

Briefing Notes

THE NATIONAL FAMILY PLANNING PROGRAM IN INDONESIA: REVIEW OF PAST ACHIEVEMENTS, FUTURE DIRECTIONS

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14 April 2003

1. Introduction

The National Family Planning Program in Indonesia has traveled a long way towards achieving its objectives. Contraceptive prevalence, according to the Indonesia Demographic and Health Survey (IDHS), has increased from less than 10 percent during the 1960s to 57.4 percent in 1997 (including 54.7 percent using modern methods); the TFR has declined from around 5.5 live births per woman (15-49 years) during the 1960s to an estimated 2.8 for 1995-97 (BPS 1998).

Nonetheless it will still take several decades for the size of Indonesia's population to stop growing. The UN Population Division's "medium variant" projection has Indonesia's population growing by another 60.8 million during 2000-2025 (UN 2001). Moreover these projections are "optimistic" in the sense they assume that continuing efforts in family planning will be forthcoming and will bring fertility down to replacement level (TFR = 2.1) by 2010. If this effort is not forthcoming the population could continue to grow at a higher rate; the UN "constant-fertility" projection has the population growing by 84.1 million during 2000-2025. Under these circumstances any hope of attaining the nation's development goals in health, education and employment which depend on some measure of population stabilization will have to be postponed to the indefinite future.

The Asian Financial Crisis, beginning in late 1997, placed considerable strain on Indonesian society, including the FP program. Data from the annual Socio-Economic Survey (Susenas) and other sources suggest that while Indonesian couples' commitment to FP remains high, the upward trend in contraceptive prevalence rate (CPR) (apparent before 1997) has stalled (Hayes 2002; Ross 2003). This suggests Indonesia may already be "falling behind schedule" relative to the UN medium variant projections and its development goals.

A radical decentralization program of the Government of Indonesia commenced in January 2001, and the national FP program will be fully decentralized by January 2004. If the country is to realize its development goals, it is imperative that decentralization and other potential barriers should not be allowed to put the program at further risk or

¹ The authors are all Johns Hopkins University faculty members currently assigned to the STARH Program. STARH (Sustaining Technical Achievements in Reproductive Health) is a technical support program committed to improving quality and choice in reproductive health and family planning in Indonesia. It is funded by USAID.

undermine past achievements in family planning; rather it is important that the opportunity be seized to strengthen, reorganize and reorient the program so it can serve the needs of the community in a democratic and decentralized Indonesia more effectively, and to introduce better management of the country's overall population development policies. If this opportunity is taken then the nation can get "back on track" towards protecting the reproductive rights of all Indonesian couples and moving closer to replacement fertility.

2. Aims of this Paper

The aims of this paper are to review the situation in which the National Family Planning Program finds itself at present and suggest directions for its future development.²

Specifically it is to:

- review past achievements and lessons learned in FP in Indonesia;
- argue the vital importance of continued and enhanced efforts in FP if the country is to attain its development goals;
- suggest that the development of Indonesia's population could be helped by the Government establishing tighter policy linkages between FP and population development;
- support the view that Indonesia's development goals could also be served by reintroducing a Ministry of Population (or at least a strong *badan* focusing on population development issues); and
- discuss the changing role of BKKBN in these developments.

3. Past Achievements of the FP Program and the Contribution of BKKBN

The story of the family planning movement in Indonesia, and particularly of the central role played by BKKBN, has often been told and we will not repeat it here (see, for example, Hull and Hull 1977, 1997; Niehof and Lubis forthcoming; Hugo et al. 1987: 136-165; Suyono 1994, 1995). Instead we simply highlight here a few of the major accomplishments of the program, and comment on some lessons learned that may be relevant for charting future directions.

Among its achievements the FP program has demonstrably:

- helped lower fertility levels;
- reduced the population's rapid population growth;
- contributed to the success of the Government's macro-economic development plans;
- improved the health of mothers and their children;
- helped to lower maternal and infant mortality;
- established the use of family planning as a social norm;

² These issues are currently under discussion in the Government and among stakeholders in Indonesia because (i) the program is going through a critical period in his history (as discussed later in this paper), and (ii) the Government is undertaking an assessment of the role of all *Badan* in the country's development efforts. We have written this paper from the perspective of international experts working in the family planning field in Indonesia as a contribution to the on-going discussion.

- promoted modern concepts of Indonesian family life (the “small, prosperous, happy family” norms);
- explored new avenues of community empowerment and community mobilization;
- empowered many women and couples to take more control of their lives;
- encouraged initiative and innovation;
- provided a cornerstone for both government and community efforts to reduce poverty and increase family prosperity (family welfare);
- and in the process of providing these achievements for the country’s social and economic development has produced a highly trained and effective corps or forward-looking civil servants and volunteers who remain dedicated to public service.

We can only comment below on a few of these achievements as illustrations of Government successes in the field of family planning and population development.

reducing fertility and rapid population growth

BKKBN was established by President Suharto principally to address the “population problem” of Indonesia (above all on the island of Java) by reducing the birth rate. President Sukarno before him had resolutely rejected the idea of introducing birth control as public policy: “I still believe we ought not to have birth control here. My solution is exploit more land, because if you exploit all the land in Indonesia you can feed 250 million people, and I now have only 103 million” (quoted in Hull, forthcoming). After an initial period of caution President Suharto was finally persuaded by experts and advisers of the need for controlling population growth.

BKKBN was established in 1970 as a “coordinating agency,”³ but it grew rapidly in size and influence and in fact functioned in many ways like a line department designing and implementing its own programs, with offices at each of the main administrative levels and a large corps of fieldworkers reaching into every village in the country. Birth control methods were not unknown in Indonesia before, of course, but it was the New Order Government which legitimated and firmly encouraged the practice of FP, and made free (or at least heavily subsidized) FP services and commodities available throughout the country (in both rural and urban areas).⁴

The Indonesian Family Planning Program, launched in the 1970s, soon became recognized internationally as well as domestically as a “success story” (Hull and Hull 1977; Freedman et al. 1981). The CPR rose from significantly less than 10 percent in the late 1960s to 57.4 percent in 1997, and during the same period the TFR fell from an

³ Presidential Instruction No. 26 of 1968 led to the establishing the National Family Planning Institute (LKBN), charged with developing a national family planning program and managing foreign aid. Presidential Decree No. 8 of 1970 changed the LKBN into the National Family Planning Coordinating Board (BKKBN), responsible for reporting directly to the President on FP activities. Presidential Decree No. 33 of 1972 made BKKBN responsible for the program’s policy, coordination, supervision and evaluation (see Lubis, forthcoming).

⁴ See Widjojo (1970) for an analysis of population trends in Indonesia before 1970.

estimated 5.6 in 1968 to 2.8 or less in 1997 (BPS 1998). President Suharto was awarded the UN Population Award in 1989.

improving MCH

The practice of FP also serves to improve the health and reduce the mortality of mothers and their infants (Upadhyay and Robey 1999; Setty-Venugopal and Upadhyay 2002; Bernstein 2003). Some women's groups and doctors were already promoting family planning in Indonesia in the early 1950s, primarily to protect the health of mothers and children, and the Indonesian Planned Parenthood Association was founded in 1957 (for an account of the early history of the FP movement see Hull, forthcoming).

The infant mortality rate in Indonesia has declined from an estimated 145 per 1,000 live births in 1967 to 55 in 1996 (Table 2). The vigorous FP program introduced by the New Order Government has undoubtedly contributed to this decline, although it is impossible to quantify the proportion of the decline due to FP compared to other factors. Maternal mortality remains unacceptably high in Indonesia, estimated at around 400 per 100,000 live births; it is known that FP, especially if well-integrated with other reproductive health (RH) services, can alleviate this problem (see Piet-Pelon et al., forthcoming).

enhancing family welfare

The connotation of *keluarga berencana* ("family planning") in Bahasa Indonesia is broader than that of simply practicing contraception or "birth control"; it is in fact closer to the literal meaning of "planning one's family." The main benefits which accrue to a couple who are able to control their fertility go beyond the tangible benefits of better health and the economic advantages of not having to support too large a family; there are also less tangible attitudinal benefits, especially the sense of empowerment that often comes with making decisions responsibly and taking control for more of one's "life chances." This attitude of taking control over one's own fertility and a couple's planning their family can be generalized to other aspects of family life, such as taking more responsibility for one's children's health and education, the quality of the family's housing and sanitation, etc.

The national FP program, through its "beyond family planning," KB Mandiri, "quality family," and *Sahabat* (friendly provider) campaigns, has contributed quite broadly to promoting and institutionalizing modern notions of family welfare, or what BKKBN refers to as *keluarga sejahtera* (family prosperity).

promoting human rights

The UN Charter speaks of "promoting and encouraging respect for human rights and for the fundamental freedoms of all without distinction as to race, sex, language or religion." It is now widely accepted in development circles that there can be no *real* national development without improving human rights and vice versa (Sen 1999). In recent years the FP program has been more explicit in promoting FP as a basic human right.

The *Plan of Action* adopted at the UN Conference on Population and Development in 1974 in Bucharest affirmed family planning as a basic right, and also asserted: “Individual reproductive behaviour and the needs and aspirations of society should be reconciled.” The *Programme of Action* adopted at Cairo in 1994 links family planning to the exercise of reproductive rights and the empowerment of women. Reproductive rights “rest on the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.”

The GOI is a signatory of the ICPD Programme and in BKKBN’s *Era Baru* vision has made a clear shift in policy from a “population control” FP program to a client-centered approach grounded in human rights. The FP program is now in the forefront of the human rights movement in Indonesia.

assessment of BKKBN’s contributions to the program’s rapid achievements

It is manifestly clear that over the last 30 years in Indonesia fertility has declined markedly, contraceptive use has increased, and the problem of rapid population growth has been significantly curtailed (Adioetomo et al. 1989; Freedman et al. 1981; McNicoll and Singarimbun 1986). The extent to which these achievements of the national FP program have contributed to the health of the population and to other objectives in social and economic development is very hard to quantify; these relationships are the subject of on-going debate, both for Indonesia (Jones, forthcoming) and for other countries (Birdsall et al. 2001). Similarly it is impossible to measure precisely the contribution of BKKBN to all these different achievements.

What is clear is that these successes would not have happened so quickly and so widely if the national FP program had not been so effectively promoted and “coordinated” by the Government through BKKBN. BKKBN won legitimacy for the practice of birth control in Indonesia and gave leadership to the FP movement; it coordinated and gave support to “inputs” from a wide variety of stakeholders (professional associations, religious organizations, voluntary associations, NGOs and community organizations, not to mention other Government agencies and departments, especially the Ministry of Health). BKKBN provided commodities, supplies, training and infrastructure, or provided funding for these; it channeled technical and financial support from international donors; it collected data and monitored the progress of the national program; etc. In short, BKKBN played a unique and major role in facilitating Indonesia’s fertility decline; and beyond this, through its various programs and activities, contributed directly and indirectly to broader aspects of social and economic development.

Most experts credit the success of BKKBN to its firm leadership and dynamic organization, unqualified political support from the New Order Government, its innovative approaches to IEC and community mobilization, skillful use of existing national and local institutions, willingness to try new approaches and make adjustments to the program based on regular monitoring and evaluation, the commitment and training

of service providers, the high level of donor support which in turn was used very effectively by the agency, and (not least) the hard work of a large corps of dedicated field workers and volunteers providing effective outreach into villages throughout the country (Niehof and Lubis, forthcoming).

4. Present Need to Maintain and Strengthen the FP Program

present status of the program

The current status of the FP represents a transition from the past success to a new national environment for FP and broader population issues. This transition period, as is often the case, is a time for consolidation, assessment, and restructuring. This is especially true for the FP program, which even without the dramatic changes in Indonesia, would be facing its own transition to be what is often called a “mature” program. The environmental changes (decentralization, democratization, financial crises, political changes, etc.) have just magnified the need for the FP program to set aside traditional activities and develop new functions and new structures to support those functions. Consequently, the FP program is currently going through a process realignment, self-analysis and rebuilding. The results of the rebuilding will depend on political will, decentralization, economic situations, and the transitions in the role of Government in social development programs.

The current program has many transitions in progress: diminished funding and political control of the public sector FP program has allowed and expansion of private sector FP products and providers; the government service delivery structure has been declining in quality and services, and as a result, has lost client support to private and village midwives; BKKBN has been putting more attention on the managing the changes to the organization and building political will and a post decentralization structures, and less on its traditional coordination and leadership functions; contraceptive use has plateaued at around 52 percent modern method prevalence.

These changes while good and directive for future efforts are the product of random responses to circumstances and not part of an integrated, strategic, plan to achieve national development objectives. The private sector FP program is growing randomly and in fits and starts, but it is growing. The public sector program administered by BKKBN and DepKes can best be described as “in waiting,” while the political, organizational, financial structures of public sector investment in social services, and specifically FP, are resolved. As both the public and private sector FP programs move to redefine their functions and form, there is considerable opportunity for Indonesia to again take a leading position among the world’s FP programs. Defining these functions and form will be a major activity for the Government, national and local parliaments, the donor community, the implementers, and the many Indonesians who use FP to improve the quality of their lives.

present needs in the population for FP

It needs to be emphasized that the magnitude of need for a strong and effective quality FP program in Indonesia has never been greater:

- There are almost 58 million women in Indonesia currently between the ages 15-49 years, and this number will increase by another 10 million by 2015;
- 2 million women enter the child-bearing years every year;
- there are currently 39 million married women 15-49;⁵
- more than 22 million married women currently practice FP; and
- there are over 3.5 million married women with “unmet need” for FP.

The situation of the poor and other vulnerable groups regarding FP is especially precarious:

- About 40 million people live in poverty – meeting their FP needs is especially worrying as public funds for services are reduced;
- there are hundreds of thousands of internally displaced persons (IDPs) – another vulnerable group;
- there are over 41 million young people 15-24, many with minimal information or services;
- it is estimated there could be as many as 2 million abortions every year, perhaps 50 percent of which are performed for adolescents.

current challenges to the FP program

Indonesia is currently going through a uniquely critical period. The financial crisis precipitated the downfall of President Suharto and the end of the New Order Government. President Habibie introduced radical legislation to decentralize the government. The first free elections in Indonesia since the 1950s took place in 1999. The processes of economic shock and political reform have been accompanied by much social unrest and social change. Many (perhaps most) of the aspirations that inspired the rise of the *Reformasi* movement remain unfulfilled, and there is widespread disillusionment towards the country’s political elites. All these developments have an effect on the national FP program – on how it is financed, the size of its budget, on how it is organized, on who has authority to plan and implement its various components, on how it is perceived and received by clients, on the support it is given by the public, etc.

In brief, the national FP program is currently challenged by an unprecedented array of national issues:

- Financial crisis – which in Indonesia is deeper and longer-lasting than in other countries in the region, and has resulted in dramatic budget cuts for the program by the government;
- Political uncertainty – the transition to democracy is proving difficult, and some party leaders appear ready to challenge the national commitment to FP for political reasons;
- Social unrest – communal strife in several parts of the archipelago, together with some support for Islamic extremist movements, constantly challenges government authority and undermines local implementation of the program;

⁵ These demographic statistics are based on the 2000 Population Census, using proportions from the L.2 series, corrected, using the L.1 series, for non-coverage and non-response.

- Decentralization – authority for administering the national FP program will be transferred to more than 400 districts and municipalities later this year, making it increasingly difficult to grasp the program as a “coherent whole” or anticipate where threats to its sustainability may come from.

Challenging as they may be these issues in fact provide a range of “openings” and opportunities for the program to develop in new and exciting directions, particularly in opening the way to more diversity in the program and “community ownership.” At the same time these issues could, if not managed carefully, seriously undermine the FP achievements of the last 30 years and pose a very real threat to the sustainability of the program.

5. Future of the FP Program

alternative scenarios for FP

On the eve of the financial crisis in 1997 CPR had reached 57.4 percent. Since then, according to both Indonesian Family Life Survey (IFLS: see Strauss et al. 2002) and Susenas data, it appears to have “plateaued” at around this level (Tables 4 and 5).⁶ According to a well-known American demographer: “The plateau in contraceptive use is both a victory and a defeat – a victory since prevalence did not collapse during the crisis, which might easily have happened since prevalence depends so heavily upon resupply methods, which are sensitive both to supply lines and to prices in the remarkably large private sector in Indonesia. It is a defeat in the sense that staying at about 55% of couples protected means serious long-term burdens for the country. Indonesia, far from being a high-prevalence country, stands at a stalled level of contraceptive use that engenders large annual increments to the population and a continued, unfavorable age distribution for the future” (Ross 2003: 12).

Table 6 (taken from Ross 2003) gives a sense on how many clients the FP program will have to service in the future. If the CPR remains constant (in this table the figure is taken to be 55 percent), then by 2008 the number of users will have increased by 1.54 million due to population growth. But we know that if use remains constant Indonesia will never reach its goal of long-term sustainable development with more or less zero population growth. If the CPR increases by 1 percent a year (a reasonable planning target based on international experience) then after 5 years the CPR will be 60 percent; that translates into 3.50 million more users. In other words, if Indonesia is to increase contraceptive prevalence to meet its development goals the FP program must attract more users. “This translates to large increases in infrastructure capacity needed each year, in both public and private sectors” (Ross 2003: 16).

Government functions

⁶ There was some leveling off of the CPR (and of the decline in fertility) during the 1990s even before the crisis (see Jones, forthcoming), but the trend in CPR becomes quite “flat” after 1997.

Even after the FP program is decentralized the central Government will still have important essential functions to perform if it is to ensure that all citizens have access to quality FP services, for example:

- Develop national FP policy;
- ensure quality of services;
- develop national FP standards and guidelines;
- monitor implementation of national FP policy;
- monitor contraceptive security;
- monitor the status of reproductive rights, especially among the poor and other vulnerable groups;
- monitor the status of adolescent reproductive health;
- facilitate the expansion of the private sector at the same time as ensuring quality;
- address international commitments to FP and interact with donors;
- sponsor needed policy research in FP;
- provide TA services to districts and municipalities to help with their advocacy efforts and strengthen the environment for quality FP services; expand demand for quality FP services; improve the effectiveness and efficiency of FP services; and monitor contraceptive security at the district level.

Below we comment on the Government's responsibility regarding some of these essential functions.

ensuring the quality of family planning and reproductive health services

Quality health services should be the right of all Indonesians. Quality is especially important in FP, because it increases client satisfaction, improves the effectiveness of method use, improves clients interaction with and confidence in health providers, and it improves efficiency and efficacy in service provision. In is only in the last few years that BKKBN and Depkes have been active in creating more client-centered services and given greater priority to quality of care. Unfortunately there is still considerable room for improving quality, client-focus, and client safety (see for example Hull 1996; STARH 2001; Sulistomo 2003). Now and for the foreseeable future ensuring quality and protecting the well being of FP clients should be a major priority for the FP program.

Defining quality, setting the standards, disseminating the standards, monitoring compliance, and providing technical or resource support to raise sub-standard quality is commonly a function held at the national level. Historically, professional associations have provided quality standards and oversight of their individual members. The increasingly complex issues of health delivery and a long history of failed self-regulation have lead to an expanded role of governments. The poor quality of Indonesian FP services will take a long and concerted effort by national and local government agencies, the medical education system, professional associations, the legal system, consumer advocates, and informed and empowered communities and clients. Indonesia's huge investment in increasing access to FP services, while successful, will have to be matched by similar commitment and vision to improve quality.

The process of improving quality has already begun. The agencies responsible for the program recognize that quality is low, and are in the process of setting national quality standards,⁷ testing accreditation systems for health facilities (*jaminan mutu*), and developing monitoring protocols for quality.⁸ Decentralization is also contributing to defining standards of quality through the use of “obligatory authorities” (*kewenangan wajib*) and “minimum service standard” (*standar pelayanan minimal*) of services to ensure that basic health and FP services are available with devolution of control of health and FP services to local governments.

Efforts to improve quality will have to take place at several levels in the FP service delivery system. A critical level for improving quality is the facilities. In the future the formal program should ensure quality FP services are available in the health centers (*puskesmas*) FP outreach facilities (*polindes, posyandu*) and the referral facilities (*rumah sakit kabupaten*), by:

- setting standards for essential equipment;
- formalizing operating procedures (e.g. hours, scheduling);
- providing guidelines for staffing;
- providing technical and financial resources to raise standards in sub-standard facilities;
- help coordinate facilities, referrals, equipment and activities for greater efficiency and to maximize access;
- help new districts develop FP service delivery systems and associated management structures (budgeting, coordination, etc.);
- provide monitoring and supervision;
- do applied research to support empirically-based changes in quality standards or operating procedures;
- dissemination of information, lessons learned, best practices (international and domestic) to ensure that facilities continue to improve;
- providing back-up services for managing complications and problems.

Quality standards must apply to both the public and private sector components of the national FP program. Currently there are no systems for setting, monitoring, or supporting quality FP services at private facilities. Data suggests that clients see private sector facilities as being higher quality than public facilities. Although private facilities charge for services, fees for service can not be the only explanation since for many FP services public facilities charge as much or even more for the same service (Strauss et al. 2002). Qualitative data also suggests that private facilities allow clients greater flexibility in paying for care. Eventually, the same structure for ensuring quality in private facilities will have to be implemented to ensure client safety and to facilitate the shift from subsidized FP services to client self-financed FP.

Ensuring quality in health facilities is done in most developing countries by systems with various names – certification, accreditation, licensing. These systems include: set

⁷ National Family Planning Service Delivery Guidelines, produced jointly by BKKBN, DepKes, Pogi, and IBI, will be published in June 2003.

⁸ QIQ

standards, regular inspections, public awareness of quality (both achievement and failure to achieve standards), and regulatory power to punish facilities that fail to meet quality standards (Heerey and Necochea 2001). Indonesia should be moving in this direction, but it is a long, complicated and expensive process.

It will also be important to improve the quality of the health professionals that provide FP services. The role of the national FP program in upgrading the quality of FP providers would include:

- Setting educational standards;
- supporting supervision systems;
- setting skill standards;
- doing manpower planning to ensure an adequate supply of health workers with appropriate qualifications (type, gender, ethnicity, specialized skills, etc.);
- supporting the introduction of new technologies, drugs, treatments, eligibility requirements, and equipment, drawing on both international and domestic experience;
- setting standards for certification and or licensing;
- helping communities, facilities and organizations identify and recruit health workers;
- providing FP providers in unusual circumstances and beyond the capacity of the local governments (refugee crises, recanalization or other specialist skills, meeting exceptional demand, etc.);
- providing job aids to improve the quality of provider services;
- educating clients to demand higher quality services from their provider;
- providing materials or training to help providers manage services better (cost recovery, bookkeeping, marketing private practices, collaboration with other providers, etc.);
- do applied research to support empirically-based changes in provider education, supervision, support, client education, or operating procedures.

In considering future roles of health professions in providing FP services, or the role of programs in ensuring that providers are providing quality, and the different needs, roles and access of providers working in the public versus the private sector must be considered. The national program has done relatively little to support the quality of private providers. The trend towards the use of private providers makes it even more important to ensure that the quality and client-centered policies of the national program are translated and applied to the private FP providers.

Ensuring the quality of FP commodities will be another important centrally managed role for the program. This role is both specialized, complex and will require coordination with local governments, and other government agencies including DepKes and BPOM. The functions could include:

- Facilitating the procurement and importation of raw ingredients for local manufacturing of FP products (hormonals, materials for implants, IUDs, gloves, condoms);

- providing testing of new products and formulations as required for registration by the Government;
- providing guidelines and training for local supervision in product storage, transport, distribution, and expiration so as to ensure clients have access to fully efficacious products;
- monitoring in coordination with other agencies: registration of new products/brands, counterfeiting, misuse of brands, distribution of unregistered products, regular testing of product for content and potency;
- providing a central contact for product complaints, and other feedback to allow more effective roles in the above activities and facilitate rapid response to problems;
- facilitate the entry of new products into the Indonesian market, including doing the social and program assessments of new products for BPOM.

As in previous discussion of the future of quality improvement initiatives, the role of the private sector must be considered. In the area quality family planning commodities, private sector roles and cooperation are essential.

Another function that will be essential to the building of a high quality FP program is the Regulatory and Enforcement Function. These concepts are not functions of the current FP, health programs or most government agencies. Concepts such as “standard setting,” “licensing,” supervision, monitoring and inspection cross agency coordination are all activities that have their basis and impact in the regulatory functions. Quality will become national policy when laws provide the regulations and authority to set, monitor and punish or reward compliance with quality standards. Currently in Indonesia if a patient dies due to a doctor’s incompetence or negligence there is legal basis for punishment, but no enforcement. Midwives graduate from midwifery schools without adequate applied skills to practice and yet are placed in communities to provide services they are unable to provide. The regulatory and enforcement functions in the program will also be supported by: public education, development of a network of consumer advocates, education of the legal system on enforcement, and collaboration with professional associations to promote self regulation and monitoring.

TA and transferring functions and skills to the districts

Decentralization of public services across all sectors is a key reform effort of the government. The goal is to bring the management of public services closer to the communities that need and use these services. The National Family Planning Program has been mandated by the government to decentralize most of its functions and essential services to the district local governments by the end of December 2003. Therefore, starting in January 2004, local governments will be responsible for planning and implementing district family planning programs. Strong leadership and effective technical assistance is essential for this decentralization process to take place quickly and productively. This is especially important because of the key position that family planning holds in the government’s national strategy and its importance to the well being and welfare of the Indonesian people, as explained earlier.

However, the process of transferring the authorities, functions and skills of family planning service provision will be difficult and a lengthy process, some estimating a ten year time period. It is therefore essential that the center and provincial levels provide the necessary support, guidance and technical assistance to ensure that the essential family planning services are available through the district authority with the appropriate quality. To do this, specific technical assistance skills must be available for district use and capacity building of district skills must take place. An agency at the central level, with provincial branches, should be in place and empowered to provide this assistance.

The center and province must also be in the position to provide referral services to family planning clients that need special assistance due to complications, side effects, and other unavoidable technical problems that can not be addressed at the district level. A system must be in place at the provincial and central level that can provide these necessary back up services in the most appropriate level and with maximum effectiveness. Furthermore, there needs to be a national tracking system for determining the level of these sort of problems so that corrective measures, if appropriate, can be taken on a local, provincial, or national basis. Also this body needs to manage DAK funds that may become available from the central Government for FP.

advocacy – international, national, local

As with any key national priority in a democracy, there is a need to educate the public and advocate for the national family planning program at all levels. Therefore, the capacity to carry out effective and efficient advocacy is crucial for family planning because of the importance of the program to Indonesia's development. The most important advocacy work is at the district level where local government officials and the local parliament are making decisions about funding and program priorities. The Family Planning Program management as well as the providers and the community need to advocate for its activities at this level to ensure needed resources are available.

Family Planning Program advocacy is also necessary at the national level to ensure proper national policies and supplemental funds are available to support the needs of the community. Finally, there is a need to maintain support from the international donor community for the family planning program, as long as Indonesia still requires donor assistance. Therefore, national advocacy work in the international arena is necessary to ensure international support is available financially as well as technically for Indonesia's family planning effort.

expanding private sector roles

A range of factors has resulted in private sector providers being the providers of a majority of FP services. The notable increases have been in the roles of private midwives (*bidan swasta*) and the semi public village midwife (*bidan di desa*). The private commercial sector has also increased its role in manufacturing distribution and direct marketing to FP providers. These trends are the result of a variety of crises, but are also

positive for the long term sustainability of FP in Indonesia. The future of the FP in Indonesia will recast the GOI's role as the motor of the program to that of steering the program, and the private sector will take over as the motor of FP program that serves the majority of Indonesian couples. For purposes of presentation we have divided the private sector into three types the commercial sector, NGOs involved in services, and private practice providers.

commercial sector and NGOs

The commercial private sector includes manufactures and distributors. Usually these two functions are in one company, but in Indonesia transport and detailing are contracted out. This sector is quite strong, with several producers of oral pills, injectables, implants, condoms, and IUDs. For hormonal methods, raw materials are imported, but formulation and packaging is done locally. The flexibility and production capacity of these firms has helped maintain the program through the various crises and declines in Government commodities procurement. There are several actions this sector can take to speed up and support their critical role in FP.

- Current regulations have oral pills on the ethical drug list. The prescription requirements are traditional and not based on current medical guidelines. Many countries use social marketing of oral contraceptives as the foundation of their FP program. This requirement hinders the effectiveness of various health auxiliaries (*kadres*), prevents drug stores (*toko obat*) from carrying pills, and promotes a large "gray market" system that sustains many outlets, midwives and health centers. Pills would be more available, cheaper, and more easily marketed if pills became and over-the-counter medication.
- The commercial sector has become more active in distribution and marketing over the last few years. These efforts have, however, focused on the most economically viable markets. Facilitating the pace of efforts to penetrate new markets and especially more marginal markets will greatly contribute to the program goals of a sustainable FP program based on client responsibility for acquiring FP services.
- Since districts will have most of the budget for procurement of subsidized commodities, positive working relationships between local governments and manufacturers should be developed.
- The national program can support demand creation of commercial sector products without emphasizing a specific brand.
- The national program can help link the commercial sector with geographic areas, providers, facilities and NGOs that can be ongoing customers for FP commodities.

While NGO's have limited coverage in terms of FP services, they have played a critical role in innovation, advocacy and providing services to more marginalized populations. The new era of local management, community empowerment and greater democracy, NGOs will only increase in the roles they play in support of FP and the related national policies. These roles can be facilitated and expanded in a variety of ways.

- Government support to NGOs has been limited, with priority given to government activities, providers and facilities. Recognition and support for the NGOs , especially the smaller local NGOs would help focus these groups on FP, harness local resources, ensure more sustainable FP services, and provide intermediate services between a subsidized government provider and a pure fee-for-service private provider.

private practice providers

In considering the private sector, the FP program must recognize the fastest growing component of FP service delivery – private practice providers. This group of providers includes both doctors and midwives in private practice. Until recently, many of these providers were employed by the Government, and practiced privately on a part-time basis. This allowed the national program to reach these providers with information, training, and supplies through their official jobs. This situation is changing rapidly as:

- more doctors and midwives retire into private practice;
- more semi-employed village midwives (*bidan di desa*) build stronger fee-for-service practices;
- government budgets decline, making private practice more secure and lucrative; and
- as more clients seek better quality services than are available in government facilities.

The larger question for the national program is how are these private practice providers going to get commodities, updated skills, technical support to run a small business effectively, a referral structure for problem cases, new informational materials and job aids, and placements for new health professionals. In addition, how will the national program protect client safety, serve the poor, and ensure quality when the provider of choice is in private practice?

The international models for ensuring an expanding role for private providers in providing quality FP services, include:

- licensing;
- certification by professional associations;
- continuing education programs;
- centralized complaint systems to monitor problem providers;
- peer review systems;
- national clearinghouses for information and medical updates;
- insurance schemes;
- government subsidies paid to providers for services to specific types of clients (e.g. poor, refugees, high risk).

One of the highest priorities for a continuing national FP program should be expanding the use of private providers in order to reduce the government subsidies for FP services. The reality is, however, that this shift in the service delivery structure will require greater

involvement of the national program to ensure high quality, accessible, and safe FP services.

serving young adults

Almost every country in the world has had to confront the political realities of adolescent reproductive health. Those countries that failed to address the issue watched increased school dropouts of girls, increased maternal mortality, and increases in abortion to end unwanted pregnancies. When HIV/AIDS became a recognized problem the threats to the health of younger women and men increased even more. Interventions to protect young adults included abstinence promotion, sex education in schools, increasing awareness of risks, greater access to information and services. The approach selected depends on the resources, the nature of the problems and the level of political commitment.

The future national program will have to address the issues of protecting the 41 million 15-24 year olds. One of the problems in generating political will is that there is little data on the health risks young people face. Indonesian demographic data is quite positive, in large part due to past program efforts. Age at first marriage is high (19 years for females). Birth intervals are on average over three years, although they are lower for younger women. Past program successes and strong traditional values may be protecting many young Indonesians from the worst reproductive health problems observed in other countries.

The future health of these young people is not yet clear as a number of social changes are occurring that tend to increase the health risks of young adults – increased educational level for girls, a larger population of young adults, modernization, increases in other high risk behaviors, delayed age at marriage, early departure from home for work or education, and social instability. While the size of the problem and the nature of the required interventions are not yet clear, it is clear that a national FP program will have to be involved in education and behavior change of young adults.

coordination with professional groups

The relevant professional organizations play a huge supporting role in the delivery and management of the national family planning program. Therefore it is again essential that the national family planning program have the capability and mandate to build effective partnerships with professional organizations involved with reproductive health. First, coordination is very important so the family planning program can benefit most effectively from the expertise of the professional groups. Secondly, national standards and clear national policy on such areas as quality of care and reproductive health rights can provide a common reference for providers. This will help ensure that the family planning clients are best served and best treated.

international representation of the FP program

It must be made clear where the government family planning program leadership resides and who has the last say in national family planning policy. This is necessary for reasons of clarity, good management, and proper focus. This is especially important in representing the government at international events and with international bodies. Therefore, one government agency should be identified as the government representative or national spokesperson organization for the Indonesian FP program.

6. Integrating FP and National Population Policy

FP is just one aspect – albeit one of the most important ones – of population development. It is important that FP be well-integrated into the nation’s broader population policies and that different aspects of population development (or population policy) are “harmonized”. This is especially important as the FP program “matures” and its organization and functions evolve. The future of FP in Indonesia cannot be divorced from the future of population policy more generally. The current situation in Indonesia regarding the broader policy environment for FP is something of an anomaly. There use to be a clearer integration of FP and population policy than is the case today. In our view there would be advantages to re-introducing tighter links between FP and population policy: this would both serve to support and strengthen the FP program and better ensure that the country realize its population development objectives in a timely fashion.

population policy and development

“Population policy” here refers to the broad range of policy issues discussed in the decennial UN Conferences on Population and Development.⁹ These conferences have built on the growing scientific understanding of the critical interrelations and causal links which exist among population, socioeconomic development, and the environment (Birdsall et al. 2001).¹⁰

The consensus documents, signed by the Government of Indonesia, stress the importance of integrating population factors into development planning. The *Programme of Action* adopted at Cairo, for example, states: “The objectives are to fully integrate population concerns into: (a) Development strategies, planning, decision-making and resource allocation at all levels and in all regions, with the goal of meeting the needs, and

⁹ I.e. at Bucharest in 1974, Mexico City in 1984, and Cairo in 1994. What the UN and other agencies in these discussions often refer to as “population and development” we simply call “population policy.” The expression “population development” is often used in Indonesia with much the same meaning; e.g., “Population development means all activities in connection with changes in the conditions of the population which includes quantity, quality, and mobility which have an influence on development and the natural environment” (GOI 1992: Article 1.3).

¹⁰ There are actually many ways in which population may be taken into account in development planning (as well as a variety of reasons for doing so). Planning activities, if they are to be realistic, need to accommodate population processes; they also need to modify or influence those processes where appropriate (United Nations 1993). Population variables provide a basic description of the human resources which can be mobilized for development, and at the same time they give an essential profile of the very people who are the intended beneficiaries of the planning activities. From the policy perspective of population and development, population is viewed as both a means and an end of development.

improving the quality of life, of present and future generations; (b) All aspects of development planning in order to promote social justice and to eradicate poverty through sustained economic growth in the context of sustainable development” (United Nations, 1994: para 3.4).¹¹

population policy in Indonesia

Previously population policy had an institutional home in the Government; currently it does not. The need for a single clear focal point in the central government for taking the lead in addressing population issues is probably greater now with decentralization; with the transfer of authority to the districts there is a heightened need for policy and advocacy around a coherent national vision of what the population’s development should look like.

Some senior officials maintain that since population covers a range of cross-sectoral issues population policy is best left to the various ministries which already address these issues. The weakness here is that these ministries are obliged to tackle these issues primarily from the point of view of their respective sectoral responsibilities. Population policies accrue therefore willy-nilly. The ministry of health develops health policies, the ministry of education develops education policies, and so forth, and while many of these policies can be seen as “population-related,” no one has the responsibility for developing population policy per se, or even for checking that all the population-related policies in the various sectors are sound from a demographic point of view and consistent with one another. Such an eclectic approach means the Government loses the value-added advantage that deliberate, coherent, evidence-based population policies can contribute to a development strategy.

7. Institutional Base for Supporting the National FP Movement and National Population Policy Formulation

It is clear that the Indonesian Government is fully committed to providing high quality family planning services to its people. Much has been done over the last three decades to develop this program and what is described in the previous sections of this paper are substantial elements of a program that will make this effort even more effective and useful to the people of Indonesia.

The experience of the Indonesian family planning movement, as well as programs around the world, indicates clearly that there must be both a strong institutional base and a sound policy environment for the movement to flourish. Therefore we propose that a strong institutional base be part of the future of the national family planning *and* population development effort in Indonesia.

¹¹ Kofi Annan (1999: 1) has put it nicely: “So Cairo was not just a population conference. It was a conference on population and development. It was part of a process, going back 25 years or more, during which we have all learned that every society’s hopes of social and economic development are intimately linked to demography. All States now understand that, if they are to provide adequately for the future health and education of their citizens, they need to incorporate population policies into their development strategy.”

Such an institutional base is essential to ensure that the FP program is able to do the necessary advocacy to educate the public and maintain the interest of the policy makers about family planning and related aspects of population policy. Adequate technical support and strong leadership is important to continue the strong performance of the current FP movement. Also, there is a need to ensure that adequate budget support is available for the program and good quality staff are available at all levels to ensure quality services are provided and that sound population policy is formulated to support FP and other the efforts in national development.

From our experience, it would seem that Indonesia is already well positioned to identify such a strong agency that can provide this necessary institutional support. As external experts it is not our intent to be partisan in discussing governmental structure, but clearly BKKBN has demonstrated its potential for continuing to provide leadership to the national FP movement. Only BKKBN has the relevant past experience and success, the technical knowledge, and the credibility with the public, professionals, and the international community.

Aside from FP, there are also a number of advantages to having a clear institutional base for population policy. Providing an institutional home in the Central Government for population policy means:

- Someone is responsible for making sure the population-related policies developed by line ministries are fully consistent with the demographic realities of the country;
- someone is responsible for making sure the population-related policies developed by line ministries are consistent with one another;
- that where sectoral policies are likely to have effects on demographic processes, these effects are fully investigated and assessed, and that corrective measures are proposed where the “unintended consequences” are found to be negative;
- someone is responsible for assessing the medium- and long-term consequences of the country’s demographic processes for development, and for developing population policies to influence these processes where appropriate; and
- someone is responsible for monitoring progress made according to the commitments made by the Government at the various UN population conferences, and for advocating these commitments as needed.

Bearing these essential functions in mind it seems to us that BKKBN also has considerable comparative advantage regarding providing an institutional base for population policy and integrating FP into the Government’s development strategy. For example:

- BKKBN already has a core of professionals trained in demography and population-related sciences;
- BKKBN’s internationally-recognized contribution to the country’s family planning program means BKKBN has more experience (and more success) in developing population policy and integrating it into the Government’s development strategy than any other Indonesian agency;

- senior BKKBN officials have represented Indonesia at all the main UN Conferences on Population and Development, and BKKBN staff are already well-acquainted with a range of population and development issues (which go well beyond family planning narrowly conceived);
- following Law No. 10 of 1992 (GOI 1992) BKKBN has been collecting annually a unique set of data on FP and family welfare which can be used in developing national evidence-based population and development policies (as well as for developing local government regulations);
- BKKBN is widely recognized as a well-organized, highly effective organization, with a proven record in policy development, communication and advocacy, program implementation, innovation, training (including an international training program), working with international donors, etc.;
- “population” and “family planning” are commonly seen as a natural partnership among government officials and the public at large, and at one time the Head of BKKBN was also the Minister of Population.

It would be a waste of institutional resources if after its original objective of reducing fertility to replacement level is finally achieved, BKKBN’s “unique organizational resources” were allowed to atrophy or even disappear altogether (Knowles, n.d.: 1).¹² Better the human and social capital that has been built up over decades be maintained and used to help the country reach further related development goals. However in sound management practice, form follows function. If BKKBN were to be re-integrated into a Ministry of Population it would require considerable reorganization of the institution to perform all these functions well.

9. Conclusion

In summary, our assessment of current trends in FP, and of the current policy environment and institutional context, suggests:

- while the national FP program has made remarkable progress towards its objectives over the past 30 years, its work is far from complete in terms of realizing fully people’s reproductive rights;
- if current “unmet need” for FP could be met in a timely fashion this would help the Government reach its development goals and help stabilize Indonesia’s population size;
- the national FP program in the past has been as successful as it has in large part because of the strong leadership, support and coordination activities provided by BKKBN;
- as populations go through the “demographic transition” the role of government in family planning changes (Caldwell et al. 2002), but there is always a set of essential functions the government must perform if people are to be guaranteed access to quality FP services (Cross et al. 2002);

¹² Guest (2002) reminds us how, even in the short term, the organizational features of a successful family planning program can be used to advance other RH goals, e.g., regarding STDs and HIV/AIDS.

- at this critical juncture in Indonesia's social and political development it is imperative that the Government continue its high level of support for the FP program;
- this support can best be provided by maintaining the strong leadership role of BKKBN; but it is also important to reorganize the agency so it can better perform the essential functions needed in the future to support a decentralized, "mature," client-oriented FP program aimed at providing quality services for all¹³; and
- the new configuration of functions for BKKBN as a central agency could be nicely reinforced and supplemented if BKKBN were to assume more responsibility for integrating FP policy into the broader realm of population policy.

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¹³ It is important that some way be found to protect the outreach of BKKBN fieldworkers after decentralization.

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Table 1. Basic Demographic Indicators, 1971-2000

	1971	1980	1990	2000
Population (millions)	119.2	147.5	179.4	206.3
Growth rate (percent)				1.5 (1995-2000)
Under-15 (percent)	40.9	40.4	36.0	30.4
Percent Urban	17.3	22.3	30.9	42.4

Source: Population Census.

Table 2. Vital rates, 1971-2000

	1971	1980	1990	2000
TFR	5.6 (1968)	4.7 (1977)	3.3 (1987)	2.3? (1997)
IMR	145 (1967)	109 (1976)	71 (1986)	55 (1996)
E(o) male	45.0	50.9	57.9	
E(o) female	48.0	54.0	61.5	

Source: BPS 2001. Estimates for TFR are based on Own Child Method (BPS 2001: 15); for IMR on Brass Method (BPS 2001: 59).

Table 3. Contraceptive prevalence rate (currently married women, 15-49), 1991-1997

	IDHS 1991	IDHS 1994	IDHS 1997
Using modern method	47.0	52.0	54.7
Using traditional method	2.7	2.7	2.7
Using any method	49.7	54.7	57.4

Source: BPS 1998.

Table 4. Contraceptive prevalence rate, 1997, 2000

	1997	2000	Change
Currently using any method	57.5	56.4	-1.1
Currently using modern method	56.3	54.7	-1.5
Currently using traditional method	1.2	1.6	0.4

Source: Strauss et al. 2002.

Table 5. CPR 1996-2002, Urban and Rural

	Urban	Rural	Total
1996	55.4	53.6	54.2
1997	56.5	54.6	55.3
1998	56.2	54.9	55.4
1999	55.8	55.1	55.4
2000	56.8	53.5	54.8
2001	54.6	51.0	52.5
2002	55.2	53.4	54.2

Source: Susenas.

Table 6. Projection of Contraceptive Users under Four Assumptions (millions)

Year	No. of MWRA	CPR	No. of Users	Users Added
2003	36.4	0.550	20.02	
2008	39.2	0.550	21.56	1.54
2003	36.4	0.550	20.02	
2008	39.2	0.600	23.52	3.50
2003	36.4	0.550	20.02	
2008	39.2	0.625	24.50	4.48
2003	36.4	0.550	20.02	
2008	39.2	0.650	25.48	5.45

Source: Ross 2003: 15.