For limiting</td>
<td>31.0</td>
<td>32.2</td>
<td>32.1</td>
<td>36.2</td>
<td>36.3</td>
<td></td>
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<tr>
<td>Total</td>
<td>47.7</td>
<td>49.7</td>
<td>54.7</td>
<td>57.4</td>
<td>60.3</td>
<td>61.4</td>
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<tr>
<td>Unmet need for FP:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>For spacing</td>
<td>19.8</td>
<td>6.3</td>
<td>4.8</td>
<td>4.2</td>
<td>4.0</td>
<td>4.3</td>
</tr>
<tr>
<td>For limiting</td>
<td>21.4</td>
<td>6.4</td>
<td>5.8</td>
<td>5.0</td>
<td>4.6</td>
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<td>25.4</td>
<td>28.1</td>
<td>30.0</td>
<td>28.8</td>
<td>29.5</td>
<td></td>
</tr>
<tr>
<td>For limiting</td>
<td>37.9</td>
<td>38.3</td>
<td>37.4</td>
<td>41.0</td>
<td>41.1</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>63.3</td>
<td>66.3</td>
<td>67.4</td>
<td>69.7</td>
<td>70.6</td>
<td></td>
</tr>
<tr>
<td>Percentage of demand satisfied</td>
<td>79.9</td>
<td>84.0</td>
<td>86.4</td>
<td>87.6</td>
<td>87.2</td>
<td></td>
</tr>
</tbody>
</table>

Source: IDHS.

³ The definition is specified further as follows: “Women with an unmet need for ‘spacing’ include pregnant women whose pregnancy was mistimed; amenorrheic women whose last birth was mistimed; and fecund women who are neither pregnant nor amenorrheic, who are not using any method of family planning, and who want to wait two or more years for their next birth. Also included in unmet need for spacing are fecund women who are not using any method of family planning and are unsure whether they want another child or who want another child but are unsure when to have the birth. Unmet need for ‘limiting’ refers to pregnant women whose pregnancy was unwanted; amenorrheic women whose last child was unwanted; and women who are neither pregnant nor amenorrheic, who are not using any method of family planning, and who want no more children.” Ross (2003) argues the DHS definition is too conservative and that a more realistic definition means unmet need is actually a few percentage points higher.

⁴ For a more general account of plateauing, including some speculation on possible causes, see Ross, Abel and Abel (2004).
Method choice

Even if changes in CPR are currently slow this does not mean that FP is static. There are striking trends in method mix, especially increasing reliance on injectables and a shift away from the IUD (Table 3). By 2007 45.0 percent of all currently married women are using short-term hormonal methods, or more than two-thirds of those practicing FP. Sterilization meanwhile remains below 5 percent.

These trends in method mix warrant attention. Although the medical evidence overwhelmingly suggests that low-dose modern hormonal methods pose no serious health risk (except for those with counter-indications), some health practitioners still caution whether it is wise for a woman to take hormones for decades, especially when other non-hormonal long-term methods are available. Second, some FP program experts (e.g. Ross 2003) argue it may be additionally difficult to reach the high levels of CPR needed to attain long-term population stabilization if a program relies heavily on short-term “re-supply methods” because of the “churning effect” among the program’s clients. A program that depends heavily on short-term methods requiring constant re-supply is especially vulnerable to disruption during turbulent times (e.g. during a transition to decentralization). A program with more clients on long-term methods can focus more attention on reaching those couples still with unmet need.

Table 3. Trends in use of contraceptive methods among CMW, 1987-2007

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<tbody>
<tr>
<td>Pill</td>
<td>16.1</td>
<td>14.8</td>
<td>17.1</td>
<td>15.4</td>
<td>13.2</td>
<td>13.2</td>
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<tr>
<td>IUD</td>
<td>13.2</td>
<td>13.3</td>
<td>10.3</td>
<td>8.1</td>
<td>6.2</td>
<td>4.9</td>
</tr>
<tr>
<td>Injection</td>
<td>9.4</td>
<td>11.7</td>
<td>15.2</td>
<td>21.1</td>
<td>27.8</td>
<td>31.8</td>
</tr>
<tr>
<td>Condom</td>
<td>1.6</td>
<td>0.8</td>
<td>0.9</td>
<td>0.7</td>
<td>0.9</td>
<td>1.3</td>
</tr>
<tr>
<td>Implants</td>
<td>0.4</td>
<td>3.1</td>
<td>4.9</td>
<td>6.0</td>
<td>4.3</td>
<td>2.8</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>3.1</td>
<td>2.7</td>
<td>3.1</td>
<td>3.0</td>
<td>3.7</td>
<td>3.0</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>0.2</td>
<td>0.6</td>
<td>0.7</td>
<td>0.4</td>
<td>0.4</td>
<td>0.2</td>
</tr>
<tr>
<td>Periodic abstinence</td>
<td>1.2</td>
<td>1.1</td>
<td>1.1</td>
<td>1.1</td>
<td>1.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>1.3</td>
<td>0.7</td>
<td>0.8</td>
<td>0.8</td>
<td>1.5</td>
<td>2.1</td>
</tr>
<tr>
<td>Other</td>
<td>1.2</td>
<td>0.9</td>
<td>0.8</td>
<td>0.8</td>
<td>0.5</td>
<td>0.4</td>
</tr>
<tr>
<td>Any method</td>
<td>47.7</td>
<td>49.7</td>
<td>54.7</td>
<td>57.4</td>
<td>60.3</td>
<td>61.4</td>
</tr>
</tbody>
</table>

Source: IDHS.

Adolescents and the unmarried

Other significant trends the FP program must respond to concern changing patterns in family formation. At the time of the 2000 Population Census almost one third of all women 15-49 (32.9 percent, or 18.5 million women) were not currently married. Table 4 shows the sharp rise in percent never married for the under-30 female age groups. For both sexes 92 percent of all young people 15-19 are single (in 2000), and 58 percent of those 20-24. Eighty-four percent of all young people 10-24 have never been married.

5 From an evolutionary perspective on population health, see the comments on oral contraception, menstruation, and increases in cycles of cellular proliferation by McMichael (2001: 216-219).
Table 4. Marital status of women (15-49) by age, 1990, 2000

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<tbody>
<tr>
<td>1990</td>
<td>81.8</td>
<td>35.7</td>
<td>11.2</td>
<td>3.7</td>
<td>1.8</td>
<td>26.6</td>
</tr>
<tr>
<td>2000</td>
<td>86.7</td>
<td>43.1</td>
<td>16.7</td>
<td>5.3</td>
<td>2.2</td>
<td>28.5</td>
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<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Never married</td>
<td>17.0</td>
<td>60.8</td>
<td>84.1</td>
<td>89.4</td>
<td>82.5</td>
<td>67.2</td>
</tr>
<tr>
<td>Married</td>
<td>12.7</td>
<td>55.0</td>
<td>80.5</td>
<td>89.8</td>
<td>86.7</td>
<td>67.1</td>
</tr>
<tr>
<td>Divorced</td>
<td>1.1</td>
<td>3.1</td>
<td>2.2</td>
<td>2.0</td>
<td>1.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Widowed</td>
<td>0.1</td>
<td>0.4</td>
<td>0.6</td>
<td>0.6</td>
<td>2.9</td>
<td>2.2</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
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According to the 2002-2003 IDHS, among women currently 25-29 years old the median age at first marriage is 20.2 years, compared to 17.9 years reported by women currently 45-49. Among women currently 20-24 only four out of ten were married by age 20, while for those currently 45-49 seven out of ten were married by age 20. Urban women marry later than rural, and those with more education marry later than those with less. The median age at first marriage among women currently 25-29 who have some education above the secondary level is 23.9 years.

The long interval common nowadays between puberty and marriage represents an intensely challenging period in the development of a young person’s life, and the way she or he deals with it helps determine her or his future life-chances and adult personality. Young people need information and other services to help them navigate this stretch of their life, and most importantly they need information and services to help protect their reproductive health. The changing demographics of Indonesia as it completes its demographic transition are placing growing pressure on FP program managers to provide additional services for the growing proportion of population that is currently unmarried. A FP program that continues to restrict itself to providing services almost exclusively to married couples will necessarily miss a vital, and increasingly large, part of the action.

Source of supply

Another major trend is that FP clients have been shifting to the private sector at a rapid rate in recent years (Table 5). The 2007 IDHS reports 69.1 percent of clients using a “private medical” source of supply, or more than 75.0 percent when “other private” sources are included. Government-provided “public” sources account for only 22.2 percent. The trend towards the private sector was, if anything, accelerated by the Asian Financial Crisis at the end of the 1990s (Strauss et al. 2004). The precise details are complicated because the public-private distinction is not clear-cut, with many private practitioners also working in the public sector, and because what gets listed under each category heading of “source” in the IDHS has changed over the years (e.g. posyandu is listed as a “Government source” in 1991, as “Other private” in 1994 and 1997, and as “Other source” in 2002/03: see Table 5). Nonetheless, the overall trend in privatization is clear, and is corroborated by other data sources such as annual National Socio-Economic Survey (SUSENAS) and the Indonesia Family Life Survey (IFLS).
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<tbody>
<tr>
<td>Public</td>
<td>51.2</td>
<td>48.6</td>
<td>43.0</td>
<td>28.0</td>
<td>22.2</td>
</tr>
<tr>
<td>Medical private</td>
<td>22.1</td>
<td>28.1</td>
<td>41.9</td>
<td>62.5</td>
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<tr>
<td>Other private</td>
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<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
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Source: IDHS.

a This includes “community sources,” namely, posyandu and family planning post.

This trend in privatization is broadly consistent with the Government’s objectives; the policy of KB Mandiri (“self-reliant family planning”) was first introduced in 1989. Policymakers still need to question some of the nuances of this trend, however. One obvious question is whether as the program becomes increasingly privatized this leads to a rise in clients’ out-of-pocket costs so as to cause any among the poor to lose access to services. Another question is whether the private sector is adequately regulated to guarantee a satisfactory minimum standard of services, and whether adequate systems of redress are in place when needed. There is also a question regarding whether providers in the private sector are equipped and motivated to provide adequate choice of methods to clients, or whether the method mix to some extent may reflect a provider bias (e.g. the heavy reliance on injectables provided by private midwives).

Finally, there are sensitive questions about just how self-reliant the private sector really is, and how much it relies on indirect or hidden government subsidies, for example the well-known “leakage” of subsidized FP commodities from the public sector into the private, and the fact that private providers still get trained (and retrained) at public expense and often use publicly-provided facilities and equipment (Lubis 2003: 46-48). Most of these “exchanges” across the public-private divide may be legitimate but some can be shown to undermine the Government’s stated commitment to privatization.

**Regional and socioeconomic differences**

Another area of concern for program managers is that considerable regional differences in the practice of FP still exist in Indonesia (Table 6). Some provinces have CPR for modern methods higher than 60 percent (Jambi 62.5, South Sumatera 62.6, Bengkulu 70.4, Lampung 66.0, Bangka-Belitung 64.7, West Java 60.3, Central Java 60.0, East Java 62.3, Bali 65.4, West Kamilant 61.2, Central Kalimantan 65.2, South Kalimantan 63.2, and North Sulawesi 66.7); others are under 45 percent, notably North Sumatera 42.6, East Nusa Tenggara 30.1, South Sulawesi 42.9, Southeast Sulawesi 44.4, West Sulawesi 44.5, Maluku 29.4, Papua 24.5, and West Papua 39.6). It is important to focus on unmet demand in the last 8 provinces if universal access to FP services by 2015 is to be achieved.
Table 6. CPR (modern methods) for selected provinces, 1987-2007

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<td>N.Sumatra</td>
<td>--</td>
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<td>Bengkulu</td>
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</table>

Source: IDHS.

The 2002/03 IDHS also includes a household wealth index.\(^6\) While CPR for modern methods for all currently-married women 15-49 is 56.7 percent, it is only 43.4 percent for the extremely poor women (lowest quintile) and 53.2 percent for the moderately poor (second lowest decile) (Schoemaker 2004: 8). Schoemaker shows this is predominantly not because the poor have more unmet need but because they want more children than the non-poor. Schoemaker’s analysis also highlights questions program managers need to address about the targeting of subsidized FP services and supplies: Even among the extremely poor more women rely on the private than the public sector for source of supply, while among the non-poor just over 25 percent use the public sector (Schoemaker 2004: 17). The IDHS wealth index cannot be taken as a definitive definition of poverty, but Schoemaker’s analysis is consistent with others (like Ross 2003, and Strauss et al. 2004) which suggest that the government’s subsidized FP services are not largely benefiting the poor in the way intended.

**Finishing the job**

These, then, are some of the challenges facing the FP program in Indonesia today resulting from changing demographics as the country goes through the advanced stages of its demographic transition. The consensus among friends and observers of the program is that it is not tackling these challenges especially well, and that BKKBN is certainly not formulating innovative solutions and coordinating their implementation with the focus and determination the organization displayed during the 1970s and 80s. The question is, Why?

The overall goals of the program – giving couples the information and means they need to control their own fertility, reducing high fertility to bring population growth more in line with the nation’s development goals, supporting the norm of the small prosperous family – have remained remarkably stable since the program was launched in 1970. Policymakers have had to adjust the intermediate objectives periodically, however, in response to changing circumstances. Indeed as the program expanded rapidly during the 1970s and 80s new approaches were constantly being tested and applied to increase coverage and institutionalize FP as a social norm. By the 1990s a majority of couples were already practicing FP, and the depth of their commitment was demonstrated by their resolve to continue even when some supplies were disrupted for a while during the height of the Asian Financial Crisis. The program seemed on track to deliver universal access to services by 2015 and to bring about

\(^6\) It is not used in the chapter on use of family planning in the published report, however.
the program’s original goal of long-term population stabilization. Paradoxically it was at this juncture that the program first appeared to lose its focus and stall.

We argue in the next section this was largely because of changes in the international and institutional context in which BKKBN operates. BKKBN has not been able to take a convincing leadership role in tackling the challenges listed above – what many would argue should be regarded as its “core business” – because other changes in its institutional context have effectively neutralized many of the non-program factors which were vital to its organizational success in the past. BKKBN has not been able to focus during the last 15 years on how its “core business” has evolved separately from tackling other formidable challenges which have arisen regarding the international agenda, political decentralization, and governance reform.

In the longer term the central government’s responsibility will likely change in other ways too. Government-sponsored national FP programs have finite life-spans. “Family planning programs, like the fertility transition that they have helped to drive, will be a transient phenomenon” (Caldwell et al. 2002: 1). More than a dozen countries in Asia have by now a TFR at or below replacement level, and have, or are considering, disbanding their FP programs. It is only a matter of time before the Government of Indonesia will want to phase out much of its program support for FP services, except perhaps for the poor and other vulnerable groups, and for areas where there is still a demonstrable need (cf. Jones and Leete 2002).

That does not mean the Government then has no further role to play regarding the delivery of services. The Government will still need to develop national FP policy and guidelines, protect people’s reproductive rights, monitor districts’ performance of essential FP/RH services, and ensure satisfactory quality standards are followed by service providers in all parts of the country, etc. The Government will also still need to monitor fertility behavior, and perhaps do what it can to make sure that fertility in Indonesia does not eventually fall too far below replacement, as it has in some neighboring countries (and most of Europe). But the publicly-funded FP program as we know it will eventually likely be phased out or significantly refocused and reduced in scale. In fact as we saw in Table 6, this process is already far along, with only a minority of clients depending on the government for their routine FP services.

Senior BKKBN officials are, of course, aware of this situation whereby “success” can imply redundancy for the organization, and are carefully weighing alternative scenarios. We give our own recommendation on this point in section 5.

4 Understanding the Current Situation

4a Changing International Agenda

One set of challenges for the FP program arises because of vicissitudes in the international agenda. The Programme of Action adopted at ICPD in 1994 is recognized as marking a definitive shift in family planning ideology away from an approach oriented towards population control and demographic targets and towards a client-oriented RH approach
emphasizing quality services and grounded in human rights. Sinding (2007: 10) has characterized the situation as follows:

Cairo was truly a watershed. Some have already seen it as the end of the family planning movement, an event celebrated by many feminists and women’s rights activists as a paradigm shift and equally regretted by traditional population advocates, including many demographers and others concerned about high fertility rates, as abandonment of a decades-long commitment to population stabilization. In the years since the conference, global attention has increasingly shifted away from population growth as a central political or development concern, while the rising toll of HIV infection and AIDS deaths has captured the attention of policy makers.

The Indonesian delegation was very active in ICPD. Cairo did not spell the end of the national FP program in Indonesia but it did pose a hard dilemma for BKKBN. BKKBN was set up as a stand-alone agency within the central government in order to take the lead on population control. If FP was now to be seen as essentially a health and gender issue that would imply handing over responsibility for FP policy to the MOH; after all, it was always government health personnel and public health facilities which were actually delivering the public FP services. This BKKBN was clearly reluctant to do. Without a radically new mission it means BKKBN is stuck institutionally in an impossible position: they cannot move forward and wholeheartedly embrace ICPD because that requires acknowledging that FP is first and foremost a matter of RH and therefore belongs logically to the mission of the MOH, and they cannot move backwards towards the direction of population control because that requires using language no one else wants to speak anymore and the original “population problem” has mostly be resolved by now anyway. Institutionally BKKBN are stuck between the proverbial rock and a hard place.

In short BKKBN chose not to redefine its central vision and mission explicitly in terms of Cairo (i.e., in terms of promoting reproductive rights and reproductive health) even though it has adopted specific elements from ICPD. As a result neither the goals of the government’s FP program nor the explicit contributions of BKKBN to the nation’s development objectives are defined today with the same clarity and conviction that they were during the 1970s and 80s. An increasing number of reproductive health advocates and feminists have come to regard BKKBN as now “behind the curve” in matters of RH and FP (see, for example, Juliantoro 2000).

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7 In fact the Programme is more complex than this because it seeks to combine a number of perspectives on population and development – the economic, ecological, NGO, etc. – and not just that of human rights (Hayes 1995).

8 On the pivotal issue of targets, BKKBN was already moving away from targets before Cairo and towards “demand fulfillment” (see Galway 1996).

9 Similar agencies in other countries that were initially established with foreign assistance to manage vertical population control programs presumably face a similar dilemma. ICPD articulated well an important paradigm shift and the international community promptly shifted its support from one paradigm to the other, but it hasn’t offered much help when it comes to the practicalities of effecting such a change in the typical political context of a developing country.
MDGs and numerical targets

At the same time the victory of women’s RH advocates at the Cairo conference did not translate into all the promised results either, and international funding for implementing the Programme of Action has fallen far short of expectations (Schindlmayr 1999; Population Action International 2005). When 189 member states adopted the Millennium Declaration in September 2000 with the commitment to “making the right to development a reality for everyone” and “creat[ing] an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty” (UN 2000), they did not include RH as an MD goal or target, even though the Declaration was promoted as an explicit culmination of the sequence of UN conferences held during the 1990s, including ICPD. The omission was deliberate and calculated (Bernstein 2005; Crossette 2005).

UNFPA, the UN Millennium Project and other stakeholders continued to argue the case that population and RH policy are essential elements of successful strategies to eradicate income poverty and attain other MDGs. At the UN MDG+5 World Summit (in September 2005) the ICPD goal of universal access to RH by 2015 was re-affirmed, and it was agreed this goal should be integrated “in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty” (UN 2005: para 57g). There is an irony in seeing FP and RH once again tied to development goals expressed as numerical targets. The danger is that program managers will be rewarded more for meeting the numerical targets than for bringing about the substantive changes that the numbers are meant to indicate.10

A review of current understanding of the linkages among population, RH and poverty confirms that these factors are causally interrelated in significant ways, and that population and RH can and do impact on poverty status, even though our understanding of all the specific mechanisms involved is still far from complete (Hayes 2005). Practical measures, therefore, to eradicate poverty need to take population matters into account, and improving RH is important if they are to be effective. But whether the target-driven approach of the MDGs is the best way to accomplish this is another question (Reddy and Heaty 2008).

The challenge for central and provincial level FP policymakers is to negotiate performance targets for districts which fairly measure substantive improvements in FP/RH services, and

10 For example, a recent World Bank project aimed at helping the Indonesian Government bring about effective decentralization of the health sector included a component aimed at personnel reform. One element was to reduce the number of non-health staff at puskesmas (health centers – one of the main sites for publicly-supported FP services). This was meant to be just one element in a broader package of HR reforms (getting rid of unproductive staff, clear job descriptions, competency-based promotions, downsizing through early retirement, etc.). However this element was given a numerical target (reduce by 20 percent by a certain date) and the others were not. Consequently some district-level project managers chose to focus on reducing this particular element so they could claim evidence of success in the component as a whole. The method often chosen to accomplish this – using project funds to train non-health staff so they could then be classified as health staff – was probably not cost-effective and certainly defeated the component’s broader objective of a smaller more efficient workforce (Hayes et al. 2007).
which do not serve to distort the incentive structure of FP and RH workers so as to reward reaching easily-measurable yet essentially superficial changes rather than reaching more substantial goals.

4b Decentralization

Effective 1 January 2004, most of BKKBN’s authority for administering the program was transferred to more than 420 “autonomous” districts (kabupaten) and municipalities (kota), and much of its responsibility for developing FP policy is now shared with the regional governments.11 When it became clear in early 2002 that BKKBN would be obliged to decentralize the agency made a concerted effort to ensure that this transfer of authority would go smoothly and that access to FP services would not suffer unduly. BKKBN advocated with local government authorities to ensure that a suitable institutional home would be provided for the FP program in the respective districts/municipalities after decentralization. It developed, in consultation with regional governments and the Ministry of Home Affairs, a list of “essential” family planning services which districts would be obligated by law to provide, together with associated performance indicators to be used for monitoring. BKKBN also managed to secure central government funds to enable it to continue providing subsidized contraceptives (and some other supports) to districts on request.

BKKBN further negotiated a favorable institutional arrangement with the Government whereby the BKKBN province offices could stay “vertical” under the direct control of BKKBN at the central level (at least in the short term) rather than be part of the administrative apparatus controlled by the provincial governor.12 Other proactive initiatives included developing an Early Warning and Rapid Response System, so that even if (as seemed inevitable) routine monitoring systems faltered in the early stages of decentralization, BKKBN and other stakeholders could still have some basic information on how the program was performing from a national perspective, and could identify emerging problems quickly and work in partnership with districts to overcome them. BKKBN prepared for decentralization with arguably more care and deliberation than any other government agency involved with the delivery of public services.

Following decentralization FP program officials at all government levels now face new challenges regarding sourcing resources, planning program activities, recruitment and managing personnel, the scope of their authority for policy formulation, the need for advocacy, their relations with other government and non-government units, reporting on performance, financial reporting, and how their own performance will be evaluated. It is important to recognize that decentralization in Indonesia involves both administrative and political dimensions, so FP program officials cannot resolve all the administrative issues involved before politicians resolve outstanding issues regarding the distribution of authority across the central, province and districts levels of government.

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11 For a review see USAID (2006). Decentralization has a long and complex history in Indonesia going back to colonial times.
12 This kind of institutional arrangement is now largely pro forma after the 2004 decentralization laws.
Much of the technical assistance offered to BKKBN (and the Ministry of Health) has tended to focus on technical issues as if the political issues have already been resolved. Sometimes the “form follows function” adage is included with the advice offered. This assumes the functions are already well defined, and often they are not. Even if they were, institutions in the real world never adapt to functional requirements alone – every institution has its own traditions, and those with power are able to influence processes of change in ways more favorable to themselves; institutional reform is always path-dependent. Sometimes TA has been offered to help define the functions; but as should be clear by now, this is partly a political process, not a simple technical matter. In other words, problems facing the FP program brought about by decentralization that often seem to outsiders to lend themselves to technical solutions in fact often have an irreducible political component and therefore need to be approached as governance issues.

4c  The growing demand for good governance

Although there is little agreement on an exact definition of “good governance” as promoted by international agencies and donors (see for example Jenkins and Plowden 2006), there is broad agreement that items like freedom of speech, political party organization, public accountability of governments, transparency in political decision-making, and an independent judiciary, are all key components of a “healthy” democracy. Institutionalizing these items systemically can also make sectors, including health and FP, more responsive to local communities’ needs and aspirations.

At the program level introducing elements like accountability and transparency are relatively easy, and they engender local participation in, and ownership of, the program. Good governance in this sense is an important part of the ICPD Programme of Action. An initial obstacle, usually short-lived, is that in the early stages few officials or members of the public are familiar with these notions and the mechanisms introduced tend to be weak and innocuous: “accountability” is simply a “suggestions box” placed at a service delivery point, for example. Good governance depends crucially on the development of strong civil society institutions, not just on an efficient state apparatus, and program managers might not see it as their responsibility to foster this. Indonesian NGOs are increasingly effective in promoting good governance. Good governance and strong civil society institutions are needed to check that key “principals” in the state apparatus at all levels do indeed serve the public interest and that services are responsive to the population’s needs and aspirations. BKKBN has supported some good governance initiatives – for example, supporting local NGOs in their watch-dog functions – but they could show much more leadership in promoting good governance in the FP program. To date BKKBN invests far more energy in protecting the legal status of FP in government decrees and development plans than in ensuring a growing role for public accountability.

4d  Other recent developments in FP and population policy

There are a number of other recent developments in FP and population policy in Indonesia which are important for understanding the current situation.
Hull and Mosley review

There have been a number of reviews of the current status of FP in Indonesia in recent years (e.g. Hayes, Lewis and Vogel 2003; Hayes 2006). The most important is that undertaken by Hull and Mosley in 2009, entitled *Revitalization of Family Planning in Indonesia*. Hull and Mosley discuss many of the same issues discussed in this report. Their recommendations are reproduced in Table 7, together with snippets from their accompanying justification and clarification, and some additional brief comments of our own.

### Table 7. Recommendations from Hull and Mosley Review

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Comment</th>
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<tbody>
<tr>
<td>1</td>
<td>Reformulate the vision, mission and values [of the program]</td>
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<tr>
<td>2</td>
<td>Begin the process of building the core analytical and technical competencies related to family planning in the decentralized and mixed public private system of governance that has emerged since 1998</td>
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<tr>
<td>3</td>
<td>Develop a senior leadership advisory structure</td>
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<td>4</td>
<td>Initiate leadership capacity building for reproductive health and family planning in the districts/municipalities</td>
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<tr>
<td>5</td>
<td>Strengthen the role and functions of the new offices/boards of family planning and women and development that have superseded the previous BKKBN offices</td>
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<tr>
<td>6</td>
<td>Promote initiatives to increase nationally and locally the availability and accessibility of long acting contraceptives – IUD, implants and sterilization – to all couples</td>
</tr>
<tr>
<td>7</td>
<td>Formulate program policies and develop operational strategies in collaboration with the Ministry of Health to meet the critical service delivery needs including: a. Reaching disadvantaged women</td>
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including women with an unmet need for contraception with information and services

b. Engaging the private sector with training, technical assistance and incentives to ensure that all women can choose the contraceptive method best for their life stage

c. Assuring that women are not forced to undergo unsafe abortions, and that all women terminating pregnancy are provided with contraception

for both parties. Without addressing this issue as a structural problem invoking collaboration may prove little more than “papering over” the issue. If this collaboration had worked well it is unlikely the FP program would be in the dire state it is today. More research still needed to help identify who these women are and the factors driving their behavior.

| 8 | A central agency charged with responsibility for family planning and reproductive health should place a high priority on monitoring public and private program performance (from service statistics and surveys) with interpretation and rapid feedback to districts/municipalities |

Comment: This is a major concern of BKKBN, but new strategies not yet finalized.

| 9 | Develop and promote national communication strategies focusing on the major unmet needs and unreached groups |

| 10 | The agency should also test and introduce innovations, primarily through grants to universities, private organizations and NGOs as appropriate |

“This activity needs to be closely coordinated with the Ministry of Health.”

| 11 | The agency should encourage districts/municipalities to innovate and take other actions to strengthen programs, primarily through “block grants” |

Comment: There is now considerable experience with the block grants mechanism in Indonesia. The problems with implementation typically relate to the central government releasing funds late, and the use of the grants being constrained by a confusing and often onerous regulatory environment established by the central government (Hayes et al. 2007). |

| 12 | The agency should conduct advocacy, nationally and internationally, based on critically analysed data |

“This will not only be for increased support for all components of the family planning program, but also for new policies to ensure that unmarried women and women seeking to terminate a pregnancy can get safe, confidential services without stigma.”


This review was followed by another which suggested operational strategies for implementing the Hull and Mosley recommendations (Lewis and Haripurnomo 2009). Eight strategies were outlined:

- Strategy to support the role of the private sector in RE/FP
- Strategy for technical support for decentralization
- National communications strategy
- Capacity building strategy to address decentralization and priorities in RH/FP
- Strategy to improve the quality of RH/FP
- Support strategy for ensuring equity in access and use of RH/FP services
- Strategy for preventing high risk pregnancies
- Strategy for balancing the contraceptive method mix.

BKKBN has adopted some of these recommendations, although not necessarily in ways that others would regard as engendering a “revitalization” of the FP program. For example BKKBN has begun to address the issue of method mix, but the lynchpin of their strategy is to provide all contraceptive methods free of charge: i.e. a strategy which secures a large procurement budget for the agency without requiring any significant organizational reform. It is not clear how this strategy adds value to “working closely” with the MOH (the phrase often used in public statements) or adds value to implementing effective decentralization; and no premium appears to have been placed on providing contraceptive methods in a cost-effective way. The fact that BKKBN can command such a large procurement budget demonstrates the agency still has a lot of political capital, but it is being spent mostly to maintain business as usual, not to introduce innovative reform.

The Hull and Mosley recommendations are eminently sensible and well thought out. These qualities are rarely sufficient in any democracy to ensure the government will adopt them. In Indonesia government agencies are still largely neo-patrimonial bureaucracies; promotion in the civil service is still not clearly determined by performance, although this is slowly changing. Key political decisions are often determined by webs of patronage and the capacity to capture and command resources. Under these circumstances it is hard for any agency to adopt changes on the grounds that they will result in everyone doing a better job at serving the needs and aspirations of the public. It is hard to introduce evidence-based reforms designed to improve an agency’s performance without further civil service reform (Synnerstrom 2007).

5 Recommendations

Our recommendations are presented as discussion questions for the coming High-level Family Planning Consultation Meeting in Bangkok, 8-10 December 2010.

Recommendation 1. Can Indonesia’s national FP program be given a central focus to meet all remaining unmet need for services by 2015?

The FP program does not have a clear focus at present. Its core business should be reducing unmet need but little progress has been made on this during the last 15 years. Unmet need is primarily a health and reproductive rights issue and it needs to be addressed urgently for a number of reasons. Unmet demand for FP services means that millions of women in Indonesia today are at risk of unwanted pregnancy. This is a serious health and gender issue.

Focusing the FP program on reducing unmet need for FP services is the kind of challenge which could revitalize the program. It is a goal which has major health benefits and which
promises to empower more women (and couples), together with all the flow-on benefits this entails. It is also a goal which enjoys almost universal support, both in-country and internationally, and which if accomplished will help the nation reach its MDGs as well as achieve the ICPD target of universal access to FP by 2015.

**Recommendation 2. Can primary responsibility for FP policy be transferred to the Ministry of Health within the next few years?**

BKKBN was established at a time when there was a recognized massive “population problem” in the country which related to very high fertility levels and a high population growth rate, and the international community supported population control programs at the time. Neither condition is true today.

Thanks largely to the successful efforts of BKKBN the original “population problem” has been brought under control. Family planning is now the prevailing norm in Indonesia, although responsible practice is low for some groups and in some parts of the country. Less than a quarter of those couples practicing FP rely on the government to provide them their services. The country as a whole is close to replacement-level fertility. For most of the population whether fertility continues to fall or whether it edges up again will depend more on social and economic conditions than actions introduced by BKKBN. Fertility levels need to be monitored carefully but so far there is no compelling evidence to suggest there will be major baby boom if BKKBN no longer manages the FP program. In short, there is no convincing argument for maintaining indefinitely a separate agency with primary responsibility for family planning policy formulation outside the Ministry of Health.

Giving the MOH responsibility for FP policy will facilitate the integration of FP into the broader cluster of reproductive and maternal health services in the way envisioned by ICPD. Without “repositioning” the FP program in this way it is difficult to see how it can ever be revitalized.

**Recommendation 3. Can a new vision and mission be developed for BKKBN which satisfies three requirements: (i) it is centered on an holistic vision of population policy and its role in development; (ii) it is acceptable to other parts of the government if it is assumed by BKKBN; and (iii) it is a vision and mission which is attractive to BKKBN itself and which gives the organization an exciting future?**

The new Population Law (Law 52/2009 on Family Planning and Population Development) gives BKKBN explicit responsibility for population policy, and the name of BKKBN has been changed accordingly (while still conveniently keeping the same acronym). BKKBN is not happy with the way the new responsibility has been assigned to them because it is not associated with sufficient status within the government structure for them to be able to fulfill

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13 Reports in the press about the risk of a new population explosion following the release of preliminary results from the 2010 Population Census are mostly ill-informed.

14 BKKBN used to stand for Badan Koordinasi Keluarga Berencana Nasional (National Family Planning Coordination Board), it now stands for Badan Kependudukan dan Keluarga Berencana (National Family Planning and Population Board).
this responsibility effectively. But there is the seed of a promising core mission here. If BKKBN embraces it and advocates with the skill and persuasion it has traditionally displayed for the status and resources it needs to do the job well, then this could be a new and exciting beginning for an institution that is already a legend in population policy circles around the world.

6 Conclusion

Indonesia has a mature FP program which appears to have lost its way now that it has substantially realized its original objective. Neither BKKBN nor the MOH are happy with the present status of FP in the country. Plenty of “band-aid” solutions have been suggested in recent years, but if the FP program is to be revitalized and responsive to the evolving needs and aspirations of the population this will require significant structural changes in the current institutional arrangements.

7 References


