

*STARH Program*

Policy Briefing Paper, March 2001

**THE INDONESIAN NATIONAL FAMILY PLANNING PROGRAM  
AND THE TIAHRT AMENDMENT OF THE US CONGRESS**

**Adrian C. Hayes<sup>1</sup>**

**A. Purpose**

The purpose of this paper is to provide background information for the USAID “Tiahrt Team” (scheduled to visit Indonesia in mid-March 2001), and for other interested persons. The purpose of the Team Visit is to determine whether all the family planning and family planning-related activities in Indonesia which are supported, partly or in full, directly or indirectly, with US population-assistance funding comply with the requirements of the Tiahrt Amendment of the Foreign Appropriations Act. This paper does not attempt to make that determination; instead it provides some background information and takes a broad look at the national family planning program as a whole from the perspective of the Tiahrt requirements.<sup>2</sup>

Section B provides a brief statement of the Tiahrt Amendment. Section C views the national family planning program from the vantage point of the five principal Tiahrt requirements. An annotated guide to the key documents and other sources used in this assessment can be found in Appendix 1.

**B. Tiahrt Amendment**

The Tiahrt Amendment (H.R. 1998) requires that:

- *Re. Targets:* “(1) service providers or referral agents in the project shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning (this provision shall not be construed to include the use of quantitative estimates or indicators for budgeting and planning purposes),”
- *Re. Incentives:* “(2) the project shall not include payment of incentives, bribes, gratuities, or financial reward to (A) an individual in exchange for becoming a family planning acceptor, or (B) program personnel for achieving a numerical target or quota of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning,”
- *Re. Denied Benefits:* “(3) the project shall not deny any right or benefit, including the right of access to participate in any program of general welfare or the right of

---

<sup>1</sup> Policy Advisor, STARH Program.

<sup>2</sup> Or, as another report prepared for USAID puts it, as it appears “through a ‘Tiahrt lens’” (USAID 2000: 2).

- access to health care, as a consequence of any individual's decision not to accept family planning services,"
- *Re. Comprehensible Information*: "(4) the project shall provide family planning acceptors comprehensible information on the health benefits and risks of the methods chosen, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent of the use of the method," and
  - *Re. Experiment Trials*: "(5) the project shall ensure that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits" (USHR 1998).

These requirements apply specifically to projects that receive USAID Population Assistance (in the form of funds, goods or services) and involve service delivery activities. The Tiahrt Amendment was enacted by the US Congress in 1998 as an amendment to the Fiscal Year 1999 Appropriations Act, and was subsequently re-enacted with the FY00 Appropriations Act. The Amendment states that a "violation" of the requirements must be reported to Congress, except in the case of the comprehensible information requirement (requirement (4) above) where it is a "pattern or practice of violations" which must be so reported.

There is nothing exceptional about the content of the Tiahrt requirements and the principles underlying them are widely accepted. The first three requirements listed above in effect safeguard the principle of "voluntarism," and the last two the principle of "informed choice." These principles have always guided USAID's family planning assistance program. They are fundamental to the growing emphasis in the international FP movement during the 1990s on reproductive rights, on a client-oriented approach to family planning and reproductive health, and on the delivery of high quality services (Sadik 2000). The *Programme of Action* adopted at the 1994 International Conference of Population and Development in Cairo, endorsed by both the US and Indonesia (together with 177 other governments), states:

[R]eproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of 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 (UN 1994 para 7.3).

The aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods. ... Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-

planning providers in the form of targets or quotas for the recruitment of clients (UN 1994 para 7.12).

Tiahart and Cairo promote common values of voluntarism and informed choice. Tiahart seeks to safeguard these values by placing conditions on projects providing FP services; Cairo seeks to realize these same values by advocating an approach to service delivery that is client-oriented and grounded in basic human rights.

### **C. The Indonesian National FP Program viewed through a “Tiahart Lens”**

This section reviews the national FP program from the perspective of Tiahart. The exercise is complicated since the program covers a range of activities and implementation can vary from district to district. Furthermore the program is constantly evolving, and the current period of reform and decentralization in Indonesia following the end of the New Order regime has produced major revisions in policy regarding FP and related areas which are just now beginning to be implemented and fine-tuned. The new policies, broadly speaking, embrace the Cairo *Programme*. Another complication is that while the National Family Planning Coordinating Board (BKKBN) is responsible for FP policy and coordinating the national FP program, and is the channel for almost all USAID population funds, the actual provision of FP clinical services is in the responsibility of the Ministry of Health (Depkes) and the active NGO and private sectors.

In the following sub-sections we look at the FP program in relation to the specific requirements of Tiahart.

#### **C.1 Re. Targets**

*Tiahart:*

- ***“service providers or referral agents in the project shall not implement or be subject to quotas, or other numerical targets, of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning (this provision shall not be construed to include the use of quantitative estimates or indicators for budgeting and planning purposes)”***

*Indonesian Policies and Practices:*

- There are no current policies subjecting service providers or referral agents to such targets.
- BKKBN has used targets in the past, especially during the 1970s and 80s (Hull and Hull 1997: 399-401). Demographic goals were translated into numeric targets for numbers of FP acceptors (including sometimes for specific methods). These targets were used for planning purposes and the allocation of resources; they were also used as performance indicators. In terms of official policy performance targets were meant to apply to whole provinces and districts, and it was the

governors and *bupati* who were held responsible if targets were not met; in practice targets could and often did serve as performance indicators further down the line,<sup>3</sup> and in some cases individual service providers or referral agents may have implemented or been subjected to numerical targets although this was never an official policy of the national program.

- The question whether the use of targets (and other tools used by program managers) compromised voluntarism in unacceptable ways was frequently raised and discussed in the 1970s and 80s, both within and outside the program. With the specific wording of the Tiahr requirement in mind, suffice it to say that targets were used to assess program performance, and whilst it was never official policy of either BKKBN or Depkes to use targets in evaluating the performance of individual service providers or referral agents, it appears that local officials sometimes put pressure on individual providers to reach quotas.<sup>4</sup> It is relevant to note that even when targets were officially used they were based on numbers of acceptors not users. High drop-out rates, and of users changing method, suggest that clients were exercising a high level of voluntarism in choosing which method to use or when to terminate use of contraception.
- Far from emphasizing population control to meet demographic targets current Indonesian law emphasizes choice on the part of couples:

Every husband and wife couple may make its choice in planning and regulate the number of children and the spacing of childbirth based on awareness and responsibility to the present generation and to future generations (GOI 1992: Article 18);

The husband and wife have equal rights and responsibilities as well as equal status in determining the method of birth control (GOI 1992: Article 19).

---

<sup>3</sup> Hierarchical authority structures in Indonesia (especially Javanese) are infused with an ideology of *Bapakism*, and there is often considerable leeway at each level for interpreting just what an order means at that level and how it should be implemented. Hull and Hull (1997: 391-394) conceptualize these patrimonial structures as nested cones, or pyramids within pyramids, rather than as a simple line top-down authority structures.

<sup>4</sup> There is no clear evidence that this latter pressure itself resulted in individuals accepting contraception when they really did not want to. Hull and Hull (1997) give a balanced account, looking at the Indonesian FP program in political and cultural context, and cite much of the critical literature. A practice that seems quite benign from one point of view can readily appear ominous from another. Under the official ideology of *dwi fungsi* the military have routinely supported the national FP program, by providing transportation in rural areas, for example. This can shade over into using the military to provide a little pressure: As one FP fieldworker puts it, "If the target is still high and has not yet been reached, and the people are difficult to reach, the army makes them a little bit afraid so that they are willing to come together for a family planning session" (quoted in Hull and Hull 1997: 395). Critics of the program, especially foreign journalists not understanding the local culture, might portray this as rounding up terrified villagers for forced contraception.

- In 1994 BKKBN announced the national FP program was abandoning numeric targets and substituting “demand fulfillment” (*pemenuhas permintaan masyarakat* or PPM) as a quantitative program performance indicator instead. This was an initial step to reorienting the national program towards a client-needs approach and away from demographic targets (Suyono 1994; Galway 1996). Some observers found the language of targets still being used in the field some time afterwards in ways suggesting “a gap between new policies stated centrally, and field-level implementation” (Hull and Hull 1997). Hoesni (2000: 6) makes essentially the same point: “[T]here is genuine reason to question whether provincial and district program managers and health providers have fully implemented BKKBN’s new policy direction. ... Without a focused field assessment supported by a program of reorientation, central-level calls for emphasizing demand fulfillment could well be interpreted by providers and field workers as renewed calls for target fulfillment” (Hoesni 2000: 6). BKKBN is now addressing this issue. Even where the old language of targets may still be used by local officials and program managers there is no recent evidence that this usage is a threat to voluntarism, or that service providers or referral agents are being subjected to or are implementing numerical targets. In fact the acute problem today is meeting the demand for contraception and FP services, not whether there are enough new acceptors (Hudyono 2001).

#### *Looking Ahead:*

- The use of targets was officially abandoned by BKKBN in 1994 and is antithetical to the agency’s recent New Era strategy (GOI 2000b). This strategy advocates “[f]ull implementation of a modern reproductive rights approach to family planning as opposed to BKKBN’s traditional demographic/development approach” (Knowles 2000: 1). BKKBN is currently promoting its new strategy among field staff to ensure all program staff are familiar with the new principles and direction.<sup>5</sup> STARH is helping the agency design an effective advocacy strategy, including an internal strategy to promote the new approach among all staff, especially those working at the regional levels; and will work with BKKBN, Depkes and other partners to provide suitable training.
- In her Keynote Address to the 11<sup>th</sup> International Meeting of the Society for the Advancement of Reproductive Care the State Minister for Women’s Empowerment and Chairperson of BKKBN, Ibu Khofifah reaffirmed BKKBN’s commitment to the Cairo program, and made it clear that the policies of the national family program are (in effect) fully consistent with the Tiaht proscription on targets. “Where there is a gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families (unmet need), we attempt to close this gap by at least 50 per cent by 2005, 75 per cent by 2010 and 100 per cent by 2050. In attempting to reach this benchmark,

---

<sup>5</sup> For example, through BKKBN’s National Consolidation Meeting, 29 October – 2 November 2001; through its Rakernas Meeting, 30 January – 3 February 2001; and the publication of new Cairo-like guidelines aimed primarily at middle-level program managers (BKKBN 2001).

demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients” (Parawansa 2001).

## C.2 Re. Incentives

*Tiaht:*

- ***“the project shall not include payment of incentives, bribes, gratuities, or financial reward to (A) an individual in exchange for becoming a family planning acceptor, or (B) program personnel for achieving a numerical target or quota of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning”***

*Indonesian Policies and Practices:*

- There are no current policies which allow or otherwise encourage the kind of incentives listed above, either for FP acceptors or for their service providers.
- Some financial incentives were used in the very early days of BKKBN but were soon phased out since they were found to have little effect on the acceptance rate and were difficult to administer. They were replaced by “social recognition” kinds of rewards; for example, selected women who had practiced FP successfully for an extended period of time were brought to Jakarta to be given an award by President Suharto, and other awards were given to “successful” FP workers and program managers. Such rewards help legitimate the idea of FP within the community but since they take so long to “win” and have no significant financial value they are not likely to cause individual couples to adopt FP against their better judgement or otherwise constitute the kind of incentives proscribed by Tiaht.
- The former State Minister for Population and Chairman of BKKBN, Professor Haryono Suyono (1995: 12-13), already described the Indonesian FP program in the mid-1990s as a “truly advanced program”:

“We no longer perceive family simply as the institution that receives all of these benefits from the society. The family, in this new construct, is also the engine, the advocate, the one who make their own decision for their own development and their own future. The [FP] program has already had high acceptance rates and the necessary supplies and distribution system, the family can support themselves up to certain levels of self sufficiency. They now realize that the world has changed and that people are demanding improved, personalized services and quality family planning, and that they are getting all of these. This is the stage that demands the utmost moral support and understanding, particularly from the

donor agencies, and the utmost sophistication and flexibility in terms of time and care to position family planning as one of the basic needs of every modern individual.”

In the context of an advanced program like this, where most people in the population have come to accept FP (and even to regard it as a basic human right),<sup>6</sup> incentives of the sort often used around the world in the early days of national FP programs simply have no place, and if re-introduced would probably prove ineffective or counter-productive.

- Current policy and operational discussions within BKKBN focus on exactly the opposite of incentives, namely, on client financing of services, on shifting clients to the private sector, on client empowerment to demand quality services, and an end to BKKBN’s procurement and provision of subsidized contraceptive commodities to all but the poorest and most vulnerable members of society.

*Looking Ahead:*

- The use of incentives is antithetical to BKKBN’s New Era strategy. There are no objectives or strategies in the new paradigm for which incentives (for either clients or providers) could conceivably be used.

### **C.3 Re. Denied Benefits**

*Tiaht:*

- ***“the project shall not deny any right or benefit, including the right of access to participate in any program of general welfare or the right of access to health care, as a consequence of any individual’s decision not to accept family planning services”***

*Indonesian Policies and Practices:*

- There are no policies in place to deny any right or benefit to women or their families who do not accept FP. Nor are there any reports that this is happening in the field as an unofficial or informal policy.<sup>7</sup>

---

<sup>6</sup> The fact that CPR did not decline appreciably after 1997 in response to the financial crisis shows how deeply internalized the need for FP is in Indonesia. When people are prepared to pay for contraception, even during economically difficult times, there is little room for financial incentives to make a difference.

<sup>7</sup> There is always the possibility of occasional deviant cases. Writing primarily about the 1970s and 80s two commentators noted, “Reports regularly surface of local authorities demanding a family planning acceptor card as a prerequisite for children’s admission into school, for obtaining a child’s graduation certificate or a citizen’s identity card, and for access to immunization and other services. Not official policies, these are examples of the innovations of officials within the lower ‘cones of authority’, eager to achieve their targets and recognition” (Hull and Hull 1997: 401). These deviations were normally corrected when brought to the attention of higher authorities, if indeed they were found to have any substance and not merely a case of unsubstantiated rumor. BKKBN itself has had in place mechanisms to deal with such problems for a long

*Looking Ahead:*

- The denial of benefits to non-acceptors of FP is antithetical to BKKBN's New Era strategy. There are no foreseeable circumstances under which the national program would introduce such a policy.

**C.4 Re. Comprehensible Information:**

*Tiaht:*

- ***“the project shall provide family planning acceptors comprehensible information on the health benefits and risks of the methods chosen, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent of the use of the method”***

*Indonesian Policies and Practices:*

- The 1992 law emphasizes the importance of “competent health personnel” and the “guidance” of acceptors, rather than stating explicitly that family planning acceptors should be provided comprehensible information:
  - (1) The use of contraceptive devices, drugs and methods which give rise to a risk to health shall be carried out under guidance and or by competent health personnel.
  - (2) The procedures for uses as intended by section (1) shall be carried out according to professional health standards in accordance with prevailing laws and regulations (GOI 1992: Article 20).
- Where “counseling” is mentioned in the 1992 law it is linked explicitly to the “determination of the ideal marriage age and delivery age,” rather than any explicit requirement that acceptors be informed of risks and benefits associated with different methods of contraception.

---

time. The former Chairperson of BKKBN, Prof. Haryono, in discussing earlier problems noted: “at times [for example] there is inadvertent conflict at lower levels between the care objective and the demographic objective. Usually it takes the form of a well-meaning but not well-understanding local leader getting carried away, and ‘encouraging’ a little too strongly. A better quality program should have mechanisms in place to rapidly and efficiently follow up any rumors of such problems, and to make it clear such action is not condoned. And a better quality program should also be looking for ways of addressing such problems in a broader more systematic way. In Indonesia, we have both – an immediate follow-up system and a broader strategy. (The latter, by the way, consists of eliminating acceptor targets, and instead getting the local people to estimate the community’s demand for contraceptive services.)” (Suyono 1994: 28-29). Generally speaking, on the issue of denial of benefits, it would be difficult (if not impossible) for BKKBN to deny any health benefits to non-acceptors of FP, even if it wanted to, because the delivery of health services is controlled by Depkes and not by BKKBN. On the other hand research has shown that going to the clinic for FP can often serve as a positive “gateway” to receiving other maternal and child health services.

- Similarly while the 1994 regulation strongly endorses the right of a couple to choose if, when, and by what method they may practice FP, the notion that they should be provided “comprehensible information” in order to exercise that right safely and effectively is not explicitly mentioned:
  - (1) The implementation of planning of pregnancy postponement, space between birth and the number of children planning should be carried out by the husband and wife based on their awareness and should be voluntary.
  - (2) The implementation of pregnancy postponement as intended in section (1) to be performed by using contraceptive devices, drugs, and methods which are acceptable to the couple according to their choice.
  - (3) The kind of contraceptive device, drugs, and methods as intended in section (2) is determined by observing the following:
    - (a) effectiveness and efficiency; (b) risk against health; (c) religious values and the value of life in the community.
  - (4) The kind of contraceptive devices, drugs, and methods as intended in section (2) should be determined by the Minister after having obtained approval from the Minister of Health” (GOI 1994a: Article 16).
  
- Viewed through a “Tiahrt lens,” therefore, the wording in current Indonesian law might appear less than ideal, but it needs to be understood in relation to the context in which it was written and assessed regarding its impact, if any, on actual practice. The wording of the 1992 law and 1994 regulation does not, of course, in any way suggest that information should be withheld from acceptors; indeed, since the language used so explicitly affirms the right of a client to choose this surely entails they at least have an implicit right to ask questions about the options. The assumption underlying the language used appears to be that clients will likely not have the necessary background education to understand much about benefits, risks and side effects, and will not be interested to hear such information. The language used, in other words, reflects a kind of paternalism or traditional “doctor/provider knows best” subculture, and the emphasis is therefore placed on the provider having sufficient comprehensible knowledge rather than the acceptor.

In discussing problems associated with a earlier stages of the national FP program’s evolution, Prof. Hayono remarked, “our doctors have been working for generations within a tradition that emphasizes that it is inappropriate to explain anything to patients; as a social scientist, I happen to think this is a terrible tradition, but although we try, we are having only limited success in getting the doctors to change this attitude; should we be criticized for this?” (Suyono 1994: 15). Recent attempts to change this, however, are having much more success (e.g.

Kim 2001), especially in the context of current social and political trends in Indonesia.

- In actual practice during recent years considerable effort *has* been expended by the program (especially in various component projects) to improve the knowledge base and IPC/C (interpersonal communication and counseling) skills of providers and provide more comprehensible information to clients – especially to ensure that such knowledge is available to all clients who want it. Much of this effort was in response to the findings of the 1994 Situation Analysis (BKKBN 1994). The survey found at that time that comprehensible information was not readily available at many SDPs (service delivery points), and where it was available it was not used very much. “Between 29 percent and 73 percent of the SDPs [sampled in the 9 provinces] had visible family planning sign announcing the availability of family planning services. Posters were seen on walls at between 40 per cent and 81 percent of the SDPs. Less than half of the SDPs had flipcharts and anatomical models. Family planning brochures and information sheets were available in approximately one-third of the SDPs. The use of these IEC materials during counseling and consultation at the SDP was rare” (BKKBN 1994: v). The level of comprehensible information on risks and side effects of methods among providers themselves left much room for improvement.
- Since 1994 considerable effort has been expended to address these shortcomings and ensure clients receive the comprehensible information they need. BKKBN and Depkes have produced numerous communication and interpersonal counseling manuals, booklets and publications for providers and fieldworkers explaining the correct use, benefits and side effects of different methods (e.g. BKKBN 1992a, 1992b, , n.d.). JHU-CCP has worked with POGI, IDI, IBI, Depkes, BKKBN and PKBI to develop national curricula for IPC/C and national counseling standards to make sure uniform comprehensible information on benefits, risks, contraindications and side effects is provided to clients on the methods they choose.<sup>8</sup> JHPIEGO worked with POGI, PKMI,<sup>9</sup> BKKBN and Depkes to produce a National Resource Document for Family Planning Services (NRG-POGI 1996) to help improve quality. An enormous amount of training has been given to service providers focusing on counseling, improving the quality of client-provider interaction, and the communication of accurate comprehensible information. The USAID-funded SDES Project, UNFPA projects, World Bank projects, AusAID-assisted projects, and other initiatives within the BKKBN national program have all institutionalized the principles of informed choice and comprehensible information (although the terminology used was often different), at least in the areas where they operated. The Population Council and AVSC have also been active in this field. STARH has prepared a poster (in Indonesian) describing in plain language the benefits, risks and side effects of all contraceptive methods. The poster is being distributed for display in all SDPs.

---

<sup>8</sup> POGI is the Indonesian Society of OB/GYN; IDI is the Indonesian Medical Association; IBI is the Indonesian Midwives Association; PKBI is the Indonesian Planned Parenthood Association.

<sup>9</sup> PKMI is the Indonesian Association for Voluntary Surgical Contraception.

- It is also important to note the Indonesian FP Program puts a lot of effort into providing comprehensible information about FP methods to clients and potential clients through a number of channels aside from relying on the FP fieldworkers and health workers themselves. FP information is provided through the media and by a variety of mechanisms reaching into the community. Women often discuss the pros and cons of different FP methods with other users in their community. As a result clients usually know what method they want *before* they arrive at the SDP and are often not interested in asking the service provider questions about alternative methods, their relative risks and benefits, or in engaging in further discussion (Pariani et al. 1991). Clients obtain a lot of comprehensible information from sources other than their FP service providers or referral agents. A new approach to training SDP staff seeks to build on this strength and encourage clients to take a more active role in client-provider interaction (Kim et al. 2000, 2001). The current social and political climate of *reformasi* and decentralization appears to be reinforcing this development. Field reports suggest that clients are increasingly well-informed, and increasingly empowered to ask for the information they want and demand good services.

*Looking Ahead:*

- BKKBN acknowledges that “acceptors” were given little information about the health benefits, risks and side effects associated with different methods in the past. In recent years the agency has done much more to provide clients with comprehensible knowledge so they can make informed choices. The New Era strategy affirms the statement of reproductive rights agreed to in Cairo<sup>10</sup> (BKKBN 2001) and recognizes that “[w]omen and men need to be educated about their reproductive rights” (Knowles 2000: 21). According to Minister Khofifah, “We [are increasing] our investment designed to improve the quality and availability of family planning and reproductive health services, including ... ensuring free, voluntary and informed choices, respect, privacy, confidentiality, and client comfort” (Parawansa 2001).
- STARH is working with BKKBN, Depkes, NGOs, the private sector, and other partners, to improve the quality of FP and RH services in Indonesia through policy, strengthening service delivery systems, and advocacy. STARH will monitor the quality of the national program (at least in areas where STARH is active), and will work with its partners to address any shortcomings identified regarding the providing of comprehensible information to clients, and regarding any of the other the Tiaht requirements. STARH will conduct a QIQ (Quick Investigation of Quality) survey later this year which will allow a more

---

<sup>10</sup> “Hak-hak reproduksi tersebut didasarkan pada pengakuan atas hak-hak asasi pokok bagi semua pasangan dan pribadi dalam menentukan jumlah, jarak dan waktu kelahiran anak-anak mereka secara bebas dan bertanggung jawab, dan memperoleh informasi dan cara untuk melaksanakannya serta hak untuk mencapai standar tertinggi dalam hal kesehatan seksual dan kesehatan reproduksi” (BKKBN 2001: 3-4).

comprehensive and systematic comparison with the 1994 data and as a baseline to monitor further efforts to improve quality and choice.

### **C.5 Re. Experiment Trials**

*Tiaht:*

- ***“the project shall ensure that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits”***

*Indonesian Policies and Practices:*

- Official policy at BKKBN and Depkes stipulates that researchers responsible for experimental trails must issue a *Formulir Persetujuan* describing the goals of the trial and informing potential participants of any risks and benefits, and clients (and sometimes their husbands too) must sign an Informed Consent Form (*Surat Pernyataan Persetujuan*) in the presence of an authorized witness before participating as a subject in the trial. USAID also has a strict policy on human subjects research.

## F. References

- BKKBN 1992a. *Panduan Konseling-KB, Bagi PPKBD, Sub-PPKBD, Kader*. Jakarta: BKKBN.
- BKKBN 1992b. *Kecil Mandiri Sejahtera Citra Keluarga Masa Kini*. Jakarta: BKKBN.
- BKKBN 1994. *A Situation Analysis of the Government Run Service Delivery Points for Family Planning in Indonesia*. Jakarta: BKKBN.
- BKKBN 2001. *Pedoman Kebijakan Teknis*. Jakarta: BKKBN, Deputi KB dan Kesehatan Reproduksi. Jakarta: BKKBN.
- BKKBN n.d. *Aman berkat suntik KB*. Jakarta: BKKBN.
- BKKBN n.d. *Pil KB*. Jakarta: BKKBN.
- BKKBN n.d. *Alat Kontrasepsi Bawah Kulit (AKBK)*. Jakarta: BKKBN.
- BKKBN n.d. *SPIRAL ayau AKDR (Alat Kontrasepsi Dalam Rahim) atua IUD*. Jakarta: BKKBN.
- BKKBN n.d. *Kondom*. Jakarta: BKKBN.
- Galway, Katrina 1996. "Demand Fulfillment and Demand Creation: A Dual Approach to Family Planning Program Development." Jakarta: The Futures Group International, OPTIONS II Project.
- GOI 1992. *Law of the Republic of Indonesia Number 10 of 1992 Concerning Population Development and the Development of Happy and Prosperous Families*. Jakarta: State Ministry of Population/National Family Planning Coordination Board.
- GOI 1994a. *Government Regulation of the Republic of Indonesia Number 21 of 1994 Concerning the Implementation of the Development of Happy and Prosperous Families*. Jakarta: State Ministry of Population/National Family Planning Coordination Board.
- GOI 1994b. *Government Regulation of the Republic of Indonesia Number 27 of 1994 Concerning the Management of Population Development*. Jakarta: State Ministry of Population/National Family Planning Coordination Board.
- GOI 2000a. *Keputusan Presiden Republik Indonesiam Nomor 20 Tahun 2000 Tentang Badan Koordinasi Keluarga Berencana Nasional*. Jakarta: BKKBN.
- GOI 2000c. *Undang-Undang Republik Indonesia Nomor 25 Tahun 2000 Tentang Program Pembangunan Nasional (PROPENAS) Tahun 2000 – 2004*. Jakarta: Republik Indonesia.

GOI 2001. *Keputusan Menteri Negara Pemberdayaan Perempuan/Kepala Badan Koordinasi Keluarga Berencana Nasional Tentang Visi dan Misi Program Keluarga Berencana Nasional dan Pembangunan Keluarga Sejahtera*. Jakarta: Kantor Menteri Negara Pemberdayaan Perempuan dan Badan Koordinasi Keluarga Berencana Nasional.

Hoesni, H.R. Hasan Moehammad 2000. "The National Family Planning Board (BKKBN) Central-Level Policy Review." Jakarta: The Futures Group International, The POLICY Project.

Hudyono, Yos E. 2001. Field notes from trip to Sumatera and Kalimantan. Jakarta: STARH Program.

Hull, Terence H., and Valerie Hull 1997. "Politics, Culture and Fertility: Transitions in Indonesia." In *The Continuing Demographic Transition*, ed. by G.W. Jones, R.M. Douglas, J.C. Caldwell, and R.M. D'Souza. Oxford: Clarendon Press. Pp.383-421.

Kak, Neeraj 1999. *SDES Evaluation Report: Key Findings*. Jakarta: Pathfinder International.

Kim, Young Mi, Fitri Putjuk, Endang Basuki and Adrienne Kols 2000. "Self-Assessment and Peer Review: Improving Indonesian Service Providers' Communication with Clients." *International Family Planning Perspectives* 26, 1: 4-12.

Kim, Young Mi, Fitri Putjuk, Endang Basuki and Gary Lewis 2001. "'Smart Patient' Coaching in Indonesia: A Strategy to Improve Client and Provider Communication." Presentation at the 11<sup>th</sup> International Meeting of the Society for the Advancement of Reproductive Health Care." Bali, February 2001.

Knowles, James 2000. *New Era Strategic Analysis for the National Family Planning Coordinating Board (BKKBN) 2000-2015*. Jakarta: BKKBN.

Parawansa, Khofifah Indar 2001. "The New Paradigm for the Indonesian Family Planning Programme: Implications for Advancement in Contraceptive Services in Indonesia." Keynote Address, 11<sup>th</sup> International Meeting of the Society for the Advancement of Reproductive Health Care." Bali, February 2001.

Pariani, s., D.M. Heer, J. Van Arsdol and D. Maurice 1991. "Does Choice Make a Difference to Contraceptive Use? Evidence from East Java." *Studies in Family Planning* 22: 384-390.

Sadik, Nafis 2000. "Progress in Protecting Reproductive Rights and Promoting Reproductive Health: Five Years Since Cairo." *Health and Human Rights* 4, 2: 7-15.

Suyono, Haryono 1994. "Address to the Annual Meetings of the Population Association of America." Jakarta: Office of the Ministry of Population/BKKBN.

Suyono, Haryono 1995. "Family Planning in the 1990s: A New Era ..." Jakarta: The State Ministry for Population/BKKBN.

United Nations 1994. *Programme of Action Adopted at the International Conference on Population and Development*, Cairo, 5-13 September 1994. New York: United Nations.

USAID 2000. "Assessment of Policies Affecting Informed Choice in Family Planning Services in Egypt." Draft dated April 4. Cairo: USAID.

United States House of Representatives (USHR) 1998. *Congressional Record*, October 19. Text of Tiahrt Amendment cited in this paper appears on pages H11085 and H11356.

## Appendix 1: National FP Program -- Notes on Sources Used

Basic population law determining FP policy in Indonesia is found in:

- Law Number 10 of 1992: *Concerning Population Development and the Development of Happy and Prosperous Families* (GOI 1992). This law took more than a decade to prepare. It gives the Government the legal basis it needs for its efforts at controlling the size of the population, for developing the quality of the population, and for developing the quality of the family (GOI 1994: 3-4). Consistent with previous usage in Indonesia, “family planning” is given a broad connotation to suggest a variety of ways in which a person can plan his or her own family to improve the welfare of all its members, thereby contributing to the development of society as a whole.<sup>11</sup> The use of birth control is just one method of family planning, in this perspective, and the law nowhere suggests or advocates a strong link between birth control and population control. At the time of drafting the law the language of reproductive rights was not yet in vogue and it is not used. The rights of couples to choose if and when to have children, and the number of children they want, is clearly recognized and affirmed.
- The 1992 law is supplemented by two 1994 government regulations: (i) Government Regulation of the Republic of Indonesia Number 21 of 1994: *Concerning the Implementation of the Development of Happy and Prosperous Families* (GOI 1994a) and (ii) Government Regulation of the Republic of Indonesia Number 27 of 1994: *Concerning the Management of Population Development* (GOI 1994b).
- Law Number 25 of 2000: *Concerning National Development (PROPENAS) 2000-2004* (GOI 2000c). Presents the Government’s development plan for the period 2000-2004, including the health and family planning sector.

Presidential Decrees also have the force of law in Indonesia.<sup>12</sup> Relevant to the purpose of this paper:

- Presidential Decree Number 20 of 2000: *On National Family Planning Coordinating Board* (GOI 2000a). Enacted in February 2000 this decree prescribes that the State Minister for Women’s Empowerment shall serve as Chairman of BKKBN.

Laws and regulations passed by the Indonesian Parliament (DPR) are intended to present only the basic principles and broad directions of public policy. Specific operational policies are stipulated in Ministerial Decrees (*Surat Keputusan*) and Instructions (*Surat*

---

<sup>11</sup> “Keluarga berencana adalah upaya peningkatan kepedulian dan peran serta masyarakat melalui pendewasaan usia perkawinan, pengaturan kelahiran, pembinaan ketahanan keluarga, peningkatan kesejahteraan keluarga untuk mewujudkan keluarga kecil, bahagia, dan sejahtera” (Chapter 1).

<sup>12</sup> But a Presidential Decree cannot contradict or nullify existing laws passed by the DPR.

*Tugas*), and in the corresponding technical standards and guidelines issued by their respective ministries. Among the most important in determining FP and RH policy, at least as it relates to the principles of voluntarism and informed choice, are:

- *Panduan Konseling-KB, Bagi PPKBD, Sub-PPKBD, Kader* (BKKBN 1992) (FP Counseling Guide for BKKBN Fieldworkers and Volunteers). This document in effect presents BKKBN's operating policies for its fieldworkers.
- *Buku Acuan Nasional Pelayanan Keluarga Berencana* (NRC – POGI 1996). While this National Resource Document for Family Planning Services is not an official government document it was prepared as a consensus document with the full participation of both BKKBN and Depkes to give providers in both public and private sectors basic information and guidelines regarding realistic best practice in the country.

Actual practice, of course, may not conform to official policy. Relevant data for describing and evaluating actual practice in the national FP program can be found in:

- *A Situation Analysis of the Government Run Service Delivery Points for Family Planning in Indonesia* (BKKBN 1994). This is the most comprehensive "situation analysis" conducted to date to assess the quality of care of the national FP program.<sup>13</sup>
- There has not been another comprehensive quality of care study done on such a large sample since 1994, but STARH is planning such a survey using the QIQ approach later this year. Pathfinder International commissioned a number of studies in 1998 as part of an evaluation of the SDES Project (see Kak 1999), but these data focus more on whether providers follow the correct medical procedures and are not so relevant for evaluating current practices relative to the Tiahr requirements (on voluntarism and informed choice).<sup>14</sup> Other data, usually more partial and based on small samples, can be found in various project baseline studies, monitoring reports, etc., and/or publications issueing from these (e.g. Kim et al. 2000).

Indonesia is currently undergoing some major transitions, especially the complex processes of democratization and regional autonomy. BKKBN and Depkes have both published new vision and mission statements in response to these changes. These documents announce some significant changes in FP policy and foreshadow more changes to come to further improve quality of services and correct current weaknesses:

---

<sup>13</sup> The situation analysis was carried out in all 7 provinces included in the Service Delivery Expansion Support (SDES) Project (West Java, Central Java, South Sulawesi, North Sumatra, South Sumatra, and Lampung), plus 2 additional provinces (Nusa Tenggara Barat and West Sumatra). A total of 308 SDPs were observed, and interviews conducted with 1,625 FP clients, 651 service providers (doctors, nurses, and midwives), 914 potential long-term method clients, and 59 volunary sterilization providers.

<sup>14</sup> The usefulness of the Kak study is also limited for methodological reasons.

- *Keputusan Menteri Negara Pemberdayaan Perempuan/Kepala Badan Koordinasi Keluarga Berencana Nasional Tentang Visi dan Misi Program Keluarga Berencana Nasional dan Pembangunan Keluarga Sejahtera (GOI 2001)*. This Ministerial Decree formally promulgates BKKBN's New Era vision of "Quality Families 2015."
- *New Era Strategic Analysis for the National Family Planning Coordinating Board (BKKBN) 2000-2015* (Knowles 2000). This strategy paper gives a clear exposition (in English) of the new long-term strategy for quality families adopted by BKKBN.
- *Pedoman Kebijakan Teknis* (BKKBN 2001). This document (still in draft) is intended to explain the new approach at BKKBN towards FP and RH to its own middle-level program managers. The new approach here is basically the Cairo agenda for FP and RH.