Contraceptive Security in Indonesia: What do the Data Say?

A consultancy report by

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Contraceptive Security in Indonesia: What Do the Data Say?

Introduction

"Contraceptive Security" takes many meanings, only some of which can be considered in this analysis. Internationally a deep anxiety has arisen as to whether the sheer quantities of needed supplies will be forthcoming, since donors are critical to those supplies but have not shown a willingness to keep pace with the growth in users. Many countries, lacking foreign exchange and local production, have little recourse except to rely upon the uncertain commitments of donors.

The concerns are broader within a country like Indonesia, where local production is robust, donor-dependence is less, and the engines of the private sector are so active. Most probably the supplies themselves will be forthcoming in the gross quantities needed, at least approximately so, even if the decentralization process causes an adjustment period. Without the large central Government procurement in the past, the slack will have to be taken up by either the private sector, the district governments, or other sources, and the private sector is likely to grow to fill in clear market openings. The likely problems, long-term in nature, concern the options open to the individual woman, man, or couple. Some, in remote areas or extremely poor, cannot get supplies or clinical services from either sector. Others do not have ready access to a reasonable choice of methods, so some of them cannot use what little is available and will lack protection. Services too are less than ideal. Depending upon the area, the imperfections of supplies and services, both public and private, mean that prevalence is depressed and many births are unwanted. In that sense, contraceptive security goes beyond the international concern of donor commitment; here it will rest instead heavily upon the districts' commitments to continue and improve their programs, and upon what the private sector does.

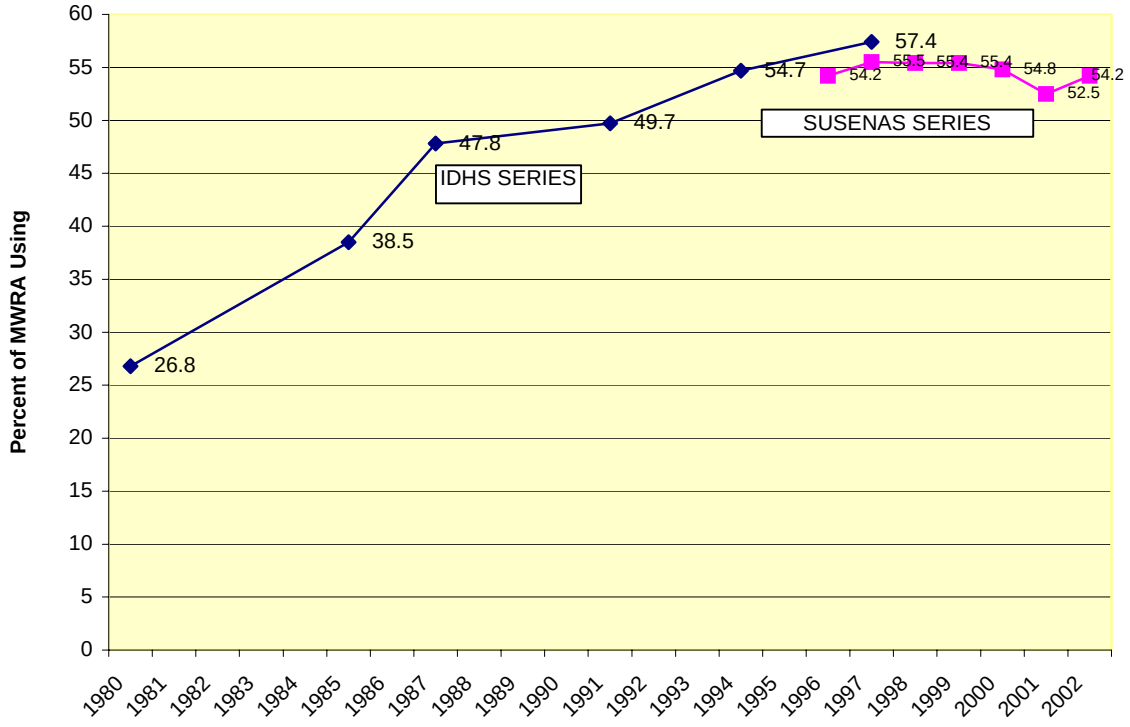
The purpose here is to look for trends and patterns in the national data to see what they imply for the above concerns. What does the stalled rise in prevalence of use imply? How did the disadvantaged subgroups fare during the economic crisis? What changes are underway in the method mix and in the sources for each method? What demographic changes will affect the future method mix? What projections of needed commodities seem reasonable?

Prevalence of Contraceptive Use

By using the long Susenas series of annual surveys a full ten-year trend can be constructed for contraceptive use through 2002. This is provided below, first for prevalence of use (including non-use, on the base of married women of reproductive age (MWRA 15-49), and second for method mix. Supplementary information is added at points from the IDHS series, the IFLS, and other sources.

Figure 1 tells the story for prevalence trends: first the long term trend in Figure 1, showing the remarkable rise from 1980 to 1997, averaging 1.8 points per year, but then the apparent plateauing in the Susenas series in recent years. (The 1980 figure, taken from the census, is probably too low; if the calculation starts with 1985 the average growth was 1.6 points per year.)

Figure 1
Percent of Married women of Reproductive Age (MWRA) Using Any Contraception
National Surveys, 1980-2002



The Indonesia Family Life Surveys (IFLS) in 1997 and 2000 were not national but covered major provinces[1] totaling 83% of the total population. They give basically similar figures to the IDHS series: 56.3% using in 1997 and 56.4 using in 2000. The method distribution for current users in 1997 also closely resembles that of the 1997 IDHS. The IFLS report (Strauss et al. 2002: 70) also states that the 1998 survey (Frankenberg, Thomas, and Beegle 1999) found a constancy of use between 1997 and 1998 during the worst of the financial crisis.

In the unique Susenas year-by-year series prevalence has been essentially level in every population subgroup for six years running, as the Figures show by residence (Fig. 2) and education (Fig. 4), and for three years by economic status quintiles (Fig. 3.) (The quintiles are based on household expenditures per person in the household.) It is not surprising that the Susenas yields a slightly lower prevalence level overall than the IDHS since the IDHS has more detailed questions and specializes on family planning.

[1] East, Central, and West Java; Jakarta; Yogyakarta; Bali; North, West, and South Sumatra; Lampung; South Kalimantan; South Sulawesi; and Nusa Tenggara Barat.

Figure 2
Percent of MWRA using Contraception by Rural, Urban, and Total
1993-2002 (Susenas Series)

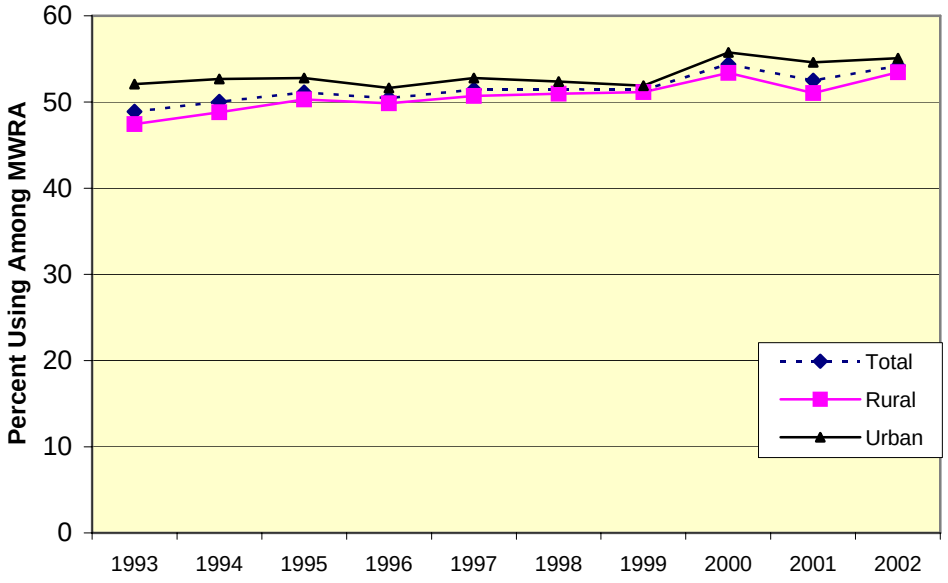


Figure 3
Percent of MWRA Using Contraception by Quintiles (Household Expenditure)
2000-2002 (Susenas Series)

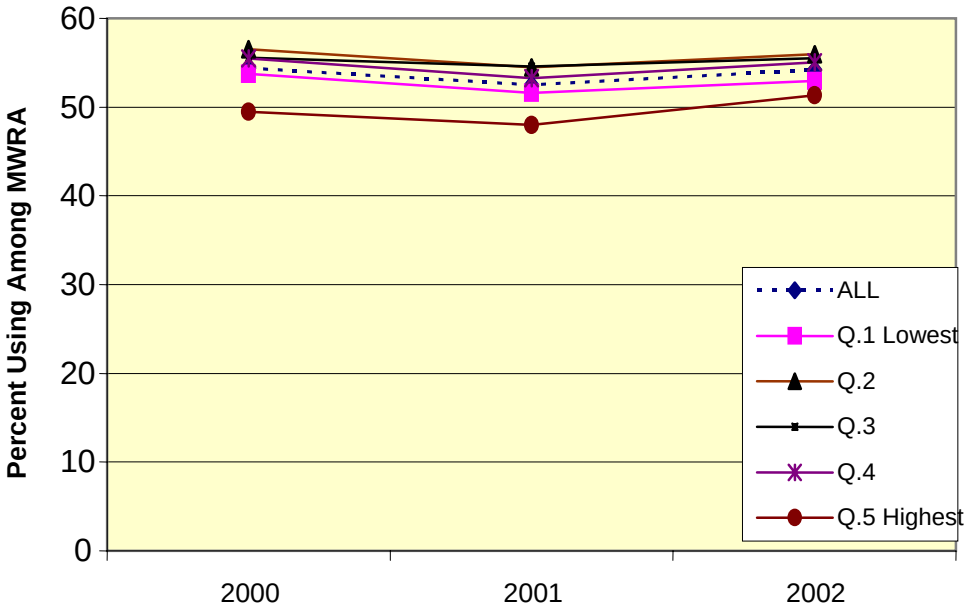
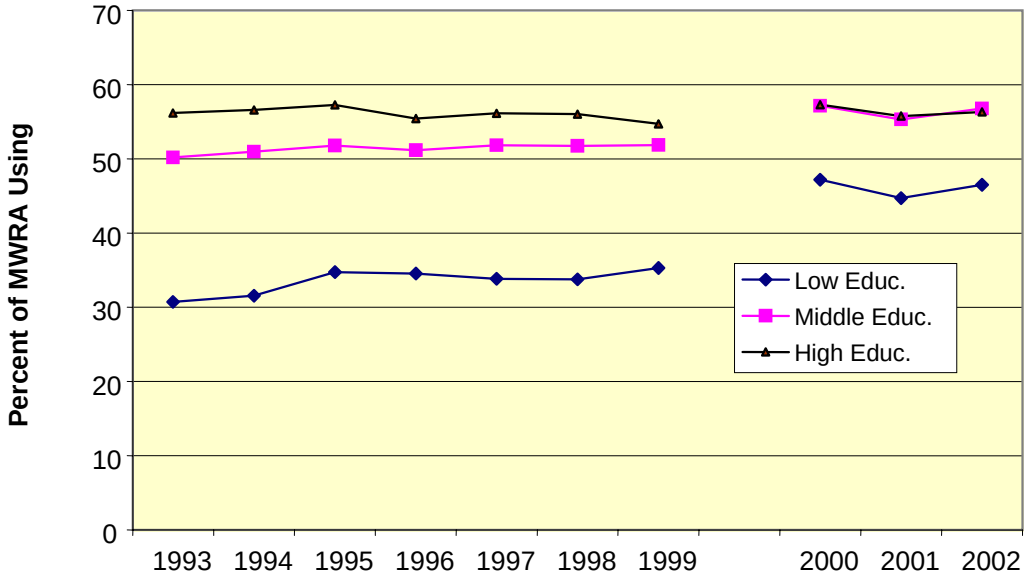


Figure 4
Percent of MWRA Using Contraception by Education
1993-2002 Susenas



The education time series is broken because the definitions of education groups differ between the 2000-2002 series and that for the earlier years. However the message is consistent with that from the other figures, that **prevalence experienced no large disturbance during the crisis years, and that it unfortunately has not risen appreciably since.**

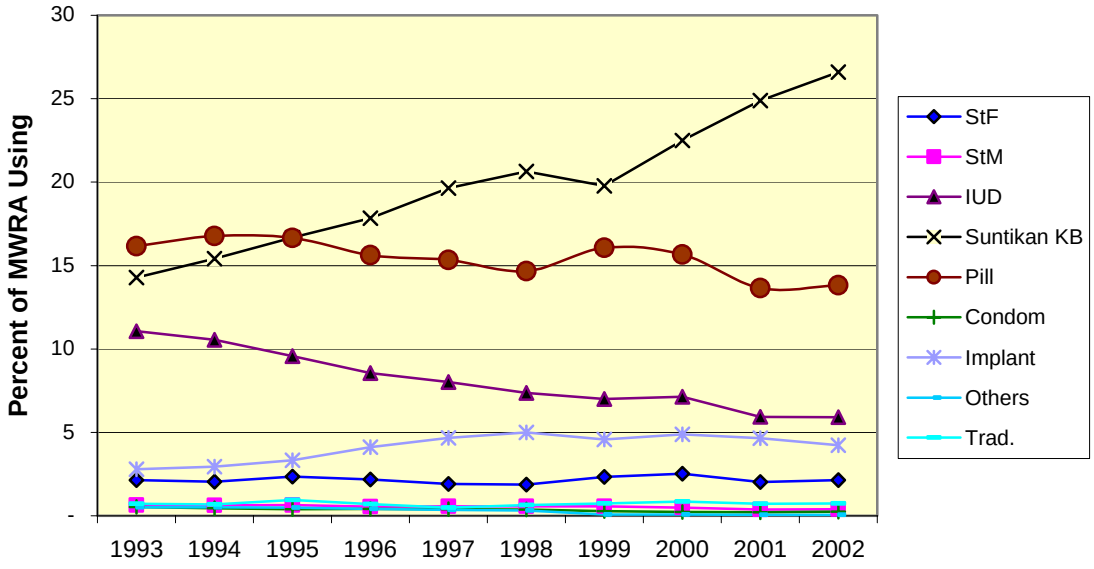
Method Mix Changes

However beneath the rather unchanging level of total prevalence many women have been switching their method (Fig. 5). In particular, use of the injectable (*suntik*) took off from 2000 onward, rising even more sharply than it had before. The Figure shows the national trends by method. Note this figure shows method use among MWRA, not just among users, to give a more immediate sense of each method's presence in the whole population.

Injectable use has risen to an internationally unprecedented level, to 27% of couples (nearly half of all users.) Meanwhile use of the pill has fallen off some. In addition the IUD continues its long-term decline. Use of the implant is level at less than 5%, but because of high cost it is supply that has been level while demand is high. Female sterilization runs at less than 3% (it and male sterilization totaled 3.4% in the 1997 IDHS survey).

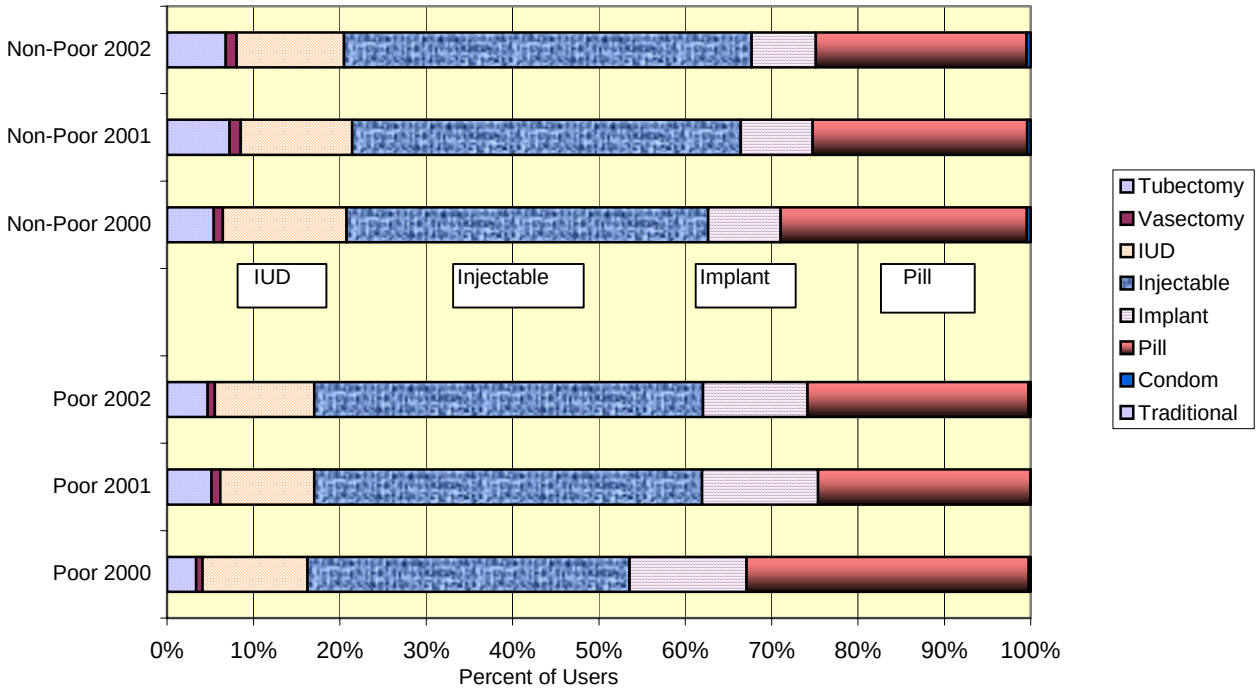
This pattern of prevalence changes for the various methods is not much different across the major population subgroups. The injectable has taken off throughout the population, in both rural and urban sectors, in every economic quintile, and in every family-size group from one to four-plus living children. This is also true in all three education groups. (The top education group uses the IUD more than other education groups, but IUD use has declined even there, down to about 10% of women compared to 5% in the other education groups.)

Figure 5
Prevalence by Method,
Susenas 1993-2002



An example of this similarity across two quintile groups appears in Figure 6. The "poor" are the bottom quintile and are compared to the other four, as "non-poor" which therefore contain most of the population. (These quintiles differ from those above; they are also defined by the Susenas variable for household expenditures but are not divided by household size.)

Figure 6
Percent of Users by Method Mix for the Non-Poor (2-5) vs. the Poor (1)
Susenas, 2000-2002



Another way to see the pattern is by the longer time trend, from 1995 onward, shown in Figures 7 and 8 based on the same data source. Note that there is no particular break during the crisis years, and that the trends are all relatively smooth through 2000, excepting only the shift between the pill and injectable in 1998 that lessens in 1999. **The two groups, basically the poorest vs. everyone else, are quite similar in their method mix shares over time.** (The poor are the lowest quintile, that is, 20% of the population, so the non-poor contain 80% of the population.)

Figure 7
Percentage of All Users by Method Mix for the Non-Poor (Q.2-5)
Susenas, 1995 - 2002

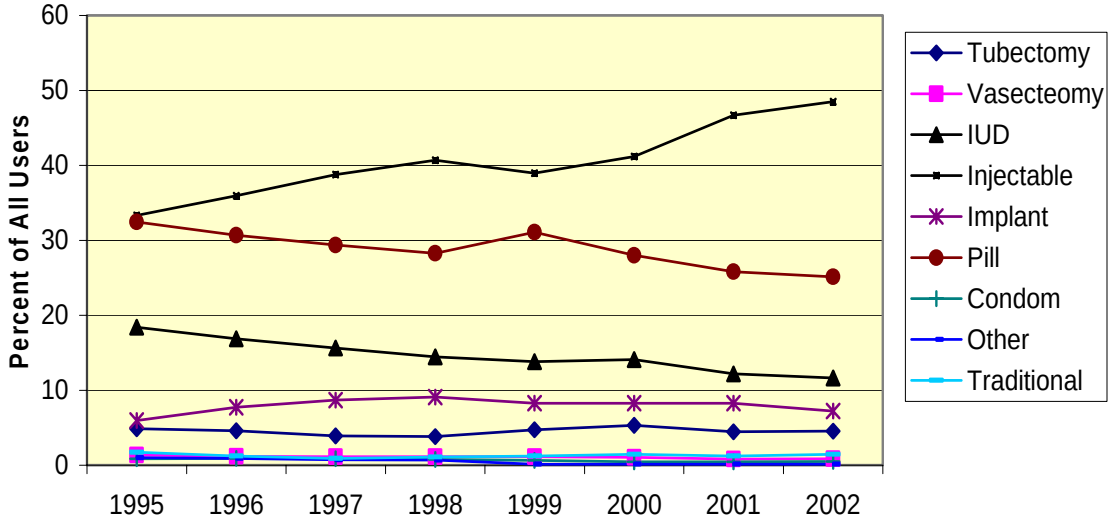
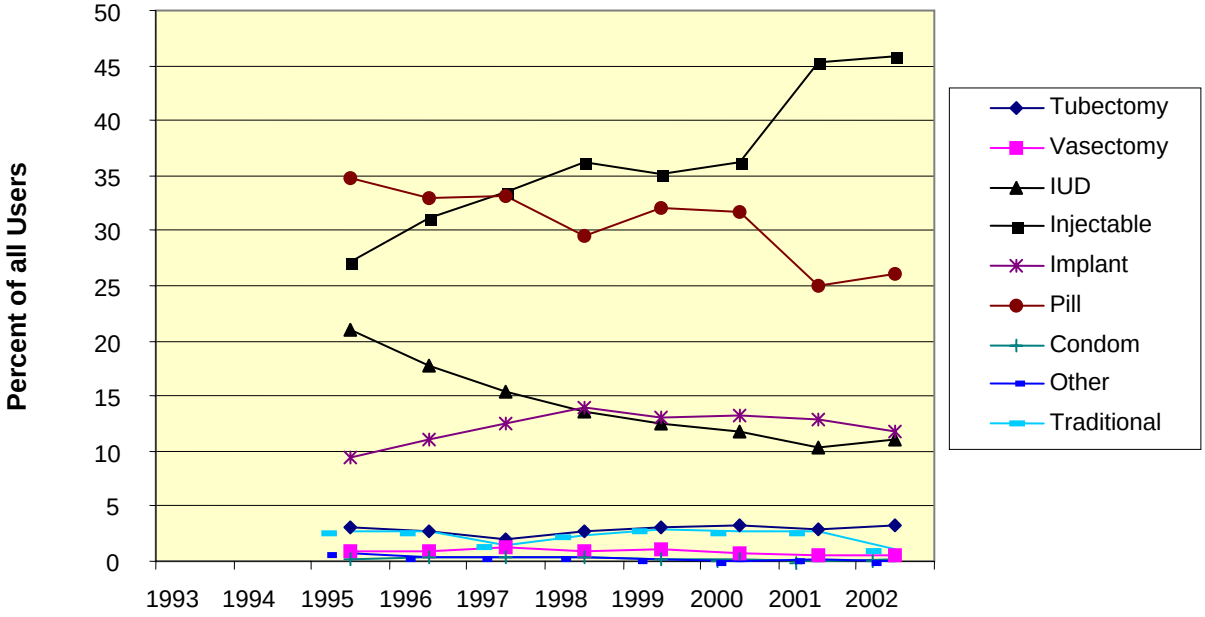


Figure 8
Percentage of All Users by Method Mix for the Poor (Q.1)
Susenas, 1995 - 2002



Changes in the Source of Supply

The private sector has for many years been assuming a larger role in contraceptive provision, and the trend can now be extended to 2002. Table 1 shows the source of supply, first for all modern methods as a group, and then for the three principal methods of the injectable, pill, and IUD. (The condom is provided mainly by the private sector including the large social marketing component.)

"*Bidan*" in the survey responses means a midwife in private practice, whereas "*bidan-di-desa*" (BDD) is different. The BDD is essentially private but has a nursing degree supplemented by one year of midwifery training by the government, who is then assigned to a village (a lower residential level than for most *bidans*) and is paid a government subsidy. The "*Puskesmas*" source refers to a fully government facility at which services are often provided by *bidans* on the regular staff. It is possible that some of these government *bidans* also give services privately but respondent reports specifying the *Puskesmas* must predominately refer to government personnel as the source. In all these categories the source is as obtained from the women respondents.

Two trends are paramount in this table. First is the decided shift toward the private sector, quite dramatic for the *bidans*, and also for private doctors and for pharmacies, depending upon the method. Second is the corresponding decline not just in the share of the public sector, but also in the overall proportion of women relying on it. The IFLS report (Strauss et al, 2002:73) also found "…large and statistically significant declines from 1997 to 2000 in the fraction of both pill and injection users who obtained their supplies in public facilities."

To read the table, note that for simplicity rows are shown only for the major sources, and all the rest are collapsed into the "other" line. Also, the columns incorporate the IDHS estimates, first for the particular sources and again below for the three IDHS summary categories of Public, Medical Private, and Other Private.

The "Poor" group is for Quintile 1 in the Susenas data, while the Non-Poor include Quintiles 2-5 and represent most of the population. Therefore the time trend is best seen by reading across from 1994 to 1997 and then over to 2000-2002 in the Non-Poor columns.

Remarkably, the Poor and Non-Poor do not differ much in their sources for the injectable and pill, both of which cost. They both rely strongly upon the *bidans* for the injectable. For the pill, by 2002, they relied about equally upon *bidans* and pharmacies on the one hand, and upon public sources on the other. Some differences between the Poor and Non-Poor appear especially for the IUD, which involves clinical costs.

Table 1

Sources of Supply by Method, 1994-2002

Percentage of Distribution for Source of all Modern Methods

			Poor			Non-Poor		
	1994 (IDHS)	1997 (IDHS)	2000 (Susenas)	2001 (Susenas)	2002 (Susenas)	2000 (Susenas)	2001 (Susenas)	2002 (Susenas)
Bidan	16.1	28.3	30.3	36.1	40.3	33.5	39.9	43.0
Polindes/BDD/Posyandu	13.7	10.0	16.6	20.2	18.1	12.7	13.5	11.4
Puskesmas/Pustu	36.5	31.3	31.6	28.9	28.1	26.8	24.6	22.8
Other	33.7	30.4	21.5	14.8	13.5	27.0	22.0	22.8
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Public	48.6	43.0						
Medical Private	28.1	41.9						
Other Private	23.1	15.1						
	100.0	100.0						

Percentage of Distribution for Source of Injectable

			Poor			Non-Poor		
	1994 (IDHS)	1997 (IDHS)	2000 (Susenas)	2001 (Susenas)	2002 (Susenas)	2000 (Susenas)	2001 (Susenas)	2002 (Susenas)
Bidan	37.5	49.9	51.2	54.0	58.2	51.8	58.6	60.8
Private Doctor	9.2	6.0	2.7	4.1	2.2	6.4	6.9	6.1
Polindes/BDD/Posyandu	6.6	6.2	12.0	15.7	15.0	9.6	10.0	9.4
Puskesmas/Pustu	39.4	29.0	27.4	24.9	22.2	24.6	22.1	19.3
Other	7.3	8.9	6.7	1.3	2.4	7.6	2.4	4.4
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Public	41.9	31.2						
Medical Private	50.4	61.3						
Other Private	7.7	7.5						
	100.0	100.0						

Percentage of Distribution for Source of the Pill

			Poor			Non-Poor		
	1994 (IDHS)	1997 (IDHS)	2000 (Susenas)	2001 (Susenas)	2002 (Susenas)	2000 (Susenas)	2001 (Susenas)	2002 (Susenas)
Bidan	8.5	18.5	18.1	21.0	28.0	20.5	25.9	29.9
Puskesmas/Pustu	24.9	24.3	22.1	21.0	21.2	23.9	22.3	22.5
Pharmacy	3.3	7.9	7.8	11.4	9.1	10.3	14.2	17.0
Polindes/BDD/Posyandu	26.3	18.9	26.7	36.5	29.9	23.1	26.6	20.3
Other	37.0	30.4	25.3	10.1	11.8	22.2	11.0	10.3
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Public	32.1	33.7						
Medical Private	14.6	31.9						
Other Private	53.1	34.4						
	100.0	100.0						

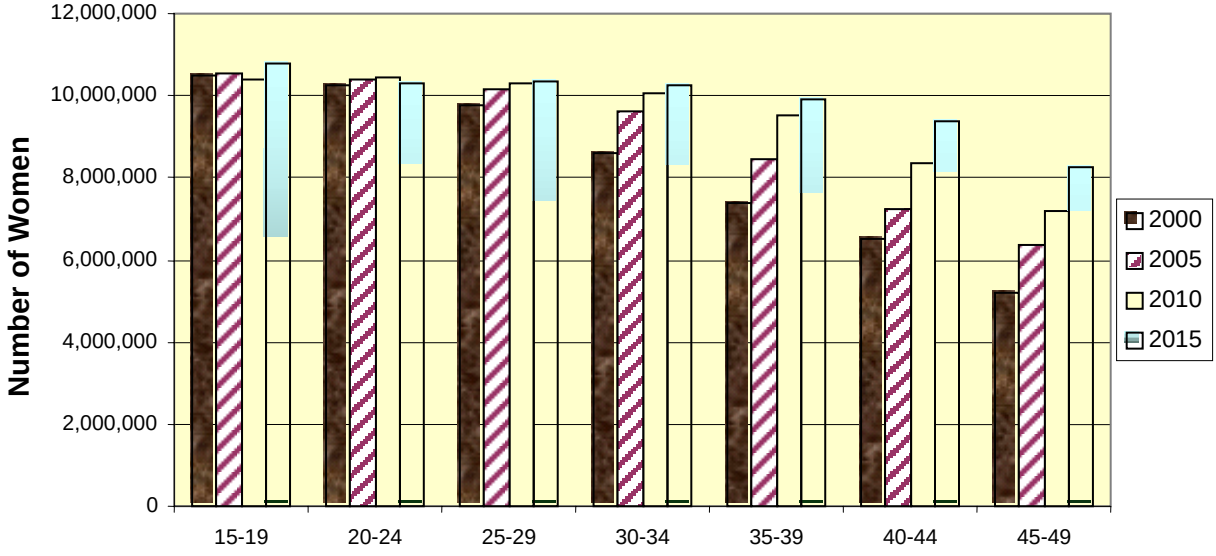
Percentage of Distribution for Source of IUD

			Poor			Non-Poor		
	1994 (IDHS)	1997 (IDHS)	2000 (Susenas)	2001 (Susenas)	2002 (Susenas)	2000 (Susenas)	2001 (Susenas)	2002 (Susenas)
Bidan	10.2	17.2	20.4	23.8	24.4	25.3	26.7	28.7
Private Doctor	8.5	8.1	3.4	5.0	2.2	12.3	15.2	16.6
Puskesmas/Pustu	53.0	46.8	51.3	48.2	52.8	34.1	34.2	30.7
Govt. Hospital	8.3	8.0	6.6	6.8	7.1	10.1	11.2	11.3
Polindes/BDD/Posyandu	6.5	7.5	10.0	13.6	9.9	5.4	6.1	4.3
Other	13.5	12.4	8.3	2.6	3.6	12.8	6.6	8.4
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Public	65.8	60.2						
Medical Private	25.4	32.1						
Other Private	8.8	7.8						
	100.0	100.0						

Demographic Considerations

There is one influence that may move the method mix (modestly) toward long-term methods. The prospects for this cannot seem very great since the system is so profoundly oriented to resupply methods. But currently the sum for male and female sterilization, implant, and IUD is an interesting 13% of all married women, or one in eight, so there is in fact a base of interest from which longer-term method use might grow. The influence in question comes from rather remarkable age distribution changes now underway, as seen in Figure 9. It shows that with cohort effect, women over 30 will be a larger proportion of the user population, by which age considerable motivation toward longer-term, simpler methods emerges.

Figure 9
Projected Increasing Numbers of Women over Age 30



Source: UN Pop Division

The absolute numbers of younger women remain essentially constant, but because the age at marriage is rising even more young women will be removed from the married pool (Table 2). A counter tendency, much to be desired, is that more of those who do marry may tend to initiate contraceptive use before the first birth, something that is uncommon now. At least use at young ages has been rising steadily (Fig. 10). In any case, the changing age distribution is an important factor affecting the potential market for a better balanced method mix.

The following estimates in Table 2 for the marriage age ("singulate mean age at marriage") show a decided upward trend (Hull 2002b Table 1).

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APPENDIX

OUTCOMES FROM THREE PROJECTIONS FOR CONTRACEPTIVE PREVALENCE

Contraceptive prevalence in Indonesia may rise or fall, or may continue at the present level. What does that mean in terms of numbers – demographic and programmatic? Projections follow that encompass more detail than those in the text, which concern only users. These are from a full population projection including the age-sex distribution and fertility and mortality assumptions. This also embraces a set of program characteristics for prevalence, method mix, and failures, with outcomes for demographic results and commodities needed.

The purpose is to show the implications of three assumptions concerning the future path of contraceptive prevalence. (1) Assume it remains flat at the value of 57.4% (taken from the 1997 IDHS; the Susenas data indicate no change since then; also the 57.4 includes a small share of traditional methods). (2) Assume prevalence rises at one-half point a year, so over the 15 years to 2015 it reaches 64.9%. (3) Assume instead that due to various difficulties prevalence instead falls at one-half point a year, so over the 15 years to 2015 it declines to 49.9%. Historical experience in other countries shows an increase of one-half point per year to be quite modest (2% is in the high range), but given Indonesia's plateau for about five years running, a sustained increase of one-half point in the near future would be favorable.

The initial total fertility rate is set at 2.6 as of 2000. Selected fertility determinants other than contraceptive prevalence are held constant, including the method mix (taken from the 2002 Susenas), the proportion married, the length of breastfeeding, and the total abortion rate. Details are footnoted.[3]

The essential results are as follows for each of the attached figures.

1. Paths of prevalence: Figure 1 simply presents the change in prevalence under each assumption.

2. Children aged 0-4 (Figure 2). In the first five years (2000 to 2005) the number of children does not change sharply since many are already born at the outset. But after that, contraceptive prevalence matters greatly: by the year 2010 there would be 6 million more children if prevalence falls than if it rises, or 3 million more if it remains flat instead of rising. By 2015 the range is nearly 10 million more children across the three assumptions. That is well above the total population of many small countries.

3. The number of pregnancies (Figure 3). Pregnancies do not decline much even with rising prevalence since they also reflect population increase of 1.6% per year. However falling

[3] These projections are made using the DEMPROJ and FAMPLAN software contained in the Futures Group SPECTRUM package. The initial age-sex distribution and the proportions of women married come from the 2000 census. The schedule of age-sex specific mortality rates is from the UN model life tables. The TAR (total abortion rate) is set at 0.5 (women have half an abortion average over their lifetime, translating to about 12% of pregnancies being aborted.) The method mix is from the 2002 Susenas and is held constant. The method effectiveness values are from the 1997 IDHS. By keeping these parameters fixed the effects of the three alternative prevalence paths are clarified for pregnancies, births, users, etc. without interference from changes in other factors. In general, setting the above parameters at some different values would not much affect the patterns of prevalence change.

prevalence matters greatly: in the fifth year some 900,000 more pregnancies occur than with rising prevalence, or 500,000 more than with constant prevalence. The difference grows to 1.8 million more by the 10th year, and 2.8 million more by 2015.

4. The number of births (Figure 4) follows a similar pattern – a rather modest decline even with rising prevalence but a very sharp increase with falling prevalence. (Because most births survive, and occur in each calendar year, the much larger numbers for children aged 0-4 emerge in Figure 2.) By 2015 some 2.4 million more births occur with low prevalence than with high prevalence, half again of all births at the outset (4.8 million). All services related to births and children would have to be that much greater just to stay even, without any improvements in quality.

5. The number of contraceptive users (Figure 5) and the subsequent charts behave in opposite patterns from the above. Under rising prevalence the numbers now become larger rather than smaller. Total users, or users of any method (under the assumption used here of a constant method mix) all increase with population size, and that affects the trends along with the prevalence trend. Total users, starting at 22.2 million, grow to 23.1 million in five years even if prevalence falls, due just to population growth. With rising prevalence, users increase to 25.2 million, and in ten years to 27.7 million, equaling a fourth more than at the start.

6. Injectable supplies (Figure 6) increase to quantities that can hardly be grasped in absolute numbers, with one-half of all users in the country relying upon them. With flat prevalence the number of injections (all assumed for simplicity to be the 3-month variety[4]) increase from about 44 million annually to over 47 million in five years, or to nearly 50 million if prevalence rises. By the tenth year the high number is over 54 million annually. Note again that this assumes an unchanging method mix; if injection prevalence continues to rise above the initial 27%, toward the assumption of 35% by the fifth year as in the text table, that adds a factor of 30% (35/27).

7. Pill supplies (Figure 7, for number of cycles) follow the same patterns as the injectables do, given the constant method mix. Even with falling prevalence there is little decline in needed supplies, due to population growth. Under rising prevalence the number of cycles increases very sharply.

8. IUD supplies (Figure 8) involve rather modest numbers both because IUD prevalence is low and because each IUD lasts about 3.5 years. Population growth nearly offsets the effect of falling prevalence, holding up the bottom line. Under rising prevalence IUD supplies increase by about 100,000 by the fifth year.

An overview is contained in the following table.

[4] The numbers are larger if the one-month injectables are considered.

SUMMARY TABLE FOR PREVALENCE PROJECTIONS

	Prevalence Trend	2000	2005	2010	2015
MWRA (millions)		38.7	42.0	44.4	45.8
Percent Increase			8.5	14.7	18.1
Pop. 0-4	Down 1/2 pt/yr	20.8	24.7	27.5	29.7
(millions)	Flat	20.8	23.6	24.5	24.8
	Up 1/2 pt/yr	20.8	22.6	21.5	19.9
No. of Pregnancies	Down 1/2 pt/yr	6.5	7.4	8.0	8.6
(millions)	Flat	6.5	6.9	7.1	7.2
	Up 1/2 pt/yr	6.5	6.5	6.2	5.8
No. of Births	Down 1/2 pt/yr	4.8	5.5	6.0	6.5
(millions)	Flat	4.8	5.1	5.2	5.3
	Up 1/2 pt/yr	4.8	4.7	4.5	4.1
No. of Users	Down 1/2 pt/yr	22.2	23.1	23.3	22.8
(millions)	Flat	22.2	24.1	25.5	26.3
	Up 1/2 pt/yr	22.2	25.2	27.7	29.7
Injectables*	Down 1/2 pt/yr	43.7	45.3	45.7	44.9
(millions)	Flat	43.7	47.4	50.1	51.6
	Up 1/2 pt/yr	43.7	49.5	54.4	58.3
Pill Cycles	Down 1/2 pt/yr	73.7	76.5	77.2	75.7
(millions)	Flat	73.7	80.0	84.5	87.1
	Up 1/2 pt/yr	73.7	83.5	91.9	98.5
IUDs	Down 1/2 pt/yr	0.9	0.9	0.9	0.8
(millions)	Flat	0.9	0.9	1.0	1.0
	Up 1/2 pt/yr	0.9	1.0	1.1	1.1

*For 3-month injections

Figure 1.
Three Projections of Contraceptive Prevalence

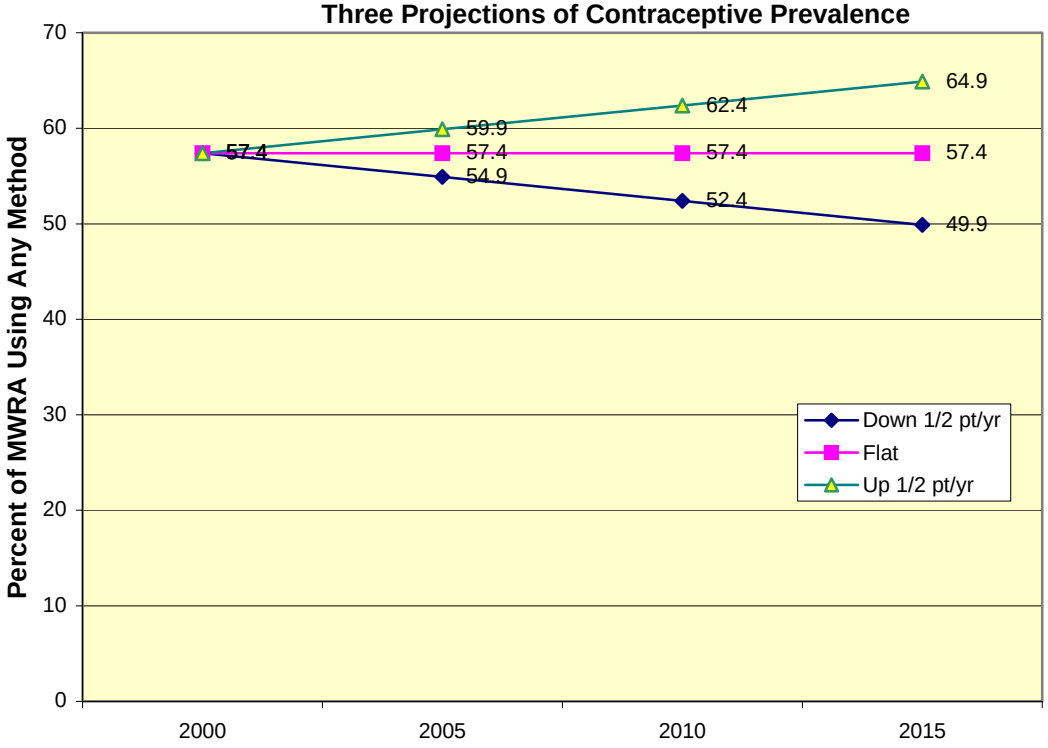

Figure 2.
Children Aged 0-4 (Millions)
Under Three Projections of Contraceptive Prevalence

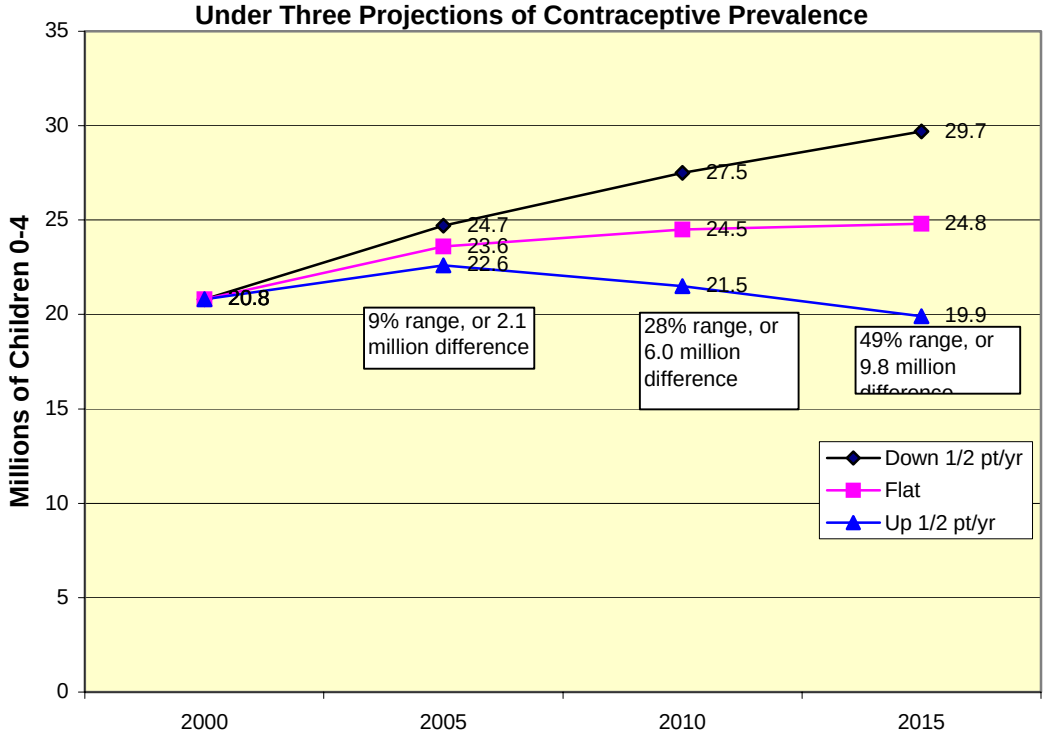

Figure 3
Number of Pregnancies
Under Three Projections of Contraceptive Prevalence

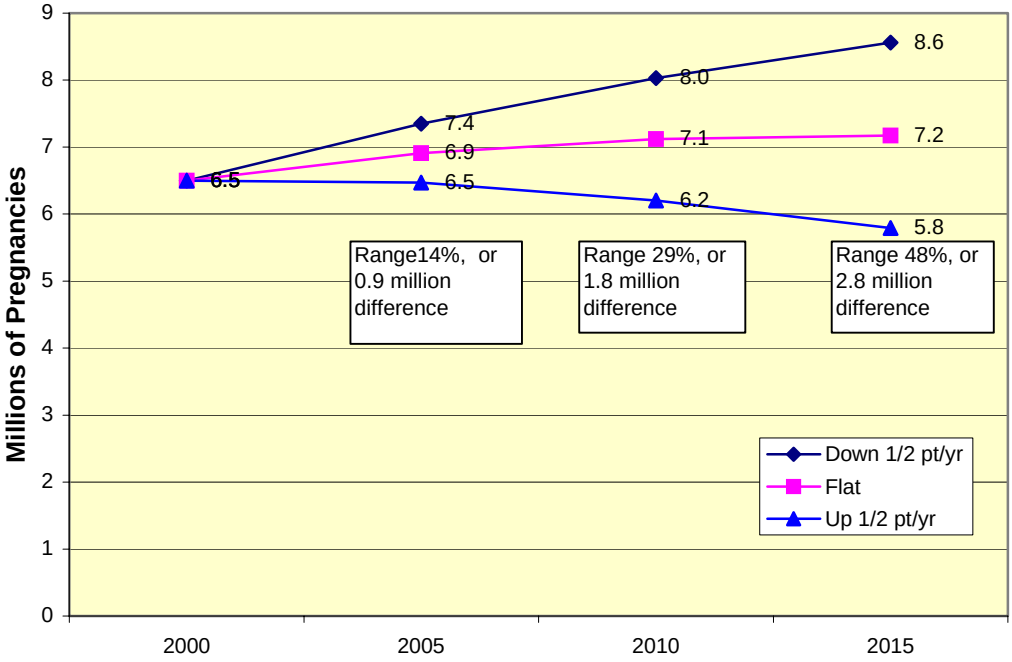

Figure 4
Number of Births
Under Three Projections of Contraceptive Prevalence

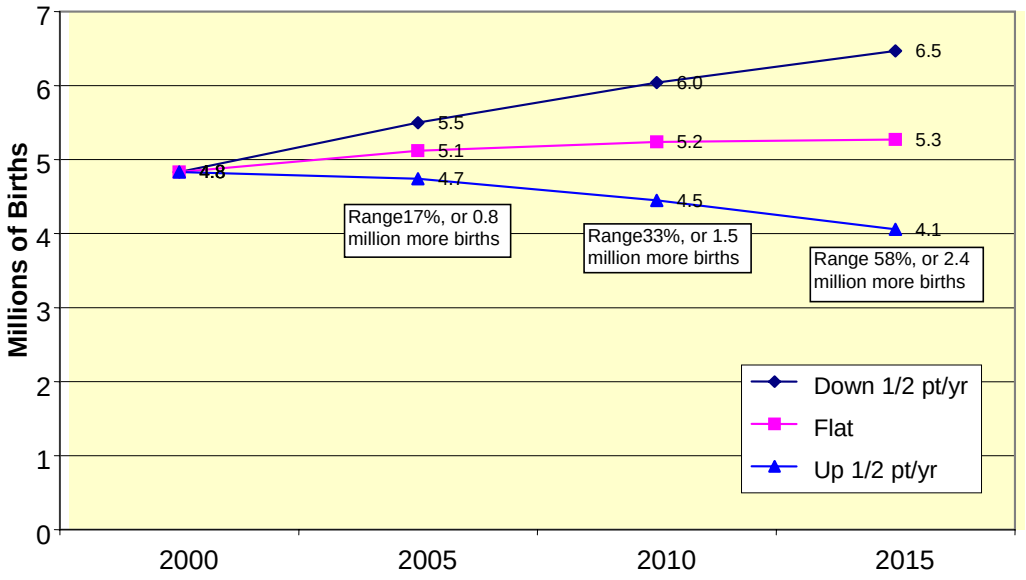

Figure 5
Number of Users
Under Three Projections of Contraceptive Prevalence

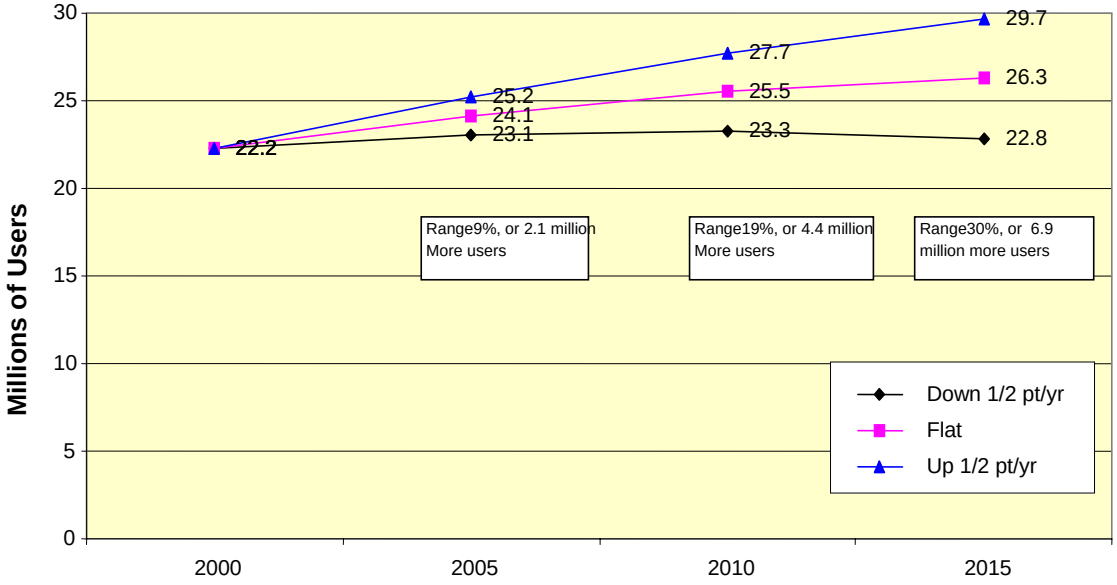

Figure 6
Number of Injectables
Under Three Projections of Contraceptive Prevalence

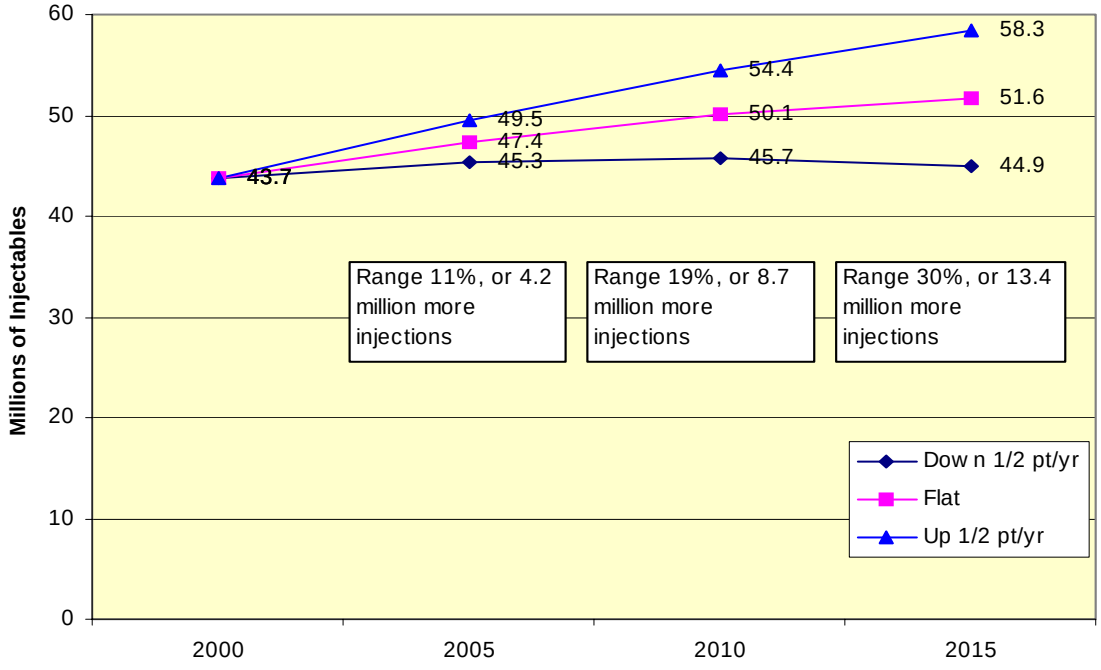

Figure 7
Number of Pill Cycles
Under Three Projections of Contraceptive Prevalence

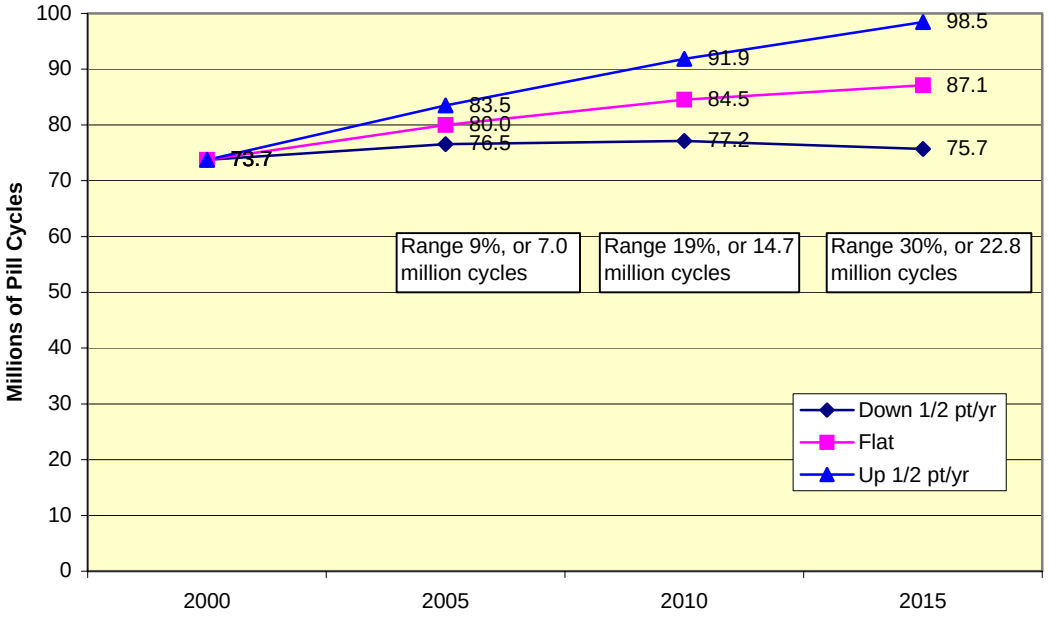
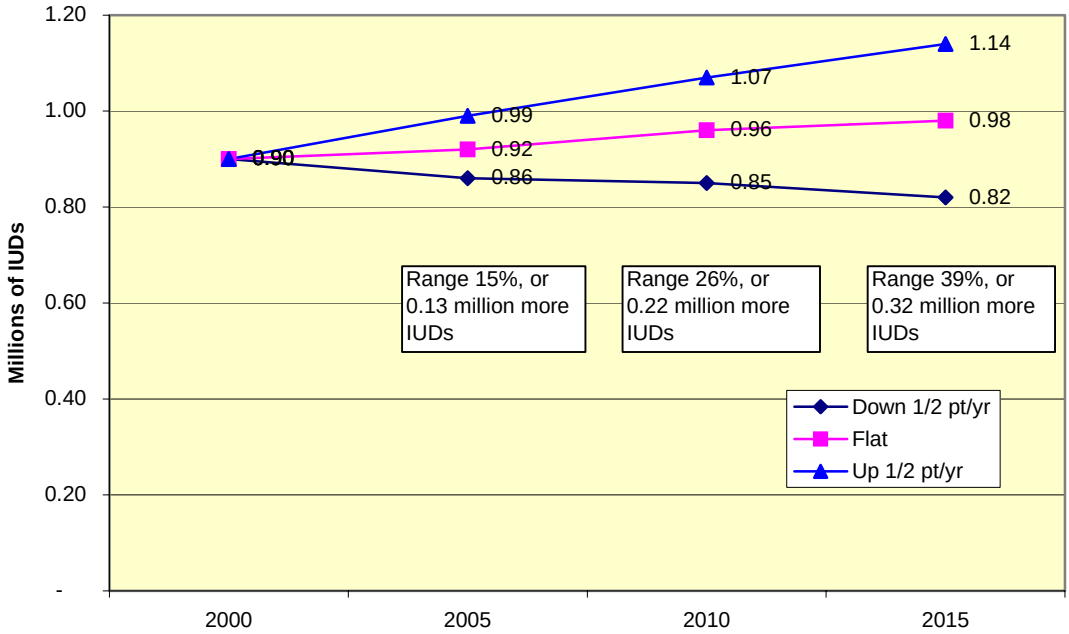
Figure 8
Number of IUDs
Under Three Projections of Contraceptive Prevalence