



Current and Future Policy and Strategy of Family Planning Program in Indonesia

(Response to Paper: The Status of Family Planning and Reproductive Health in Indonesia 2010, Written
by Dr. Adrian C. Hayes, the Australian National University)

Presented by Chairperson of BKKBN, DR. Dr. Sugiri Syarief, MD, MPA
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Mr. Chairman

Ladies and Gentlemen

First I would like to express my gratitude to the Asia Pacific Regional Office (APRO) of UNFPA and ICOMP that have invited me to attend and speak in this very important meeting.

I was asked to make a response to the paper prepared by Dr. Adrian Hayes from Australian National University. I met with Dr. Adrian in Jakarta when he made a consultation regarding this event.

I have read the paper that was prepared by Dr. Adrian thoroughly, and I would like to express my gratitude and appreciation as he has been capturing the condition of the family planning program in Indonesia so well and complete. Dr. Adrian has illustrated the journey of the program, the outcome, the key success factors and the challenges comprehensively. The points that he has

highlighted in his paper are also the concern of the Indonesian government, especially the BKKPN (NFPCB).

The issue regarding the increasing unmet need, the mix or choice methods, family planning services for the adolescents and the unmarried, the role of the private sectors in family planning, and the regional and socioeconomic differences are the concerns of the NFPCB. At present NFPCB is working hard to overcome the issues. We are all hoping that those problems would be resolved.

However, as Dr. Adrian stated in his paper on page 2 paragraphs 2 and 3 that the position of NFPCB is now very different from how it was in the past. The Political context and the non program context that gave big support for the success of the family planning program cannot be found anymore today. But the NFPCB has not been giving up and does not want to return to the past. We have to keep on facing the future and find the solution by considering the contextual situation.

The basic difference between Dr. Adrian's and my opinion in seeking for the solution to the current FP program issue in Indonesia is on the approach in making the policy. Dr. Adrian prefers the revolutionary approach to reach the goal rapidly, while I prefer that the frame of the system including the existing frame of laws is implemented evolutionarily (gradually). I According to my consideration, a revolutionary change that is not in the frame of the existing system and against the laws will generate a contra-productive impact on the development of the family planning.

As what Dr. Adrian has presented on page 13 paragraph-3, that in the decentralization era, handling of political issues has to be prioritized and followed by the technical problems. Along with the issue is the arrangement of the laws to run the program at the local level. Budgeting is also an issue that will be followed by the financing issue. It is the main concern of the NFPCB. I consider that putting the laws in force, which I will discuss on later, have given a strong basis to

implement the first field family planning program in the future. The laws have strengthened the institutional of the local FP implementation. The funding of the FP program in Indonesia has also increased rapidly (more than 100 percent in the last 4 years). Although the amount included only about 70 percent of the current need.

Currently we are working hard with the Ministry of finance and the National Development Plan Board (*Bappenas*) to find the financing scheme that will increase the FP program financing at the local/municipal level.

From the financing aspect, the FP services are also included in the Health Services Assurance for poor families. In the future, if the National Social Security System is put in force (it is being discussed by the government and the DPR), the FP services financing issue will be solved.

Now I would like to take the opportunity to explain the policy and the strategy of the family planning in the future related to the issue explained by Dr. Adrian. This policy is developed in term of the existing system and laws. The arrangement of the laws in Indonesia involves the executive and the legislative parties. Among the executive, the laws have to be approved by various relevant sectors. Therefore, the laws regarding the family planning have obtained the support from the legislative party and various government sectors as well as the NGO. They have also been the basis for the implementation of the FP program of all parties.

There are 6 regulations that have been the family planning program's basis nationally, i.e. (1) Law No. 17 year 2007 on the Long Term Development Plan 2005-2025, (2) Law No.52 year 2009 on the Population Growth and Family Development, (3) the Presidential Regulation No.5 year 2010 on the Medium Term Development Plan 2010-201, (4) Presidential Regulation No.62 year 2010 on the NFPCB Institutional, (5) Presidential Instruction No.1 year 2010 on the Development for the People and (6) Presidential Instruction No.3 year 2010 on MDGs acceleration. Besides, for the implementation of the family planning program at the local level, there are laws that are put as the basis of the implementation, i.e. Law No.32 year 2004 on the

Local Administration, Government Regulation No.38 year 2007 on Division of Authority among Government, Provincial Government and Local Government and Government Regulation No.41 year 2007 on Institutional Arrangement.

In Law No.17 year 2007 on the Long Term Development Plan 2005-2025 it is stated that the purpose of the family planning program is to control the population growth and to improve the family welfare. The target of TFR 2.1 has to be reached in 2015 and has to be sustained until 2025. The objective of the target is to reach a stable population in 2050. Therefore, although the TFR has reached 2.1 currently, Indonesia still considers the issue of the population growth management as crucial. Indonesia is not yearning for a TFR decrease beyond the replacement level. By this context, the family planning in Indonesia is still considered as a population growth management, besides the issues of reproductive rights, reproductive health and maternal health.

The importance of the population growth management is also stated by Dr. Adrian on page 10 paragraph 3. Therefore, it is rather difficult to accept recommendation No.2 yang proposed by Dr. Adrian that the FP policy is transfer to the Ministry of Health. Furthermore, by the fact that in Law No.52 year 2009 on the Demographic Growth and Family Development, the NFPCB (Badan Kependudukan dan Keluarga Berencana Nasional /BKKBN) has the power to resolve the policy on population management and family planning program. I very much agree with Dr. Adrian that FP is related to the reproductive health, especially regarding the reproductive rights and maternal and child health. In this view, the NFPCB has already implemented the matter. What we need in the future is to improve the coordination with the Ministry of Health and the implementation in the field.

The improvement of the access to the service and its quality (related to the unmet need) has been the concern of the government. The target of the unmet need is 4.5 percent in 2015. Explicitly, the target is stated in the Presidential Regulation No.5 year 2010 on the Medium Term Development Plan 2010-2014. The Government of Indonesia is working hard to reach the target. The fact that the unmet need is still high does not mean that there has been an inconsistency

between the policies to give the services to all couples who need the FP services as stated by Dr. Adrian on page 5 of his paper.

Through the Presidential Instruction No.1 year 2010, the government decided the target of improving the means and infrastructure of the FP services at 23,500 government as well as private FP clinics throughout Indonesia until 2014. The NFPCB in coordination with the Ministry of Health works its utmost to reach the goal. Besides, to reach the remote areas, slum areas and border areas, the NFPCB in coordination with the NGOs, ARMI and the professional organization increases the outreach by mobile clinic or by visiting specialists.

To reduce the unmet need among the poor people (also related to equity issue or the socioeconomic differences as described by Dr. Adrian), the policy to provide free contraceptive devices for the disadvantaged is continued. Regarding the service fee, the FP services are included in the Health Services Assurance (Jaminan Pelayanan Kesehatan Masyarakat / JPKM) for the disadvantaged families. Such policy has not been implemented when Schoemaker (2004), Ross (2003) or Strauss (2004) did their analysis. Accordingly, in their analysis, they found that the subsidy given in the FP services to the disadvantaged families were ineffective.

Still regarding the equity issue, to make a significant reduction of unmet need in areas with very high unmet need (with very low CPR), the government provides free contraceptive devices to all couples (not only to the disadvantaged). There are 7 provinces that obtained this: Papua, West Papua, Maluku, North Maluku, Nangro Aceh Darussalam, East Nusa Tenggara and West Nusa Tenggara.

The FP services for the adolescent and the unmarried is a very sensitive issue. By Law, the FP program is only for the married couples. The NFPCB has to obey the basis of the regulation. It is difficult for the NFPCB or the government to violate the existing regulation. In the discussion of the Law No.52 year 2009 on Population Growth and Family Development or the Health Law

there is an attempt to include the clause on the FP services for the adolescents and the unmarried, but it did not succeed as it was also very much refused.

Regarding the mix method, the government of Indonesia is also very much concerned. Therefore, to increase the use of the contraception in a long term, the NFPCB will put a large investment on the long term method starting 2011. In 2011 there will be training on IUD and implant fitting and unfitting for approximately 35,000 midwives and approximately 10,000 general practitioners. Those who are trained will be immediately provided with IUD kits. There will also be male and female operative medical training for 2,000 doctors. The means of implant fitting is increased while the NFPCB is purchasing implants and implant kits.

The post-delivery FP device, especially the IUD, will be increased. The usage of the teaching hospital for the operative method service will be reinforced. Among the obstacles of the operative method is the cost decided by the local government that is very high (related to the local revenue). The usage of the teaching hospital will minimize the financing obstacle. The medical issue that has also been an obstacle in enhancing the usage of the long term method is being settled.

The private sectors also get the serious attention. In the new NFPCB structure, there will be a director from the echelon 2 level that will specially handle the private sectors. I agree with what was presented by Dr. Adrian on page 8 about a number of crucial issues that need the government's attention in term of the role of the private sectors. The NFPCB will take the note as a policy that has to be made.

The impact of the above policies and strategies are hoped to be a reality in 2 or 3 years.

Lastly, once again I would like to extend my appreciation for the inputs that I have received. In general I also agree with Dr. Adrian that eventually the NFPCB has to be the leader, the developer of the demographic and FP policies, a think-tank organization, a technical assistance

provider, and not a program executive. As the program executive will be performed by the district/municipal government. However, the change of role takes time and human resources preparedness in the NFPCB milieu, which hopefully will come about in the near future.

Thank you.