



# Revitalization of Family Planning in Indonesia

The Government of Indonesia and  
United Nations Population Fund



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# Executive Summary

The Indonesia national family planning program, led by BKKBN, has been recognized as one of the world's greatest demographic success stories of the 20th century. In a period of 30 years from the late 1960s until the turn of the century, contraceptive prevalence increased from under 5 percent to over 50 percent and the total fertility rate (TFR) was cut in half. Furthermore, over this period, the family planning program successfully implemented a policy to move most of the service provision from the public sector to private providers.

Presently, national TFR trends indicate that the two child family has essentially become the norm, and there is no demographic justification for the continuation of an aggressive promotion of fertility reduction. It seems clear that married women have a desire to control their fertility as manifest in the fact that half of currently married women want no more children, and of those who do intend to have more, half want to delay the next birth for at least two years. This means that three quarters of women have an immediate need for safe and effective contraception. Unfortunately they often face obstacles in gaining access to methods of birth control appropriate to their personal preferences and needs.

Disturbing trends in the family planning picture have emerged since the mid-1990s pointing to an urgent need to revitalize the family planning program to more effectively (and efficiently) meet the reproductive needs of women and men across the nation. Among these are the following:

1. A flat trend in contraceptive prevalence in recent years, with evidence of decay in practice among the least educated women and a reversal of decades of decline in the measure of unmet need in the latest IDHS.
2. Narrowing of the contraceptive method mix to temporary hormonal methods (primarily injectables) due to major

declines in the promotion of longer acting implants and IUDs and the failure of the program to support and extend surgical sterilization for people wishing to have a permanent end to childbearing.

3. High rates of unintended pregnancy among both married and unmarried women manifested by: the reported high number of induced abortions among both groups and the fact that one in six mothers report that their last birth was not wanted at the time it occurred.
4. Persistent regional disparities in contraceptive availability with many poor provinces and districts lagging behind their richer counterparts, and isolated regions suffering from shortages of staff and materials for family planning services.

These trends are in part due to –

1. The success of the Blue Circle and Gold Circle Campaigns since the 1980s to shift services from public to private providers (principally village midwives in the rural areas), resulting in a private provider driven program that primarily promotes the use of injections and pills irrespective of clients' needs
2. Policy and budgeting decisions to reduce government support for surgical sterilization since 1995
3. Budgeting decisions since 1999 to reduce BKKBN procurement, distribution and training for the contraceptive implant program
4. Lack of collaborative efforts by the Department of Health and the BKKBN to develop policies, strategies and programs to ensure that private providers have the competencies, resources and incentives to provide high quality family planning services
5. Explicit policies that ignore the contraceptive needs of unmarried women (and men).

6. An ambiguous abortion law promulgated in 1992, and lack of clear policies and programs to ensure that women have access to safe abortions and to post-abortion family planning services
7. Policies and practices leading to the diversion of government contraceptive commodities into the growing private market (potentially reducing access by the poor)

Most of these actions and the worrisome trends they produced began before decentralization. Decentralization, however, has resulted in less emphasis on family planning in many districts/municipalities and so has aggravated these adverse trends.

Yet, the family planning program still has considerable momentum based on BKKBN service statistics since 2000 collected from the districts/municipalities indicating that contraceptives continue to be distributed at the usual levels, often because of the loyalty and strong training endowments of the former BKKBN staff at the district level.

Decentralization, however, does impact on the political instruments and operational strategies available to the central government agencies to revitalize the family planning program when these departments and agencies no longer have line authority, staff or budgets to direct field operations. This report identifies the challenges BKKBN faces in this new environment, and develops the following Recommendations:

# SUMMARY RECOMMENDATIONS

1. To revitalize family planning the Government should first **reformulate the Vision, Mission and Values** to respond to the new realities of decentralized government and achievement of the goal of replacement level fertility. This could possibly involve the **creation of a new identity for the BKKBN, perhaps involving a change of name.**
2. The central government needs to take the lead in the process of building core analytical and technical competencies related to family planning at all levels of government and in both the public and private spheres. There should be a central agency charged with revitalizing the family planning.
3. Develop a senior leadership advisory structure to guide the central agency.
4. Initiate leadership capacity building for reproductive health and family planning in the districts/municipalities
5. Strengthen the role and functions of the new district level Offices/Boards of Family Planning and Women and Development
6. Promote initiatives nationally and locally to increase the availability and accessibility of long acting contraceptives – IUD, implants and male and female sterilization – to all couples
7. Formulate program policies and develop operational strategies in collaboration with the Ministry of Health to meet critical service delivery needs including:

- a. Reaching disadvantaged women including all women with an unmet need for contraception with information and services
  - b. Engaging the private sector with training, technical assistance and incentives to ensure that all women can choose the contraceptive method best for their life stage
  - c. Assuring that women are not forced to undergo unsafe abortions, and that all women terminating a pregnancy are provided with contraception.
8. Develop and promote national communication strategies focusing on the major unmet needs and unreached groups.
  9. A central agency charged with responsibility for family planning and reproductive health should place a high priority on monitoring public and private program performance (from service statistics and surveys) with interpretation and rapid feedback to districts/municipalities.
  10. The agency should also test and introduce innovations, primarily through grants to universities, private organizations and NGOs as appropriate.
  11. The agency should encourage districts to innovate and take other actions to strengthen the program, primarily through “block grants”.
  12. The agency should conduct advocacy, nationally and internationally, based on critically analysed data.

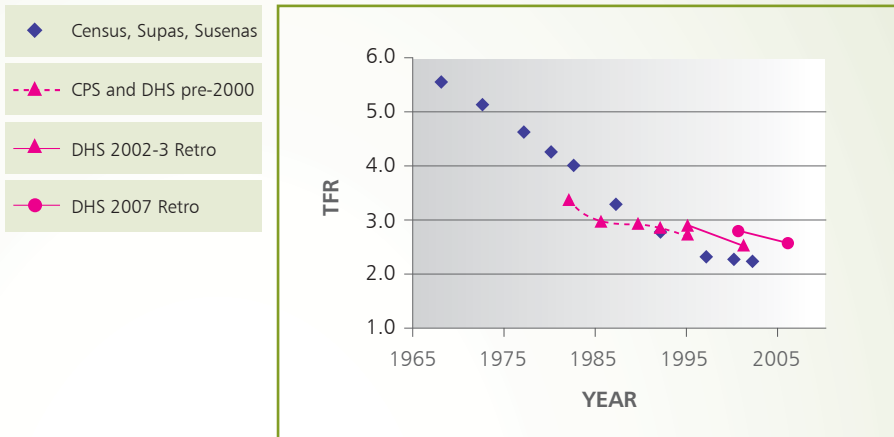
# The Demographic Picture

## Fertility Levels and Trends in Indonesia

Over the last four decades Indonesia, like most countries in Asia, has undergone a major transition from high to low fertility. Where women up to the 1970s had long borne an average of over five children, the pace of childbearing has slowed since then through a combination of delayed marriage and the increased use of contraception to prolong the time between births and ultimately end childbearing with fewer children. Underlying this major behavioural change was a national family planning program that promoted free contraceptives, small family values, and enhanced family welfare. This, along with rapid increases in school enrolments and steady reductions in the rates of poverty and rises in formal workforce participation meant that women could entertain ambitions beyond motherhood and families could invest more in the quality of their children rather than simply the quantity of family size.

The transformation in behaviours surrounding family formation is reflected in the sequence of blue diamonds in Figure 1. This gives us a long term ‘macroscopic’ view of fertility trends from the beginning of the family planning program through the most recent national surveys. Each blue

Figure 1. Indonesian fertility trends, 1965-2007



diamond is an estimate of fertility spanning a three to five year period centred on the point. This calculation is drawn from a comparison of the number of children between the ages of 0 to 3 or 4 enumerated in the population, and the number of women of childbearing ages (the Own Child method). The line is not linear but falls continuously through the turn of the century, at which point the decline slowed near the so-called replacement level of 2.1 children per woman.

The fertility calculations of the more detailed *Contraceptive Prevalence Survey* and the *Demographic and Health Surveys (CPS and DHS)* since the late 1980s do not follow the census trend lines. In early years they were below the own child estimates. Since 1995 the DHS total fertility rates have increasingly exceeded the levels found in the census-type national surveys. Since the year 2000 the published DHS estimates of current fertility (three years prior to the survey) have been stagnant at 2.6 children per woman, well above replacement level and nearly half a child higher than the census estimates.

DHS enumerators collect detailed data from ever-married women between the ages of 15 and 49, including complete histories of pregnancies and births. The total number of births in discrete periods of time prior to the survey is obtained from these histories. Thus in Figure 1 the two most recent DHS produced estimates of fertility both for the three year period immediately prior to the survey and five to nine years retrospectively. In each case they show declining fertility in same survey retrospective trend but comparison of current fertility between the two surveys shows no decline.

In the DHS it is assumed that single women are not sexually active and have not produced any children. However, to calculate fertility rates the survey needs to record all women in the population irrespective of their marital status. This number is obtained from the household census compiled by interviewers when they first arrive at selected sample households. The DHS census listing is the tool used to collect the estimate of the total population of women and men in the sample households. Table 1 reveals that the DHS household listings consistently show lower proportions of single women compared to Census, SUPAS or SUSENAS enumerations taken at around the same time, particularly for the ages from 20 through 29.

What explains the apparent lack of single women in the DHS listings? In part it appears that there is a major difference in the type of household covered by DHS and census type surveys. Essentially, the DHS interviewers are on the lookout for ever married women and given the nature of the survey they are particularly attuned to households with families. Since the 1980s Indonesia has undergone a remarkable change in the roles young women perform in society. They are increasingly likely to pursue education to higher levels, to work in expanding industrial and service occupations, or join the over four million Indonesian workers who are employed overseas sending remittances home. Single women often

live in institutional settings – dormitories, industrial barracks, and boarding houses. Anecdotal evidence from interviewers indicates that these places are often passed over in the DHS canvassing because fieldworkers concentrate on households that are more likely to yield eligible respondents. In contrast the decennial census enumeration includes all households, and the intercensal survey (SUPAS) makes special efforts to cover both family and non-family households, often with particular interest in workers and students.

**Table 1.**  
**Marital status distributions for women of reproductive ages in successive national surveys in Indonesia**

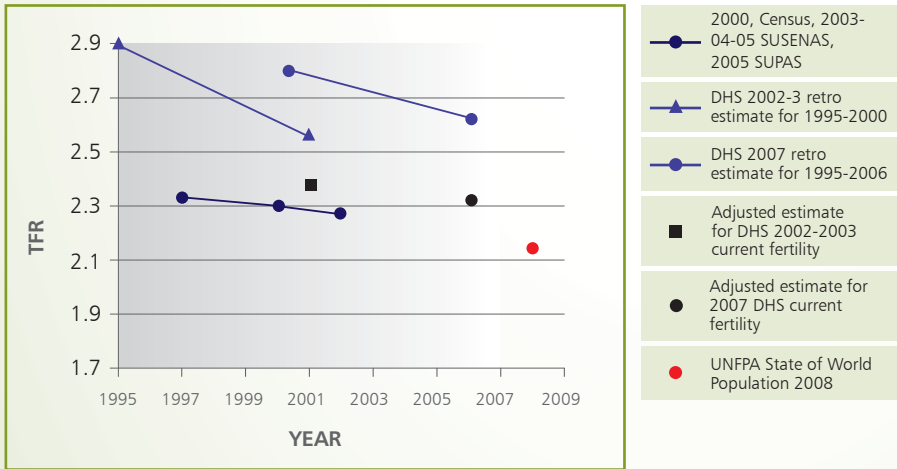
Age Group	SUPAS 1995	DHS 1997	Census 2000	SUSENAS 2002	DHS 2002-3	SUPAS 2005	DHS 2007
<b>Percentage of women in the age group who are single</b>							
15-19	85.7	82.1	89.3	89.7	85.4	90.8	86.9
20-24	40.1	36.1	43.1	47.0	41.2	51.4	38.3
25-29	15.2	14.1	16.7	16.3	13.8	19.7	15.4
30-34	5.5	5.3	6.9	6.5	5.9	8.1	7.0
35-39	2.8	2.4	3.5	2.9	3.0	4.3	3.6
40-44	2.1	2.9	2.4	2.1	2.1	2.6	2.6
45-49	1.9	1.7	2.0	1.4	2.0	2.0	1.9
All WRA	27.7	25.3	28.7	27.6	25.0	28.8	23.7
<b>Percentage of women in the age group who are ever-married</b>							
15-19	14.3	18.0	10.7	10.3	14.6	9.2	13.1
20-24	59.9	63.9	56.9	53.0	58.8	48.6	61.7
25-29	84.8	85.9	83.3	83.7	86.2	80.3	84.6
30-34	94.5	94.7	93.1	93.5	94.1	91.9	93.0
35-39	97.2	97.7	96.5	97.1	97.0	95.7	96.4
40-44	97.9	97.1	97.6	97.9	98.0	97.4	97.4
45-49	98.1	98.4	98.0	98.6	98.0	98.0	98.1
All WRA	72.3	74.7	71.3	72.4	75.0	71.2	76.3

\*Calculated from the Measure DHS STATCompiler: <http://www.statcompiler.com/> and 2007 DHS data provided by Statistics Indonesia.

The adjustment of DHS fertility rates is a two step process. First the data in Table 1 can be used to estimate the number of single women missing from the DHS sample compared to the expected number if the DHS had the same marriage status patterns as recent census or intercensal survey results. Second, once those single women are added to the total number of women in the DHS households the fertility rates can be recalculated with new denominators. Both these calculations are described in ANNEX 1, producing a pair of adjusted fertility rates for the two most recent DHS.

Figure 2 takes a 'microscopic' view of the fertility estimates. The adjusted DHS results are just above the census-type survey trend line. While they indicate a slow rate of decline, they are substantially below the unadjusted DHS levels and on track to reach replacement level fertility within a few

**Figure 1.** Unadjusted trend lines from 2002-3 and 2007 DHS and three census type surveys compared with adjusted fertility estimates for 2002-3 and 2007 DHS and the latest published UNFPA estimates from State of the World's Population 2008.



years, assuming there is no reversal in mean age at marriage or levels of effective contraceptive use in the population. It is notable that the UN Population Division calculations used in the UNFPA State of the World's Population 2008 tables is on line with the census and adjusted DHS figures, and substantially below the published DHS results.

This is an important finding for two reasons. First, the higher DHS results have been used to fuel criticisms of the Indonesian family planning program and raise alarms about possibilities of a baby boom or population explosion related to the implementation of a decentralized system of health and family planning service delivery since 2000. The adjustments show that fertility is falling, and is on track to meet planning targets, and there is certainly no baby boom on the horizon.

Second, the failure of the DHS to account for all women is not a problem unique to Indonesia. It has also been found in Bangladesh, where young women are flocking to jobs in textile factories and staying in school for longer periods of time as a result of positive government policies. DHS type surveys are likely to encounter difficulties accounting for single women wherever the roles of women are subject to rapid change, and households are in a state of flux. It serves as a wakeup call to national statisticians who will need to develop new ways to ensure that the sample designs encompass non-standard households. Adopting de facto definitions of residence rather than reliance on de jure listings of registered household members will go a long way to addressing this issue.

We can conclude that there are serious problems with the methods used to estimate fertility in Indonesia. The own-child method of fertility calculation used in the decennial census and the annual SUSENAS produces a steady downward trend of fertility from the 1970s through to the present day. In contrast the pregnancy history techniques used by the DHS

yielded lower fertility than the census prior to 2000, and higher levels since then. The discrepancy appears to be caused by the failure of the DHS sample and interview methods to capture a true profile of all women of reproductive ages and in particular failure to record a substantial number of single women. Once adjusted for these missing women the fertility rates for the three years prior to the 2002-03 and 2007 DHS are around 2.3, slightly above the long term BKKBN goal of replacement level fertility but well below the levels assumed by many government planners.

## Trends in Total Number of Births

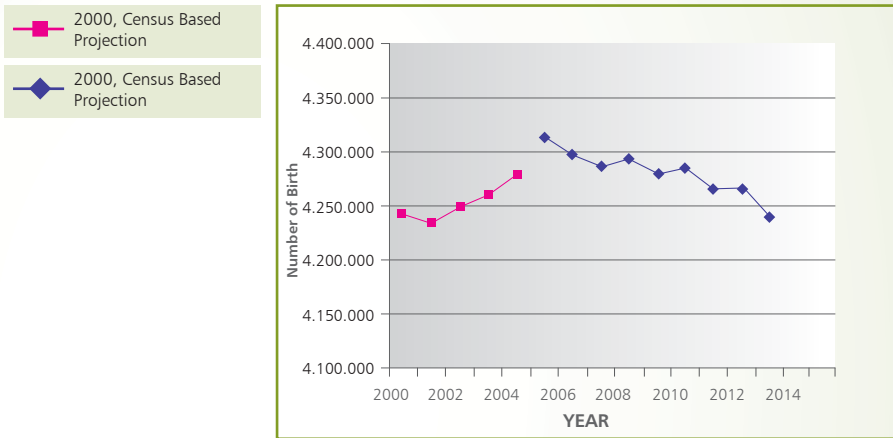
The challenge of assessing fertility trends in Indonesia is not just a puzzle for demographers, but also a tangle of challenges for health and family planning managers. If the fertility rates implied by the DHS are correct, there are in excess of 4.6 million births annually in Indonesia, and future numbers will moderate only as smaller cohorts of mothers work their way into the reproductive ages.

If the lower and slightly falling fertility rates calculated from the Census, SUPAS and annual Socio-Economic Surveys are correct, then there are currently 4.3 million births annually, and these numbers will drift lower to 4.2 million in around 8 to ten years from now. Figure 3 shows the trend in births embedded in the most recent population projections commissioned by BAPPENAS and carried out by BPS.

Interestingly the assumed fertility rates are slightly lower than the census and adjusted DHS fertility points in Figure 2. They show estimates of TFR of 2.23 for 2005 falling very gradually to reach 2.15 in 2010, when the BKKBN target calls for 2.10, and going on to reach 2.10 in 2016. Demographically there is no reason to criticize the assumptions, but politically they raise

questions about the degree to which government intends to invest resources to improve reproductive health and in the process speed the pace of fertility decline. A revitalisation of family planning would lead to a quicker decline in fertility which would translate into a smaller number of births in future than the numbers shown in Figure 3.

**Figure 3.** Estimated and Projected Annual Number of Births Indonesia, 2000-2015

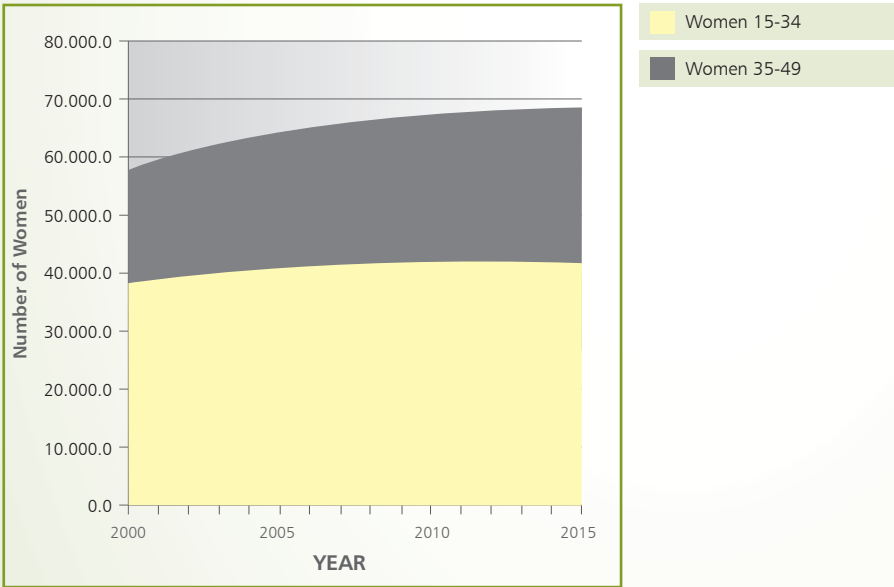


According to the BAPPENAS/BPS population projections the number of women of reproductive age will continue to climb in coming decades, but at a diminishing rate of growth (Figure 4). There are currently just over 64 million women between the ages of 15 and 49. In 2015, the target year to achieve the MDGs, there will be over 68 million women demanding services to deal with a full range of reproductive health issues.

An increasing proportion of these women will be in the later reproductive age groups of 35-49, a time at which they will have two, three or more children, but are still potentially fertile. The vast majority of women in this group want no more children. These are the people who need long term

contraceptives like the implant or surgical sterilization. At the turn of the century this group represented 32 percent of all women of reproductive potential and today they are 37 percent. By 2015 they will be over 40 percent of the clientele for contraception and will number nearly 28 million women. Translating that into estimates of the need for permanent contraception is a challenge for policy makers and health planners. Certainly the most cost-effective and practical option is the promotion of male sterilization using no-scalpel vasectomy techniques in primary health care facilities. However despite substantial investments in the 1980s and 1990s the Indonesian vasectomy program has never reached a point of self sustaining take-off, and in recent years the numbers of men having vasectomies has waned.

**Figure 4.** Estimated and Projected Number of Women of Reproductive Ages in Indonesia, 2000 – 2015

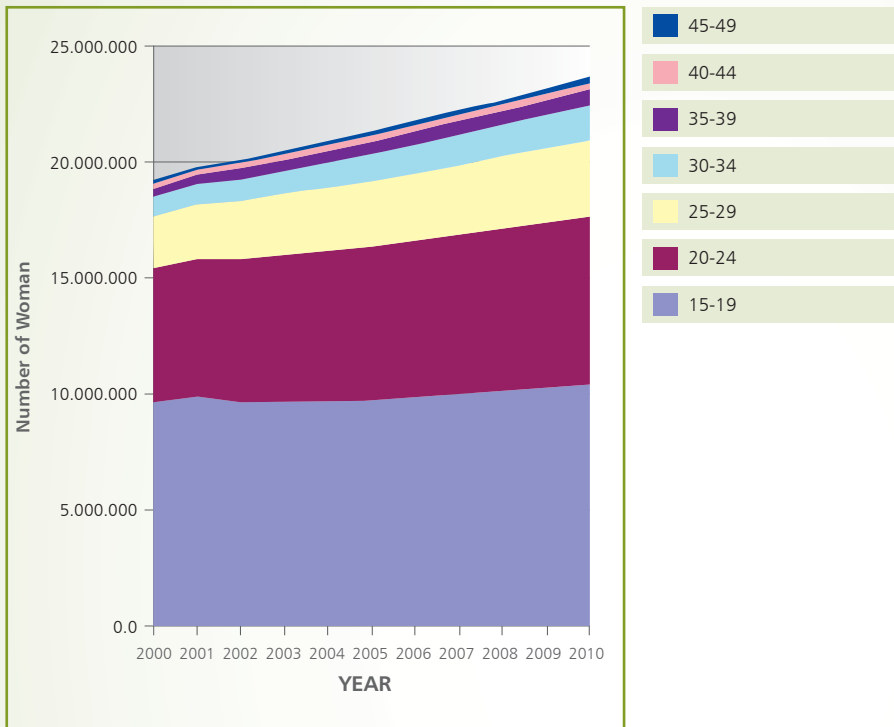


## Unmarried Women – a Growing Need for Contraception and Family Planning Services

Indonesia's national family planning program explicitly excludes unmarried women (and men), therefore these women receive little attention in the usual DHS surveys. This policy may have been rational 40 years ago when the family planning program began and most women, with no opportunity for education, married and began childbearing early. But with development and urbanization, times have changed dramatically, as has the demographic picture and sexual behaviour of unmarried women, yet the old policies remain.

There has been a steady change in marital status of young women since the inception of the national family planning program. (Figure 5). In 1971, just over 60 percent of women 15-19 years of age were unmarried; by 2005, 91 percent of this group were single. More strikingly, in the 20-24 year age group, the proportion single increased from 19 percent to 51 percent. Overall, there are currently 24 million unmarried women in the reproductive age group of whom just over 9 million are in the teenage years of 15-19. Less well recognized is the fact that over 11 million young adult women (age 20-34) are single.

**Figure 5.** The growing numbers of single (never married) women in the reproductive age population of women



Source: BAPPENAS/BPS Projections 2008

Even in the absence of any survey, it is safe to assume that essentially 100 percent of these young women (and men) want to delay their first birth until marriage. Many may be practicing abstinence, but many others, as they leave school, become employed and mature both physically and socially, may be sexually active, thus running the risk of an unintended pregnancy.

However, since these women are often ignored by the IDHS questions on sexual behaviour, the nation has no idea at

all of the contraceptive options being taken up by sexually active but unmarried women. Since the consequence of an unintended pregnancy can mean termination from school or employment, many (if not most) of unintended pregnancies are illegally aborted by untrained practitioners with adverse consequences for the woman, and for society at large. (See the discussion of abortion below.)

# Family Planning Program Data

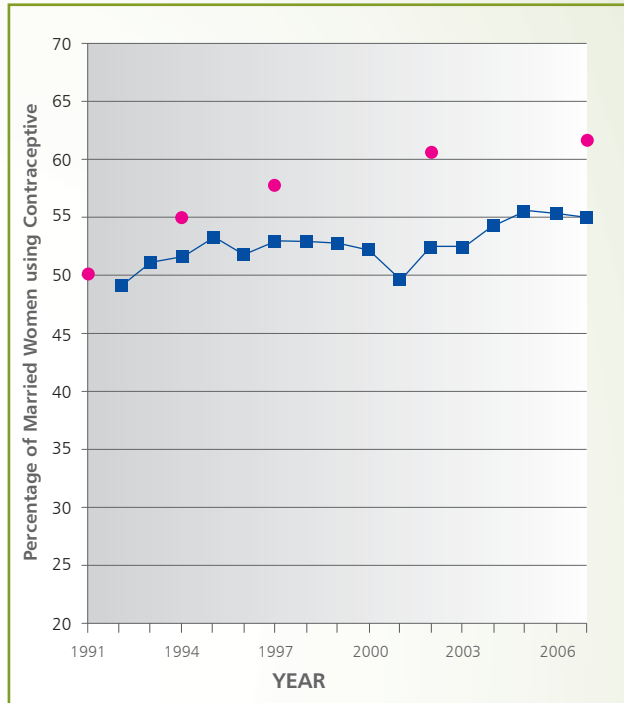
## Trends in Contraceptive Prevalence Rates (CPR)

The credibility gap surrounding fertility data is also found in the data on prevalence of contraceptive use by currently married women, but here the implications are reversed. The CPR on the annual socioeconomic household survey is consistently lower than those found in the occasional DHS, and the gap has been widening over time (Figure 6). This is not surprising since the respondents for the two surveys are different – the DHS interviewers must talk to the woman, while the SUSENAS interviewer may meet with the male head of household or another responsible household member. In the complex extended family units sometimes found in Indonesia it is quite possible that the SUSENAS respondent would not know about the method of contraceptives used by a married in-law, child, niece, or visitor. A few percentage points difference is not a matter of concern.

**Figure 6.** Contraceptive prevalence in Indonesia, 1991-2007

■ Susenas Estimates

● DHS Estimates



Both types of survey, and especially the SUSENAS, do reveal lethargy in the rate of growth of CPR since the mid 1990s. Many commentators talk of “continuing multiple crises” in Indonesia from 1997 to the present. A wide range of social data shows that Indonesia has experience substantial development in the decade since the Asian Financial Crisis of 1997-99. Education levels have been rising steadily, particularly among women. The age at marriage has continued to increase, and the average age at first birth is higher than ever. Women have entered the formal workforce in unprecedented numbers, and a growing number of married women are in salaried employment that takes them away from their homes. All these social changes point to

the growth of demand for contraceptives among women who increasingly want to space or limit births. But almost in defiance of these trends the CPR measured by the last seven annual SUSENAS remained stuck at just over half of married women of reproductive ages.

This picture is likely an indicative of a relaxation in family planning program effort in this decade and is consistent with the fact that since decentralization in 1999 many districts have placed a lower priority on family planning programs. Other evidence for this is the fact that while overall modern method CPR rose slightly between the 2002-03 DHS and the 2007 DHS, it actually declined from 45 to 44 percent among women with no education. Concurrently, knowledge about modern methods declined in this group as well.

## Sources of Contraceptives for Current Users

One of the most successful policy initiatives of the family planning program over the last two decades is the shift of the program from one of universal free access to a user pays system with subsidies built in to ensure access by the poor. This was implemented through a three pronged approach.

The **Blue Circle** set prices for contraceptives which encouraged clients to seek out their own providers, either public or private, with a heavy emphasis on marketing in ways to create a notion of differentiated brands reflecting quality. Poor clients were still given free contraceptives (though there were often charges for registration at clinics or other small fees), but private providers sold contraceptive services at subsidized prices to clients able to pay. The **Gold Circle** services were not subsidized, but promised a high quality product from a highly skilled provider. Market segmentation

was promoted with an emphasis on quality for all, but better quality for those who could pay more.

The challenge of poverty and isolation of large parts of the country was met by a **Village Midwife** program, which trained and placed tens of thousands of young women to provide birthing and family planning assistance in every village. Though initiated by the BKKBN this idea was quickly adopted by the Ministry of Health along with a system of short term contract employment for doctors, midwives and nurses, to ensure staff availability in disadvantaged regions.

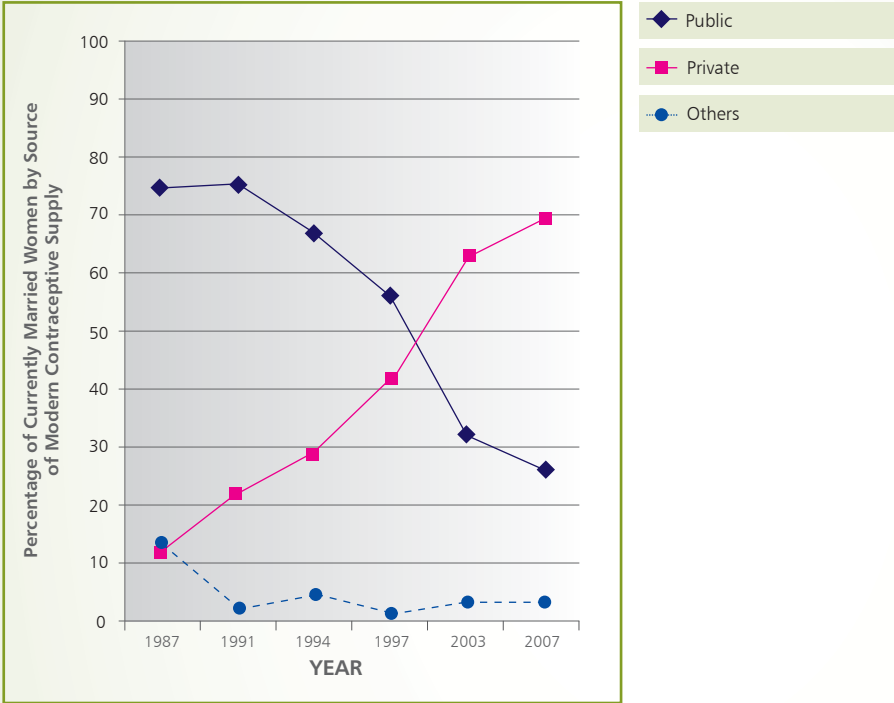
Finally a mixture of **Poverty Alleviation** measures has been implemented to ensure access to medical services including family planning. Sometimes based on cards promising free services, insurance schemes paying for service, or subventions to institutions coupled with requirements that they serve the poor, these schemes are generally based around public facilities, but they sometimes include the private sector.

The scissors shaped lines on the graph in Figure 7 demonstrate the substantial transformation of the family planning service delivery from a public to a private sector dominated system over the two decades between 1987 and 2007. The data on the graph are somewhat different from those shown in DHS reports because the survey categorized village *Pos KB* (*family planning posts*) or *Posyandu* (*health post*) as “other private” sector, but they are actually organized by government officials. Even with these minor changes, it is clear that family planning in Indonesia is now heavily dependent on private institutions and practitioners, with all the implications this has for the possibility of government policy to shape, influence and direct.

In short, not only has control of programmatic initiatives shifted from central to district government authorities, the routine decisions about how women are treated has shifted

from government to private agents. It is thus more important than ever to consider what incentives health professionals have to provide family planning services as well as what 'demands' consumers may have.

**Figure 7.** Source of supply for modern contraceptive methods, Indonesia, 1987-2007



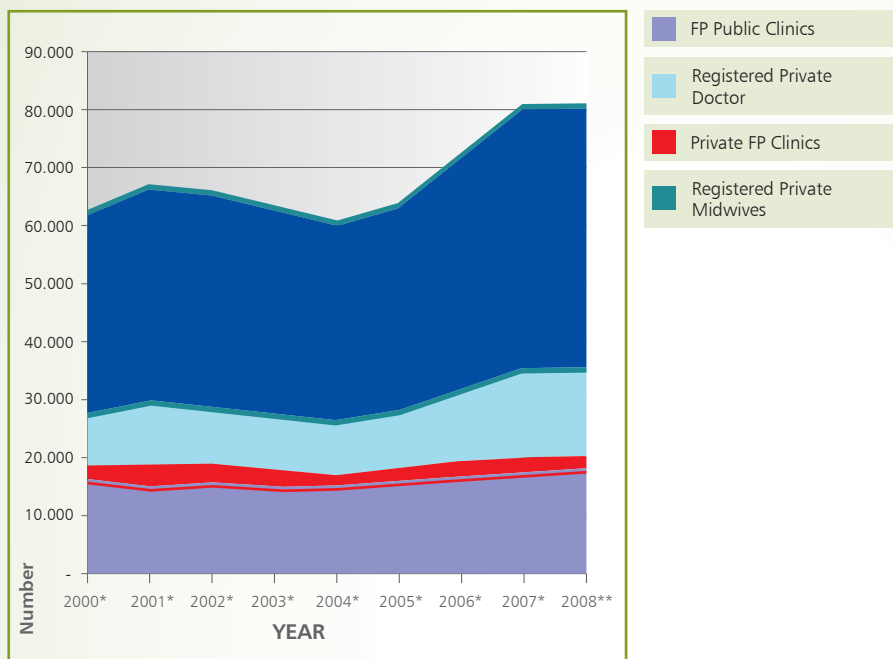
Note: Posyandu and Pos KB desa are shown as "public" in this graph, though they are categorized as "other private" in DHS survey coding.  
Source: Contraceptive Prevalence Survey, 1987 and Demographic and Health Surveys, 1991, 1994, 1997, 2002-3, 2007.

## The Changing Profile of Family Planning Service Providers

Today family planning providers can be seen either as individual professionals, like doctors, midwives, nurses, or pharmacists, or as institutions, like PUSKESMAS (Community Health Clinic), hospitals, Polindes (Village Birthing Post), surgeries, or drug stores. In the 1970s, 1980s and 1990s the program trained an army of volunteers and large numbers of fieldworkers to promote acceptance of family planning and distribute pills and condoms directly to the hamlets where women lived and worked. In recent years government regulations have inhibited the effectiveness of such workers as service agents.

Obviously the institutions are largely dependent on individual professionals to have direct contact with the clients, but the organization of that contact can vary enormously depending on the size and location of the institution. Nurses in a large urban teaching hospital may have day to day responsibility for delivering service under the general supervision of a physician, and there would be a network of professionals overseeing policy and standards for the service. In contrast a midwife running a private practice out of her home would be making decisions to give the injection or distribute the pills that the clients want with little or no oversight by the broader profession.

**Figure 8.** Numbers of Registered Family Planning Service Points



Source: BKKBN Service Statistics, 2000-2008.

Over the time of decentralization the number of institutions registered as part of the BKKBN network of family planning service points has remained fairly steady but the number of private practitioners, both doctors and midwives, has grown overall. The total number of service points is now just on 80,000, compared with around 62,000 just eight years ago (Figure 8). Of course some of the private practices represent government workers who supplement their incomes and serve their communities by running a clinic in the evening.

It is unclear how decentralization has affected these numbers, but the one clear dynamic is the large shift of

contract midwives (*bidan PTT*) to the private sector as their limited term contracts expire. It is estimated that of a total of 67,000 midwives trained under the village midwife programs around 40,000 remain under contract as of September 2008. It is worth noting that there are around 44,000 midwives registered as private practitioners in the BKKBN data system. A portion of these are former contract midwives, some are government workers with after hours practice and some are graduates from private midwifery schools who have never worked for the government.

## Problems of Contraceptive Method Mix

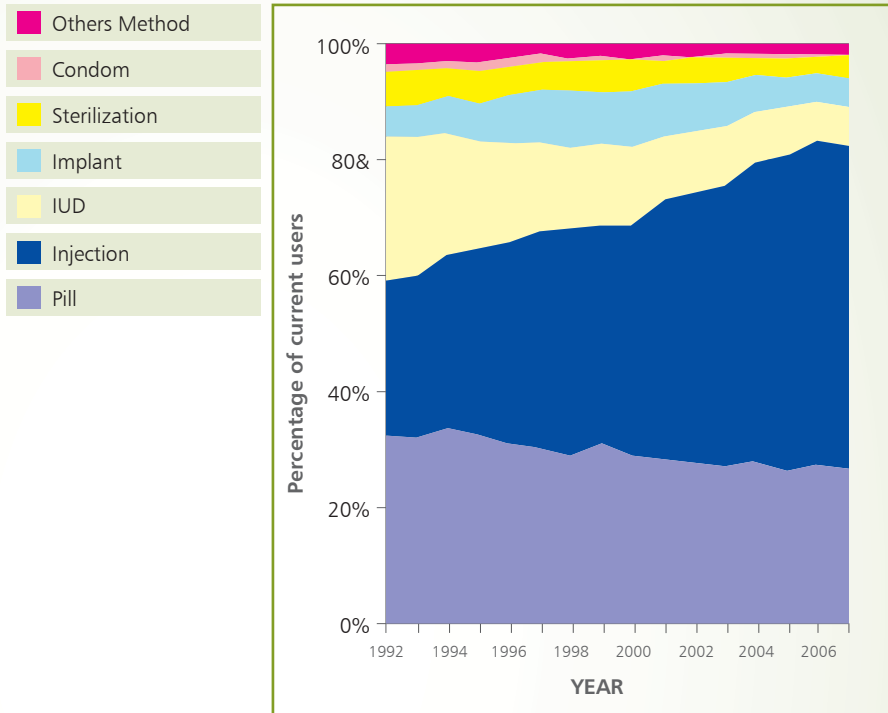
One of the strongest manifestations of a privatized family planning program is found in the transformation of the mix of contraceptives used by women and men over the last fifteen years. The Indonesian program had long offered the widest choice of contraceptives in the developing world, and in most cases the supplies were free. The result was a real 'cafeteria' with couples and providers having good access to very inexpensive methods like pills as well as more expensive methods like implants and sterilization. Among the choices were a wide range of different dosages, allowing the provider to ensure that women with particular biological conditions (like breastfeeding, sensitivity to hormones, or anxiety about gynaecological exams) would have options.

While there was no doubt that Indonesian women did show some preference for injectable contraceptives, many studies also showed that there were large numbers who preferred implants and both men and women were attracted to the benefits of sterilization as methods appropriate to people who have completed their childbearing and not wanting to

continue taking hormones for the rest of their reproductive lives.

The annual National Social and Economic Survey (SUSENAS) shows the relative decline of all forms of contraception except the injectable (Figure 9). (Similar data from the DHS surveys are presented in ANNEX 2.) This occurred coincidentally with the shift from public to private providers. The majority of private providers are not doctors, but rather the village midwives who were recruited, trained and for a brief time contracted by the government to provide services to villagers. When their contracts expired, many of these women transformed themselves into general health providers, offering routine medical care for their neighbours, and relying on a steady stream of clients for their income. The injectables, once a three monthly treatment, but more recently a monthly shot, were an ideal way for the private practitioner to lock in a flow of payments – particularly in contrast to implants which involve only five yearly visits and male and female sterilization which provide a lifetime of protection if properly carried out.

**Figure 9. Contraceptive Mix, Indonesia, 1992-2007**



Source: SUSENAS data sets 1992-2007.

## BKKBN Procurement versus DHS Estimates of CPR

Another issue related to the source of contraceptives is the ultimate source of method procurement. It is important for the central family planning authority to monitor the volume of contraceptives distributed through government channels (whether central or local), private sales via doctors, and private sales direct to users.

**Table 2.**  
**Comparison of DHS based estimate of number of current users of hormonal contraceptives and reported BKKBN procurement of supplies in 2007.**

Methods	2007 DHS Estimate of Current Users	2007 BKKBN Procurement in Person Years of Use	Percentage from BKKBN
Pill	5,624,634	3,725,263	66.2
Injectables	13,550,254	5,164,175	38.1
Implant	1,193,104	786,248	65.9

Source: Calculated from DHS and BKKBN data

In Table 2 a simple comparison is made. Of the nearly 43 million women in the population in 2007, over 20 million were using hormonal methods of contraception, including the pill, injectables and implants. Two thirds of the pill and implant users or about 4.5 million married women, obtained their supplies from the BKKBN. Only one third of injectable users were served by the BKKBN supplies, meaning that 8.4 million users were paying full price through the private sector.



# Reproductive Health Consequences for Women

## A Rising Unmet Need for Contraception

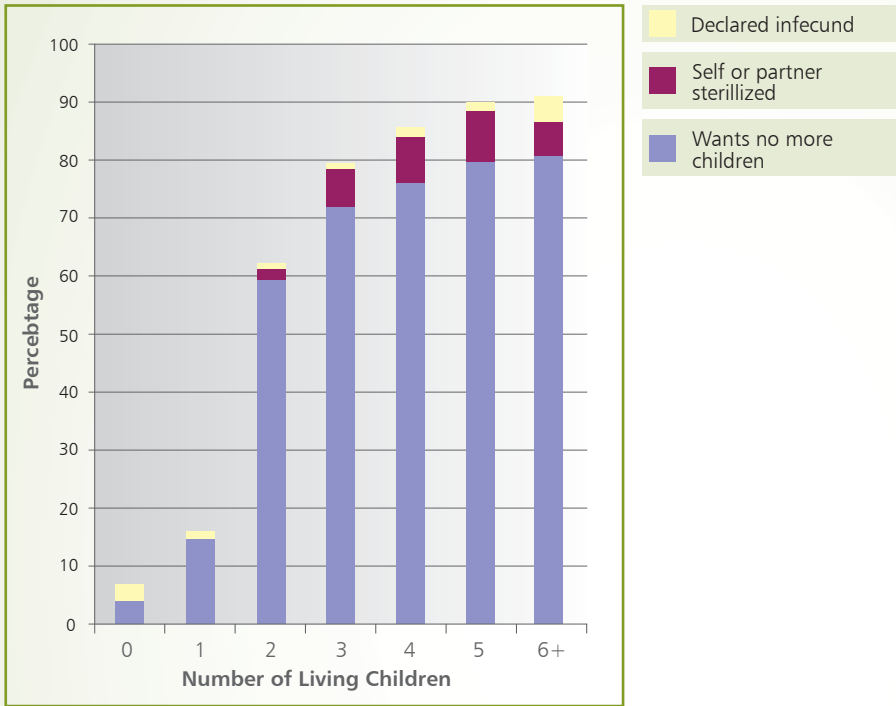
As noted earlier, the overall increase in CPR has almost halted and a significant decline has been observed among uneducated women since 2002-03. Coupled with this has been a disturbing trend in the unmet need for contraception. Between 1991 and 2002-03, the trend in unmet need was favourable, declining from 13 percent to 8.6 percent, but the 2007 DHS showed increase to 8.8 percent for the regions comparable to the 2002-03 survey. It is not surprising that there is a correspondence between the trends in CPR, method mix and unmet need, which together are indicative of a decline in family planning program effort while demand for fertility control is increasing. One consequence of this can be an increase in abortions, as women seek other means to avoid an unwanted birth. This is discussed below.

## **“Met Need” and the Disconnect Between Fertility Preferences and Method Choice**

While we do not have data whether or not women are receiving their method of choice, depending on where they are in their reproductive life cycle, it is reasonable to assume that when women decide that they want no more children, the majority are likely to choose a long acting method like sterilization, IUDs or implants if these methods are readily available at low cost. The alternative is having injections monthly or tri-monthly or taking pills daily for over ten years or more, an option that will be burdensome for women and costly for the program if the contraceptives and costs of provision must be subsidized for the poor. Furthermore, these short-term methods have a higher likelihood of failure compared with the long term methods. This question can be examined indirectly by looking at the fertility preferences of women according to number of living children, and then comparing these findings to the level of contraceptive use and methods mix by parity. These data from the 2007 IDHS are shown in Figures 10 and 11.

Figure 10 shows the rapid decline in the desire for an additional birth as family size increases. Sixty percent of women with two children want to stop childbearing. This rises to around 75 percent for those with 3 or 4 children and over 80 percent for those with larger families. Very few women have either been declared infecund or have had themselves or their partner sterilized. This indicates a very substantial demand for ongoing contraceptive services.

**Figure 10.** Percentages of Currently Married Women Wanting No More Children, According to their Current Family Size

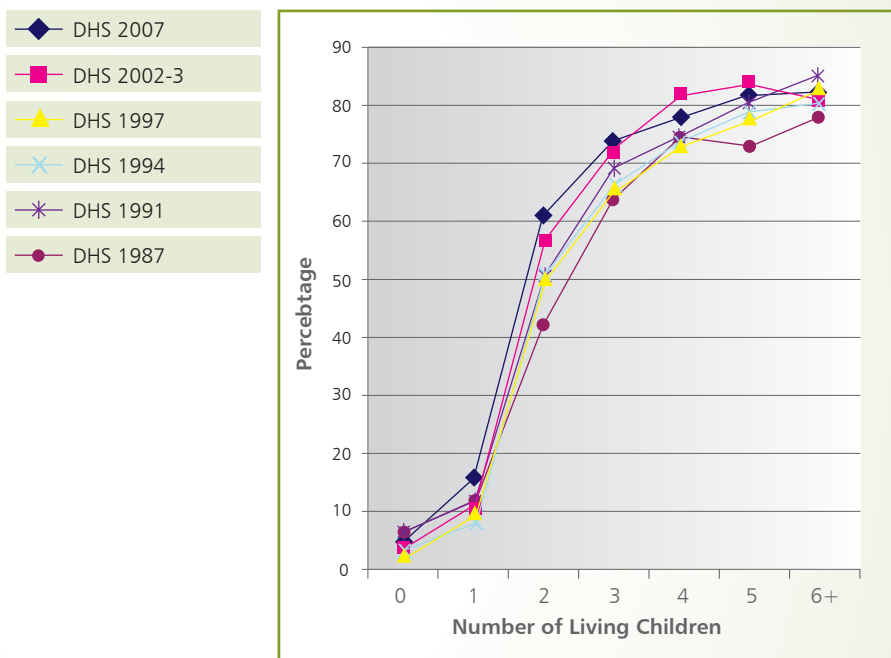


Source: IDHS 2007: Preliminary Report, Table 7.

This pattern of high potential demand for fertility control services according to the family size is not new. As Figure 11 shows, from 1987 to the present, the percentage of women with three or more children who say they want no more pregnancies has consistently been a majority, and over the years the line has pushed higher. This is consistent with an emerging two child family norm. Looking specifically at Parity 2 we can see a major change with just over 40 percent of mothers with two living children saying they wanted to stop childbearing in 1987, and 60 percent, or fifty percent more,

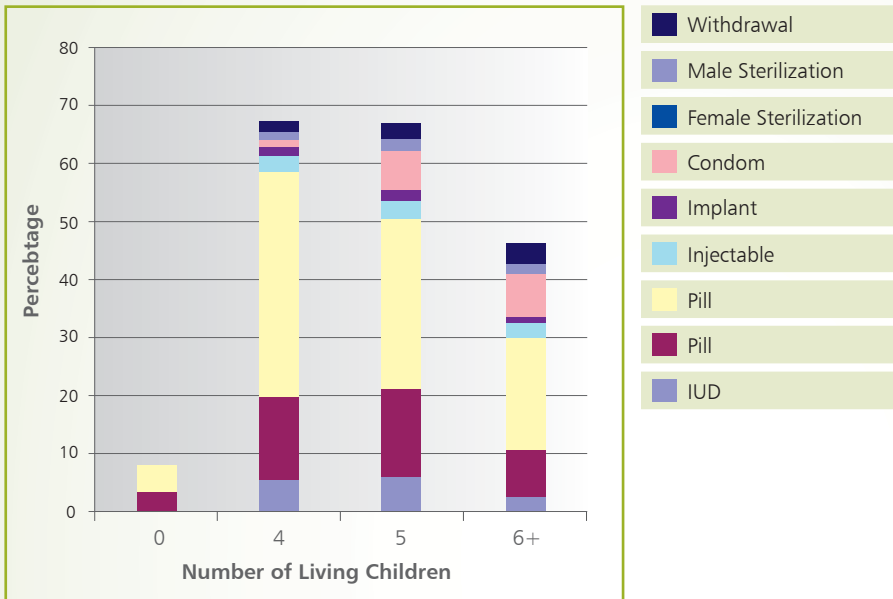
displaying that preference in 2007. Though not shown in the graph, it is notable that the percentage of currently married women with two living children was only 21 percent in 1987, but had risen to almost one third in 2007. This is one area where women's preferences have been changing, and they have changed their actions in concert.

**Figure 11.** Percentages of Women Who Do Not Want Any More Children, According to the Number of Children They Currently Have.



The data on contraceptive use by family size in Figure 12 shows a favourable picture for women with 1 to 2 children – over 65 percent are using contraception, with the vast majority using injectables and pills. This same high level of use is seen for women with 3 to 4 children, but the method mix has hardly changed – injectables and pills still dominate.

**Figure 12.** Contraceptive Method Used by Currently Married Women 15-49, by Number of Children Still Living



Source: 2007 IDHS Preliminary Report, Table 5.

Among older women with the largest families injectables and pills still dominate despite the fact that they overwhelmingly do not want to have further pregnancies. The failure of providers to promote and provide methods that are appropriate to the clients' age, parity and desire for an end to child bearing is perhaps the most striking shortcoming of the program today.

To summarize, we have the situation where fully 50 percent of all married women do not want another child yet the great majority do not have effective access to the most secure methods of fertility control. This is a huge "hidden unmet need" for the method of their choice to avoid another birth

over the remaining decade or more of their reproductive life. Yet because of a program failure to meet this need, these women will be contributing to the majority of unintended pregnancies, many of which will be terminated by unsafe abortions.

## **Unintended Pregnancies Leading to Unintended Births and Abortions**

The most obvious evidence of unmet needs for fertility control among women of reproductive age is the number of unintended pregnancies leading to unintended births and abortions. While there are significant problems in measuring both of these events, there are some estimates of the magnitude of these problems.

In the 2002-03 DHS, married women of reproductive age reported that 17 percent of their births were unwanted or mistimed. This represents about 720,000 unintended births among 4.3 million births occurring annually and implying an even higher number of unintended pregnancies.

It is difficult to gauge exactly how many pregnancies are unintended in any given year. If a woman becomes pregnant by accident or misadventure she may react in a variety of ways, depending on her situation. Many women will accept the pregnancy as a welcome surprise, and will make plans to have the baby. Others will begrudgingly accept the birth as an unwelcome but unavoidable "fate", in the process accepting all the implications this has for her relationships and her life prospect. Many will reject the birth, opting instead to take measures to terminate the pregnancy through the use of a variety of problematic traditional measures, or by recourse to safe professional medical interventions. In making decisions

among these options each woman will be heavily influenced by the cultural, legal, religious and personal dimensions of her life and upbringing, but in the end these influences will not necessarily determine a particular outcome, either in terms of what the woman decides or what impact it has on her own life or the fate of the pregnancy. Chance and risk play a crucial role in pregnancy. In fact, for a fifth to a third of pregnancies a spontaneous abortion or miscarriage will intervene, often well before a woman is even aware that a conception has occurred.

It is very difficult to estimate the number of women who opt to purposefully terminate their pregnancies through induced abortion. In Indonesia various attempts have been made to estimate the numbers through analysis of the most common sources of supply of effective abortion services. While Indonesian women are very familiar with the widely distributed forms of traditional herbal methods of provoking a delay menses (*jamu terlambat bulan*) there is no evidence that these are effective in terminating pregnancy. Hull, Widyantoro and Sarwono (1993) took reports of numbers of potential abortion service workers (traditional midwives, midwives, nurses, doctors and specialist OBGYN) and attributed rough average numbers of abortions per provider to estimate that Indonesia had over 700,000 abortions per year. Later Budi Utomo refined this approach by conducting a sample survey of providers in selected abortion “service delivery points” done in 10 cities and 6 districts across Indonesia in 2000. This provided a national estimate of almost 2 million abortions annually, including both spontaneous and induced terminations (Utomo et al. 2001:21). Two-thirds of the women admitted their abortions were induced; this would translate to about 1.3 million induced abortions annually, or nearly 30 induced abortions for every 100 live births.

Considering the estimates of unintended pregnancies and abortions together with the total births, this would mean

that among 6.3 million pregnancies, 1.3 million were aborted purposefully, and 0.7 million were spontaneously aborted or miscarried. This leaves 4.3 million live births among which 0.7 million were unintended. From both a health and socio-economic perspective, the problem of at least 2 million unintended pregnancies (the total of induced abortions and unintended births) poses major challenges for mothers, families and society as a whole.

The abortion study cited above was revealing in other ways, specifically:

- One-third of the abortion clients were unmarried; this was consistent with the fact that about 36 percent of women said they were aborting their first pregnancy.
- Fifty percent of the women had never used contraception; no doubt the vast majority of these were unmarried women.

These data reinforce the necessity of addressing the contraceptive needs of sexually active unmarried women (and men).

One final point; in the rural areas the vast majority (77 percent) of induced abortions were done by unqualified providers (*dukun bayi* or traditional birth attendants), posing a great risk to the women. Noteworthy, in the urban areas, the single largest provider of induced abortions were family planning clinics, accounting for 47 percent of reported procedures. This is an interesting observation, considering that abortion is not officially condoned by the national family program, but it reflects the fact that family planning NGOs, university supported specialist family planning clinics, and some private providers are known to offer abortion services, though with a minimum of publicity.

We can reasonably assume that most if not all abortions done by unqualified providers did not receive post-abortion

care including family planning services to prevent subsequent pregnancy. But since even abortions done by qualified providers in family planning clinics are not officially monitored, there is no way of knowing if their clients received post-abortion contraception, or if they were counselled on ways of protecting themselves from sexually transmitted infections. The confused legal status of abortion, and the widespread concern amongst Indonesia's moral guardians implies that this would be a difficult issue to tackle directly, but if it is not addressed the nation will continue to deal with thousands of deaths and untold morbidity caused by unsafe abortions.

## **Clarifying Adolescent Family Planning and Reproductive Health Needs**

Indonesia has long carried out projects and activities targeting adolescents. However, unlike the situation in many African and Latin American countries, these interventions have not addressed the realities of young adult sexual behaviour, and contraceptive services have been restricted to adolescent women who are legally married.

In Table-3 the first row shows how the number of married adolescents in the DHS has declined over the last decade and a half even as the total sample size of women listed in the household has increased from 38,000 to 45,000. If the DHS captured all women of reproductive age in the sample, they would have likely recorded around 9000 adolescent (15-19) women in recent surveys. However, because they missed between 2400 and 2900 women in the last two surveys, representing one third of all single adolescents, the picture that emerges on unmet reproductive health service needs is very skewed.

The published figures of unmet need among 15-19 year olds fell from 13.7 in 1994 to 6.8 percent in 2002-3, before rising to 9.8 percent in 2007. However these numbers only refer to the dwindling number of married adolescents. If the program were to address the reproductive health service needs of single adolescents the total number of potential adolescent clients would grow enormously. Essentially today 92.4 percent of this group is unserved by the system, and this represents a large “unmet need”. Until some way of ensuring that all women of reproductive age have the same rights to information, services and supplies, the twin problems of unwanted pregnancy and untreated reproductive tract infections will continue to grow.

**Table 3.**  
**Family Planning Services and DHS Sample**  
**for 15-19 Year Old Women**

Indonesian DHS				
	1994	1997	2002-3	2007
<b>Married women aged 15-19 in DHS Sample</b>	<b>1291</b>	<b>1246</b>	<b>912</b>	<b>814</b>
<b>Using contraception (%)</b>	<b>36.4</b>	<b>44.5</b>	<b>47.3</b>	<b>46.8</b>
to space	34.7	43.6	43.5	41.8
to limit	1.7	0.9	3.8	5.1
<b>Unmet Need (%)</b>	<b>13.7</b>	<b>9.1</b>	<b>6.8</b>	<b>9.8</b>
to space	12.7	9.0	6.4	7.3
to limit	1.0	0.1	0.4	2.5
<b>Total demand met and unmet</b>	<b>51.3</b>	<b>54.1</b>	<b>54.3</b>	<b>56.6</b>
<b>Singles aged 15-19 eligible for DHS household listing</b>	<b>na</b>	<b>na</b>	<b>8000</b>	<b>8885</b>
<b>Included in sample</b>	<b>6216</b>	<b>5992</b>	<b>5577</b>	<b>5949</b>
<b>Missing from sample</b>	<b>na</b>	<b>na</b>	<b>2423</b>	<b>2936</b>
<b>Percent missing</b>	<b>na</b>	<b>na</b>	<b>30.3%</b>	<b>33.0%</b>

# The Family Planning Program – Past, Present and Future

## Past Operational Structure of the Family Planning Program

The Indonesian national family planning program began with the establishment of National Family Planning Institute (LKBN) in 1968 that changed to the National Family Planning Coordinating Board (BKKBN) in 1970. Key elements of the national family planning program in the period prior to decentralization included:

1. A strong central agency (BKKBN) with direct access to, and strong support by the President
2. Strategic, financial and technical support from the international donor community
3. Highly qualified professional staff at the centre – oriented to introducing innovations in a “learning by doing” mode
4. A mandate to coordinate all government agencies and private groups to support the national family planning program – with a budget to support this mandate
5. An ability to organize vertical programs from the central level to the village, with lines of control and structures for implementation of actions
6. A working relationship with the Ministry of Health to provide the technical services for the contraceptive program in hospitals, clinics and outreach facilities

7. A growing structure of field operations, ultimately with 37 regional training centres, 25,000 trained and salaried family planning field workers (PLKB) and over 100,000 local family planning volunteers (PPKBD), 40,000 of whom re-supplied pills and condoms from their homes.
8. Funds and a national distribution system to provide contraceptive commodities and related supplies and equipment for the national program.

In addition to building a large public sector family planning program, in the early 1980s BKKBN began a strategy to develop private sector services – first in the urban areas with the Blue Circle (*Lingkaran Biru*) and then more broadly with the concept that family planning clients should be self-reliant (*KB Mandiri*) and pay something for services (public and private). Following this was a program to greatly expand the availability of midwives in the rural areas to provide services to private sector clients. This led to a great expansion of village midwives (*Bidan Desa*) to upwards of 75,000 by the late 1990s who became the major providers of services in the rural areas.

## Changes with the New Government and Decentralization

The intrinsic vitality of the national family planning program by the late 1990s was evident by the fact that during the economic crisis of 1997-2000, there was no measurable diminution in contraceptive use. The crisis and related political events led to the resignation of President Soeharto in 1998. This was followed by a series of political and administrative changes that had a major impact on the operations of BKKBN. These included:

1. Professor Haryono Suyono, who had been a key leader in BKKBN since its inception was elevated to Coordinating

Minister for People's Welfare in 1998 in the Cabinet under President Habibie

2. The government passed decentralization legislation in 1999 and major ministries (e.g., Health and Education) began to implement regulations to divest themselves of centralized implementation duties in 2001
3. BKKBN was granted a waiver and so did not decentralize until January 2004. With decentralization, the BKKBN district offices were moved in most cases. In some districts the responsibility for family planning came under the office of Health, or Population, or Civil Registration, or Women's Empowerment or some combination of these. The PLKB (Family Planning fieldworkers) were also shifted to other offices, and some no longer worked in contraceptive delivery or community promotion activities.
4. At the time of decentralization in 2004, BKKBN, with the Ministry of Health and the Ministry of Home Affairs established minimum standards for maintaining the quality of the family planning services at the district level and developed a guide book for managers that explained the responsibilities and regulations
5. In 2003, USAID, a major donor, decided to phase out technical support on the grounds that Indonesia had "graduated" from the need for bilateral assistance. This was completed in 2006.
6. Indonesia's Medium Term Development Plan (MTDP) 2004-09 recognized the importance of Family Planning services for "reducing the total fertility rate."
7. Government Regulation (PP) 38/2007 stipulated that Population and Family Planning are among 31 obligatory functions at Central/Provincial and District/Municipal levels, along with, but separate to health.
8. Government Regulation (PP) 41/2007 stipulated that Population, grouped with Civil Registration should be structured at the level of an Institution (*Lembaga*), and that Family Planning, grouped with Women's Empowerment

should be structured at the level of a Board (*Badan*) or an Office (*Kantor*) level. Health was to continue in the form of an Office (*Dinas*) and would be responsible for clinical services.

BKKBN's loss of central control of family planning with decentralization did weaken program effort as is evident from the data on contraceptive method mix, prevalence and unmet need presented earlier. The emphasis on family planning in the MTDP and the subsequent Government Regulations promulgated in 2007 are designed to strengthen the Family Planning program, though there has not been sufficient time to observe the effects of these directives. However, it is already clear that strong national leadership with a new agenda will be required to address the emerging problems that have been identified in the analyses above.

The decentralized government structure does present challenges for a central agency interested in promoting family planning programs and population policies. BKKBN must find new ways to engage the district/municipal authorities, relevant ministries (especially Health) and private providers to ensure that every woman has the information, contraceptive methods and related fertility control services she needs to meet her reproductive goals at every stage in her life cycle.

## **Developing a New Vision, Mission and Values**

The transformation of the authorities and operations of the agencies of Government of Indonesia accomplished by the decentralization over the past nine years requires a corresponding transformation in the "ways of getting things done" by those persons at the central level who formerly

operated with direct administrative powers over operations at the provincial and district levels. This requires a deep change in mindset from “command and control” to an approach that:

- 1) engages others in a shared vision of a future that all will commit to work for;
- 2) creates an environment characterized by teamwork, trust, open-mindedness; transparency and shared accountability for all outcomes; and
- 3) encourages mutual learning drawing on the perspectives and experiences of a diverse group of stakeholders, through an ongoing critical analysis of program performance.

Basically, this requires the development of leadership skills to engage people who do not work *for* you to ensure that they work with you to reach mutually held goals.

The first step in organizational transformation to meet new challenges in a changing environment is to re-examine the Vision, Mission and Values.

The **Vision** is a concrete picture of the future that the organization seeks to create. It should make clear what is important for the organization and what is not. Most importantly, it should inspire people to take action, and create new levels of energy.

The **Mission** statement provides the focus for the organization’s efforts. This is essential since every organization has limited resources and cannot do everything necessary to reach the Vision. Focus demands sacrifice; this means giving careful consideration not only to new activities, but also to current activities that the organization should no longer be doing.

The **Values** are the foundation of all the organization's efforts. These will guide the organization, especially when confronting social and cultural barriers. In the case of family planning, the bases for these values come from international conventions that Indonesia has signed including the International Convention of Human Rights and the Cairo Declaration in 1994 among others.

BKKBN has articulated a Philosophy, Vision, Mission and Values in recent years, but these must be re-examined to see their relevance to the current situation. The current version is as follows:

<b>Philosophy</b>	Encourage the participation of the community in family planning
<b>Vision</b>	The whole family supports family planning
<b>Mission</b>	To create small prosperous and happy family
<b>Values</b>	<i>Smart</i> : Acts quick, precise, effective and efficient. <i>Tough</i> : Able to survive and recover immediately in difficult condition. <i>Partnerships</i> : To build networks and work out cooperation by mutually advantageous principles.

These operating principles have served BKKBN in the past, however given that there has been a fundamental change in the government structure and that disturbing new demographic and contraceptive trends are emerging, serious consideration needs to be given to totally revising these statements.

*A critical first step in organizational transformation is to engage everyone in a process of reformulating the Vision, Mission and Values that will provide the basis for everything that they do. Because this process and the outcome must*

be “owned” by the members of the organization itself, we are only presenting an outline of some of the key issues that should be considered.

**A. Vision** – What is the future we want to create? The focus here must be on the specific elements of prosperous Indonesia in the future where BKKBN can make a contribution.

Based on the data provided above, it seems clear that the long term goal for the future needs to move away from the current policy of restricting family planning services to married couples towards *reaching every sexually active person both men and women*. In particular, every woman of childbearing age, - married or unmarried, rich or poor - must have the knowledge and full access to method(s) of her choice to control her fertility and protect herself from sexually transmitted diseases at every stage of life. Related elements of this Vision should include a society where all family members and community and national organizations, public and private, secular and religious, are committed to this goal and are taking actions to ensure that equity and access are promoted for all citizens.

**B. Mission** – Why do we need a central organization working on family planning and reproductive justice in a decentralized system? The Mission identifies the essential purposes (objectives) of a restructured and reinigorated BKKBN.

The proposal here diverges from the current Mission statement of BKKBN. The reason is that the current statement could more appropriately be defined as the Mission of the entire government of Indonesia. An organization’s Mission statement must have focus and specificity in order to justify the reasons for the organization’s existence. The process of formulating the

Mission statement will provide the foundation defining the critical functions of the transformed organization.

Key tasks that can only be done centrally involve such things as:

- a. Collaboration - Working with other Ministries at the national level to ensure that policies, strategies and standards are developed and coordinated and that funds are appropriated as required
- b. Data analysis for informed action including:
  - i. Monitoring and analysing data covering critical program activities at the provincial and district/ municipal levels from service statistics and other sources to get a national picture of the progress of the program and areas requiring interventions, and providing rapid feedback
  - ii. Analysing relevant national data from other agencies that are consequential for reaching the family planning goal
  - iii. Generating original data from surveys, focus groups and other sources to gain a deeper understanding of the social, economic and cultural underpinning of the family planning program
- c. International networking- Learning about international trends and innovations in family planning that can be adapted to the local context
- d. Communication and behaviour change – Designing communication strategies that are to be applied nationally to improve program performance
- e. Training and technical assistance to build local skills in program leadership including planning, management and evaluation
- f. Research – to develop a deeper understanding about provider and client behaviour and to introduce innovations

- g. Advocacy - Being a voice for the program at national and international levels

Consideration must also be given to tasks that should no longer be done at the central level, since these divert attention and resources from the core Mission. For example, because the central organization will not have any direct operational control over field operations, it should not be doing tasks related to program implementation, for example, management of field staff and distribution of commodities. Since these tasks have already been devolved to the districts and municipalities, the new challenge is to develop standards and procedures to ensure that the program will perform satisfactorily under local control. In fact, in all matters related to service delivery, close collaboration with the Ministry of Health will be essential (see ANNEX 3).

A revitalized family planning program central agency's Mission is complicated by the multiple levels of government it will deal with, and the multiplicity of agencies concerned with reproductive health and rights at each level, and the wide range of professional skills required to carry out the mandate.

We have struggled to gain a clear understanding of training and finances in the current Family Planning Program. Consider Table 4:

**Table 3.**  
**carried out by the BKKBN, 2004-2007**

Type of training	2004	2005	2006	2007	Total
Leadership	1208	790	465	1401	3864
Management	3623	5528	8895	9806	27852
Research and Policy	640	1810	1868	903	5221
Medical technique	376	965	1650	1690	4681
IPCC IEC	3045	2957	3130	1806	10938
Fieldworker (LDU)	5850	5592	8424	3148	23014
Total	14742	17642	24432	18754	75570

Source: BKKBN offices.

Ideally we would like to see the numbers of trainees each year according to type of training and level of government – central, provincial, district and below district. Such breakdowns are not centrally available for a comprehensive monitoring of training related to the Family Planning Program.

Instead it is necessary to contact a range of different units to obtain figures for the training they carry out under their various budget lines, including: PULAP, PULIN, PUSJA, PUSNA, PUSRA, DITREM, DITMAS, DITTEK, DITYAN, BIKPA, BIBEK. While we tried to compile this information, it seems clear that there is no standard metric used by all units, and many groups have lost or have never collected any detailed data on the training they funded. As might be imagined each unit has different ways of recording and reporting the data, and for many units training is not a central concern, so they do not pay much attention to monitoring who is being trained.

There is no central BKKBN effort to monitor the training of medical personnel in contraceptive technologies. Instead it is assumed that the professional associations such as IBI, POGI and IDI will have such information. Unfortunately they do not. There is no way for central planners to know how many provincial and district doctors are certified to do vasectomies, how many midwives are up to date with training on implants and injectables, or how many surgeons are available to do tubectomies. The central agency needs new methods to ensure that such complex information is collected, analysed and maintained in a systematic way.

Similarly, financial analysis is very complex, and decentralization makes it all the more so. A true accounting of the family planning program would necessarily include funds from the central budget (APBN) for the BKKBN and parts of the Department of Health; provincial and district budgets (APBD); Direct transfers for Special Purposes (Block Grants or DAK), fees paid by clients to government service providers, and fees paid for private services. A study by the World Bank and BAPPENAS (2008) revealed the complexity of financial analysis of the health service sector, and could well serve as a model for a study of family planning and reproductive health, and a guide for the creation of a system of monitoring and analysis.

### **C. Values** – How are we going to carry out our mission?

Here the discussion must centre on formulating the basic principles that will underpin how the organization will go about achieving its objectives. The core value is to put the welfare and choices of women in the forefront of every operational decision. For example, there may be competing “professional” values such as restrictions on non-medical people providing oral contraceptives that will need to be confronted if these medical barriers limit

access to services, particularly among the poor. Another challenge will be from cultural and religious traditions that may restrict fertility control options - such as providing family planning services to unmarried women and men and assuring safe pregnancy terminations and post-abortion care. Ultimately these will need to be addressed, since failing to do so may wreck a woman's future or even threaten her life. Here is where research clearly documenting the consequences of failing to meet these needs will be an essential foundation for addressing these issues.

The BKKBN's current statement of *Values* mentions partnerships almost as an afterthought. A new statement would make working in partnerships a central value in the new, decentralized environment. There must be the commitment to collaboration with a wide variety of stakeholders with different interests.

Another Value must be openness to listening to the voices of people at every level in society – not just the leaders, but ordinary people, especially the poor and disadvantaged women who are, in fact, the most important stakeholders of all.

## **A Future Agenda for a Revitalized Family Planning Program**

The main thrusts and accomplishments of the family planning program in the last century up to the present have been summarized above. An agenda for the future in a decentralized government, taking into consideration the challenges evident from recent trends in the survey data and program statistics, must include building mutually productive relationships with key stakeholders. Among these stakeholders are:

- a. Local political leadership and family planning and health services program managers in the districts and municipalities
- b. Ministry of Health, Ministry of Women and Development, and Ministry of Home Affairs officials, among others
- c. NGOs, particularly professional groups such as IBI, POGI, PKMI, PKBI, religious groups and women's organizations
- d. Private sector enterprises
- e. National political leaders from all parties

These relationships should all be designed to achieve the following goals:

- a. *assuring that the family planning program has expanding resources and qualified personnel to provide for the needs of a growing population of women of childbearing age*
- b. *identifying and serving all childbearing women with an unmet need for contraception, especially in more deprived districts*
- c. *promoting policies and developing program strategies to ensure that long acting contraceptive methods, especially IUDs and sterilization, are readily available to the population*
- d. *meeting the information needs of adolescents, both male and female, who are not yet sexually active*
- e. *developing policies and programs to ensure that contraceptive information and services are provided for all sexually active unmarried women and men, including adolescents*
- f. *directly addressing the problem of abortion including:*

1. disseminating information about emergency contraception and increasing the availability of these products
  2. generating support for high quality post-abortion care that assures that all women get appropriate contraception
  3. developing the data to support advocacy for policies to ensure the availability safe abortions and to reduce unsafe abortions
- g. developing policies in collaboration with the MOH, relevant professional organizations and the district authorities to monitor and improve the performance of private sector providers*
- h. initiating a staff development program that builds the leadership, management, service delivery, analytical and communication skills in the districts/ municipalities and the provinces to the level required for the family planning program to accomplish its objectives*

# R Recomendation

## 1. Reformulate the Vision, Mission and Values

This is an essential first step in organizational transformation, since it sets the course for everything that follows. This process should be supported by data and involve a wide range of staff in the organization as well as outside stakeholders with vital interests in the reproductive welfare of women. The process should not be rushed, and should not be looked on as a forum where various parties can justify their own interests. (An outside facilitator can be helpful in this process.) Through this process a new identity will be created for the BKKBN, and it is likely that a change of name and structure will emerge, though that is an issue beyond this consultancy.

## 2. Begin the process of building the core analytical and technical competencies related to family planning in the decentralized and mixed public private system of governance that has emerged since 1998.

The central government needs to take the lead in promoting core competencies at all levels of government and in both the public and private spheres. In particular a **central agency concerned with revitalizing FP** will need to harness the social and behavioural sciences including disciplines such as demography, sociology, anthropology, economics, political science, communication and management (financial, personnel,

policy formulation, etc.). These skills are required to analyse and interpret data being regularly generated by a wide variety of external sources (including BPS, DEPKES, BAPPENAS, DIKNAS, and Home Ministry) as well reports from district/municipal and provincial level activities. These analytical skills are crucial for development of strategies, setting standards, monitoring program performance, identifying program constraints, improving provider performance, understanding how to effectively reach and serve women and men with an unmet need for FP, and, most importantly, for advocacy. The BKKBN has some nascent skills in these areas, but lacks the breadth, depth and focus to achieve the quantity and quality of work required.

### **3. Develop a senior leadership advisory structure**

In order to gain the commitment of key stakeholders and maintain a central agency charged with revitalizing the family planning, reproductive health, and population program on course, key stakeholders should be recruited to advise on all major policy and programmatic decisions. These stakeholders would be organized in practical working groups and could include selected representatives from: the central government including the Ministry of Health, Ministry of Women and Development, Home Ministry, BAPPENAS, and legislative branch members; representatives from a number of local governments representing a variety of cultural and economic conditions; NGOs like IBI, POGI, PKBI, IDI; major research universities; religious organizations; major representative private enterprises (ideally led by women); and from the wider society, e.g., the press.

### **4. Initiate leadership capacity building for reproductive health and family planning in the districts/municipalities**

This must be a collaborative effort with the Home

Ministry, the Ministry of Health and the State Ministry of Women's Empowerment. This will ensure cooperation with the *Bupati and Walikota*. Working together through a network of training centres, coherent courses in leadership and management should be developed to teach the significance of family planning to overall development goals, best practice methods to ensure financial adequacy for service systems, and the techniques for ensuring quality of care.

**5. Strengthen the role and functions of the new Offices/Boards of Family Planning and Women and Development that have superseded the previous BKKBN offices**

In collaboration with the Ministry of Health, build the planning, managerial and data analysis skills by providing training, on-going technical assistance and routine two way communication.

**6. Promote initiatives to increase nationally and locally the availability and accessibility of long acting contraceptives – IUD, implants and sterilization – to all couples.**

The current program of contraceptive delivery gives too many provider incentives for the use of injectables, and too little support for vasectomy, implants and tubectomy. Appropriate interventions to support long acting contraceptives will require strong policies at the central level, and effective financing and cooperation at the local level. In particular attention will have to be paid to health insurance schemes to ensure they cover long acting contraceptives in their policies.

**7. Formulate program policies and develop operational strategies in collaboration with the Ministry of Health to meet the critical service delivery needs including:**

- a. Reaching disadvantaged women including women with an unmet need for contraception with information and services
- b. Engaging the private sector with training, technical assistance and incentives to ensure that all women can choose the contraceptive method best for their life stage
- c. Assuring that women are not forced to undergo unsafe abortions, and that all women terminating a pregnancy are provided with contraception.

Since this involves private as well as public service delivery, this must be done in close collaboration with the Ministry of Health, engaging professional associations, government and private health insurance agencies and the pharmaceutical industry (See ANNEX 3 regarding the rationale for close collaboration with the Ministry of Health.) Because this will no doubt require investments in a major restructuring of provider incentives, any changes should involve cost-effectiveness and cost-benefit studies before being implemented on a wide scale.

- 8. A central agency charged with responsibility for family planning and reproductive health should place a high priority on monitoring public and private program performance (from service statistics and surveys) with interpretation and rapid feedback to districts/municipalities.**
- 9. Develop and promote national communication strategies focusing on the major unmet needs and unreached groups.**
- 10. The agency should also test and introduce innovations, primarily through grants to universities, private organizations and NGOs as**

**appropriate.**

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

**11. The agency should encourage districts/municipalities to innovate and take other actions to strengthen the program, primarily through “block grants”.**

These grants must be based on action plans and budgets that may be developed with technical assistance from the centre and provinces.

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

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



# ANNEX.1

Adjusting DHS Fertility for the Missing Single Women

When looking into the algebraic source for an adjustment it is possible to achieve the same result in two distinct ways. First we can solve for the missing single women, represented in Table A1 as **x**.

Start with the basic entity that the proportion single in the DHS (ds) in each age group can be represented as  $D_s/D_w$  (Single women in the DHS divided by all women in the DHS), for each age group. Then the proportion single in the DHS population if all the single women were restored to both the numerator and the denominator to achieve the same proportion single as found in the recent census enumeration (cs) gives us:

$$cs = (D_s+x)/(D_w+x)$$

$$D_s+x = (cs * D_w) + (cs*x)$$

$$x-(cs*x) = cs*D_w - D_s$$

$$x(1 - cs) = cs*D_w - D_s$$

$$\mathbf{x = [(cs * D_w) - D_s]/(1-cs)}$$

This calculation is shown for the two most recent DHS in Table A1.

**Table A1.** Estimation of total number of women if reflecting recent census based marriage patterns -- solving for missing single women:  
 $x = [(cs * Dw) - Ds] / (1 - cs)$

### 2002-03 DHS Estimate

	DHS numbers recorded by age group	DHS single recorded by age group	DHS Proportion single in age group	2000 Census Proportion single in age group	Estimate of missing women	Adjusted total DHS women
	Dw	Ds	ds	cs	x	D'
15-19	6715	5735	0.8540	0.8927	<b>2423</b>	9138
20-24	6738	2776	0.4120	0.4312	<b>227</b>	6965
25-29	6302	870	0.1380	0.1667	<b>217</b>	6519
30-34	5844	345	0.0590	0.0695	<b>66</b>	5910
35-39	5349	160	0.0300	0.0349	<b>27</b>	5376
40-44	4704	99	0.0210	0.0241	<b>15</b>	4719
45-49	4170	83	0.0200	0.0198	<b>-1</b>	4169
All WRA	39822	10068	0.2500	0.2870	<b>2974</b>	42796

### 2007 DHS Estimate

	2007 DHS numbers recorded by age group	2007 DHS single recorded by age group	2007 DHS Proportion single in age group	2005 SUPAS Proportion single in age group	Estimate of missing women	Adjusted total 2007 DHS women
	Dw	Ds	ds	cs	x	D'
15-19	6849	5949	0.8686	0.9080	<b>2936</b>	9786
20-24	7040	2693	0.3825	0.5142	<b>1908</b>	8948
25-29	7156	1099	0.1535	0.1974	<b>391</b>	7548
30-34	6730	468	0.0695	0.0810	<b>84</b>	6814
35-39	6473	235	0.0364	0.0431	<b>45</b>	6518
40-44	5722	148	0.0259	0.0255	<b>-2</b>	5720
45-49	5127	96	0.0188	0.0197	<b>5</b>	5132
All WRA	45098	10689	0.2370	0.2879	<b>5368</b>	50466

An alternative approach suggested by Professor Peter McDonald solves for the adjusted total population of women in each age group rather than the number of missing women. The numbers missing can be derived from the difference between the recorded and the adjusted populations ( $Dw' - Dw$ ).

The basis of the calculation is the ratio of the percentage ever married in the each age group of DHS population and the percentage ever married in the census population. The ratio of the absolute size of the recorded and adjusted populations ( $Dw'/Dw$ ) is assumed to be the same as the ratio of percentages ever married:  $de/ce$ . To solve for  $Dw'$  we calculate  $Dw*(de/ce)$  as shown here:

**Table A2.** Estimation of total number of women if reflecting recent census based marriage patterns -- solving for missing single women:  
 $Dw' = Dw*(de/ce)$

	2007 DHS numbers recorded by age group	2007 DHS Percentage ever married in age group	2005 SUPAS percentage ever married in age group	<b>Adjusted total 2007 DHS women</b>	Implied Estimate of missing women
	Dw	de	ce	Dw'	x
15-19	6849	13.1	9.2	<b>9786</b>	2936
20-24	7040	61.7	48.6	<b>8948</b>	1908
25-29	7156	84.6	80.3	<b>7548</b>	391
30-34	6730	93.0	91.9	<b>6814</b>	84
35-39	6473	96.4	95.7	<b>6518</b>	45
40-44	5722	97.4	97.4	<b>5720</b>	-2
45-49	5127	98.1	98.0	<b>5132</b>	5
All WRA	45098	76.3	71.2	<b>50466</b>	5368

Comparison with the bottom panel of Table A1 shows that the same result is obtained for both the estimate of missing women and the adjusted total number of women for the 2007 DHS.

## Adjusting the fertility rates for missing single women

The census based estimate of missing women allows the reconstruction of age specific and total fertility rates for the 2002-3 DHS. In the Main Report the method used for calculating fertility rates indicates that:

*Numerators of the ASFRs are calculated by summing the number of live births that occurred in the period 1 to 36 months preceding the survey (determined by the date of interview and the date of birth of the child) and classifying them by the age (in five-year groups) of the mother at the time of birth (determined by the mother's date of birth). The denominators of the rates are the number of woman-years lived in each of the specified five-year groups during the 1 to 36 months preceding the survey. Since only women who had ever married were interviewed in the IDHS, the **numbers of women in the denominators of the rates were inflated by factors calculated from information in the Household Questionnaire on populations ever married in order to produce a count of all women. Never-married women are presumed not to have given birth.** (IDHS Main Report, 2003:43)*

In Table A3 the published age specific fertility rates and the calculated numbers of women recorded in the Household Questionnaire are used to estimate the annual number of

births for all women in 2002, assuming no decline in fertility over the period 2000-2002. Then the annual fertility rates are recalculated using the adjusted numbers of women who should have been listed in the DHS Household Questionnaire if the 2000 Census marriage patterns had prevailed for the 2002-03 DHS.

Where the 2002-03 DHS Main Report showed a TFR of 2.57, adjusting the fertility rate for missing single women produces a TFR of 2.35 for the three year period 2000-2002 (centred on 2001). This is slightly below the trend line for census-type own-child calculations of fertility.

A similar adjustment applied to the 2007 DHS using the marital status distribution from the 2005 SUPAS produces a TFR of 2.33 for the period from 2005-2007 centred on the point estimate for 2006.

**Table A2.** Adjustment of ASFR and Total Fertility Rate for the 2002-3 DHS and the 2007 DHS

2002-03 DHS Estimate					
Adjustment of 2002-03 DHS ASFR and Total Fertility Rates					
Age of mothers	Current Fertility rates of 2002-3 DHS Final Report (2000-2002)	Women recorded in 2002-3 DHS	Annual births implied by fertility rates and number of women in 2002-03	Women adjusted for 2000 Census marital status	Adjusted 2002-03 DHS Fertility Rates using 2000 Census based estimate of women
15-19	51	6845	349	9138	38
20-24	131	6422	841	6965	121
25-29	143	6134	877	6519	135
30-34	99	5484	543	5910	92
35-39	66	5127	338	5376	63
40-44	19	4361	83	4719	18
45-49	4	3500	14	4169	3
<b>Total</b>		<b>37873</b>	3046	42796	
<b>TFR</b>	<b>2.57</b>				<b>2.35</b>

2007 DHS Estimate					
Adjustment of 2007 DHS ASFR and Total Fertility Rates --					
Age of mothers	Fertility rates of 2007 DHS Final Report (2005-2007)	Women recorded in 2007 DHS	Annual births implied by fertility rates and number of women in 2007	2007 DHS Women adjusted for 2005 SUPAS marital status	Fertility Rates with 2005 SUPAS based estimate of women
15-19	51	6849	349	9786	36
20-24	135	7040	950	8948	106
25-29	134	7156	959	7548	127
30-34	108	6730	727	6814	107
35-39	65	6473	421	6518	65
40-44	19	5722	109	5720	19
45-49	6	5127	31	5132	6
<b>Total</b>		<b>45098</b>	3546	50466	
<b>TFR</b>	<b>2.59</b>				<b>2.33</b>



# ANNEX.2

Contraceptive Prevalence Rates by Method,  
WFS, CPS and DHS, 1976 - 2007

## 2007 DHS Estimate

Methods	1976 WFS	1987 CPS	1991 DHS	1994 DHS	1997 DHS	2002/3 DHS	2007 DHS
<b>Official Program Methods</b>	17.2	40.7	43.7	48.4	51.3	52.4	54.0
IUD	4.1	13.2	13.3	10.3	8.1	6.2	4.9
Pill	11.6	16.1	14.8	17.1	15.4	13.2	13.2
Injectable	-	9.4	11.7	15.2	21.1	27.8	31.8
Implant	-	0.4	3.1	4.9	6.0	4.3	2.8
Condom	1.5	1.6	0.8	0.9	0.7	0.9	1.3
<b>Program Promoted but Non-official Methods*</b>	0.1	3.3	3.3	3.8	3.4	4.1	3.2
Female Sterilisation	0.1	3.1	2.7	3.1	3.0	3.7	3.0
Male Sterilisation	0.0	0.2	0.6	0.7	0.4	0.4	0.2
<b>Traditional and Folkloric Methods</b>	1.0	6.0	2.7	2.7	2.7	3.6	4.0
Rhythm	0.8	1.2	1.1	1.1	1.1	1.6	1.5
Withdrawal	0.1	1.3	0.7	0.8	0.8	1.5	2.1
Traditional (Herbs or massage) and other	0.1	3.5	0.9	0.8	0.8	0.5	0.4
<b>Reported Use of Any Method</b>	18.3	49.8	49.7	54.7	57.4	60.3	61.4
<b>No Method</b>	81.7	52.3	50.3	45.3	42.6	39.7	38.6

# ANNEX.3

Family Planning and Health Services – Synergies in the Benefits, and Complementarities in Program Operations

A new agency concerned with revitalizing the Family Planning program should not have direct responsibilities for the managerial or technical aspects of contraceptive service delivery, or more broadly, for women's health. These rightly rest under the jurisdiction of the Ministry of Health.

It would be appropriate to change the name of BKKBN along with the change in mission, vision and activities.

Nonetheless there are powerful synergies of benefits to be gained if women have full access to the resources of both of these programs. There are clear areas where the two organizations might intersect operationally. Therefore it is essential that at the national, provincial and district/municipal levels the health and family planning programs work in harmony and close collaboration to maximize the benefits for women and their families.

The rationale for this may be summarized in the following key points:

1. A woman's ability to control her fertility will have major direct and indirect health benefits:
  - Direct benefits -
    - i. To her in preventing unintended pregnancies with the health risks to her of an added childbirth or even abortion
    - ii. To her child by avoiding births when she is too young or too old, or when the interval is too short or when there are other health contraindications for a pregnancy.
  - Indirect benefits –
    - i. To her entire family if there are economic constraints such that an additional child would add a significant burden, threatening the nutrition and health of other members

2. Conceptually, all preventive health services (e.g., immunizations, pre-natal care, maternity care, ORT, nutrition, school health and dentistry, sex education, hygiene) including family planning are fundamentally social interventions supported by technologies – and therefore all face fundamental demand and supply constraints. Demand creation and quality of services are equally important in reaching all preventive health objectives. Like family planning, there is an “unmet need”, since many mothers will not come for these services, even when they are free. From this perspective, there should be close collaboration among the staff of the health and family planning programs, since their efforts will be mutually reinforcing in serving the hard-to-reach clients.
  
3. Operationally, there are areas where the health and family planning programs can be mutually supportive to the benefit of the health and welfare of the mother and her child. Using 2007 IDHS data, some of these areas include:
  - Antenatal care: 93 percent of women receive antenatal care from a health professional. Asking these women if this pregnancy was planned for this time (or if the desire was for a later pregnancy or none at all, and if so was there a contraceptive failure) would not only be directly helpful to the provider in knowing how to counsel the mother, but these data would also be a powerful monitor of the effectiveness (or failure) of the FP program.
  
  - Childhood immunizations: 85 percent of newborns receive BCG vaccine and 81 percent receive Hepatitis BA vaccine, 89 percent receive a first dose of polio at around 6 weeks and 76 percent receive measles vaccine at around 6 months. Since the post-partum mother is present at these times, these can be critical periods to

discuss her need for birth spacing or limitation. At the same time, children missing these vital immunizations should be reached together by health and FP workers, since these will likely represent much of the unmet need for FP as well as health services, and thus are more likely to have an unintended pregnancy.

- **Post-abortion care:** This is a vitally important entry point for BKKBN. Many women experiencing a complication of an abortion (spontaneous or induced) will appear in the health system for care. All of these women need special counselling, and contraceptive services are critical to prevent repeated induced abortions with all the risks to women's health and lives if this abortion is the consequence of an untended pregnancy. The MOH and BKKBN need to work together: first, to develop and introduce standards and procedures for post-abortion management; and second, to set up a routine registration and reporting system so that the magnitude of the problem, its underlying causes and the consequences for the woman and the health system are documented..
- **Contraceptive service statistics:** BKKBN has a system for routinely gathering statistics on the provision of contraceptive services, but it is recognized to be very incomplete. With decentralization, BKKBN has no direct power to improve the situation. The MOH also has an interest in collecting routine service statistics on preventive services like ante-natal care, deliveries, immunizations, etc. Since both of these systems need improvement, and both agencies will need to work through the decentralized system, it will be more effective if they work together – and more efficient for the provider who will not need to be completing multiple reporting forms for different agencies.

- Procurement and distribution of contraceptives: BKKBN currently controls procurement of about 20 percent of the national requirement for contraceptives – ostensibly for the poor - and manages their delivery to provincial warehouses. However, with decentralization control of the distribution within the districts has been lost. Since these “medical” commodities are required by the service delivery programs, they are technically under the control of the District Office of Health and this Office is accountable to the Ministry of Health. The Ministry of Health also has a much larger logistics system in place to distribute preventive health products (vitamins and vaccines to pregnant women, immunizations and micronutrients to infants and children) to essentially the same target group of childbearing women. Given these realities, a new operational system should be established in close collaboration with the Ministry of Health. It will be in the interest of both agencies to ensure complete coverage, maintain quality of services and complete reporting, and both agencies will need to learn how to achieve this is a decentralized system. There will be FP client groups that will not be reached by this system – e.g., unmarried women, women who have stopped childbearing, and most men. BKKBN will need to develop innovative systems in collaboration with districts to meet these needs, but the task will not be any easier if BKKBN is “burdened” with a logistics system that is really does not control at the district level.
- Inclusion of all contraceptive services in health insurance coverage. With the major shift of family planning service from public to private sources it is important to monitor the coverage of family planning services by public and private health insurance policies. It appears that some schemes do not underwrite the

costs of more expensive contraceptive options like implants and sterilization. This is an issue requiring collaboration between the central agency for family planning and the Ministry of Health.



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The background is a solid green color with several large, overlapping, semi-transparent circular and triangular shapes in a lighter shade of green, creating a layered, abstract effect.

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