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**INDONESIA'S  
NATIONAL FAMILY  
PLANNING PROGRAM:  
INGREDIENTS  
OF SUCCESS**

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Charles N. Johnson  
Andrew B. Kantner  
Alex Papilaya

*Sustained Political  
Commitment*

*Population Policy  
Development*

*Creative Leadership*

*Adequate Funding*

*Cohesive Village  
Structure*

*Occasional Paper No. 6*

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## Preface

This is the sixth in a series of Occasional Papers published by the Population Technical Assistance Project (POPTECH). Like its predecessors, this paper focuses on an issue of particular interest to the population community — in this case, the ingredients that have contributed to the success of Indonesia's family planning program.

The paper was written at the request of the Office of Health and Population of the USAID mission in Indonesia with the purpose of taking "a broader more comprehensive look at the national family planning effort — its development, its achievements and demographic impact, as well as the role that A.I.D. has played." Timed to coincide with the twenty-fifth anniversary of the beginning of Indonesia's determined effort to address the major challenge of rapid population growth, the report highlights the two major reasons for the achievements to date. It explores the role played by donors, particularly A.I.D., the largest single international contributor to the program. It also examines the key factors in the Indonesian setting that have been critical to the program's achievements and sustainability.

Indonesia has become an example to other countries, drawing family planning leaders from throughout the developing world to study its program. It is hoped that this paper will distill the lessons learned over the program life for an even wider audience.

The report was prepared principally in Indonesia in April and May of 1992 by four individuals with extensive experience in the Indonesian demographic and family planning setting. Team leader Charles Johnson is associate technical director of POPTECH. He was a foreign service officer with A.I.D. for 27 years, specializing in population and family planning. He served as chief of the Office of Population for USAID/Jakarta for four years (1979-1983). Leslie Curtin is a career foreign service officer with A.I.D. She served as health and population officer with USAID missions in Burkina Faso and Haiti. She is currently deputy chief of the Family Planning Services Division, Office of Population, A.I.D. Andrew Kantner is a senior demographer at the East-West Population Institute in Hawaii. He served as technical advisor to the Program Development Division at the Indonesian National Family Planning Coordinating Board (BKKBN) from 1988 to 1990. Alex Papilaya is director of the Center for Child Survival, University of Indonesia and a former dean of the School of Public Health, University of Indonesia.

The authors wish to thank the staff of USAID/Jakarta and in particular John Rogosch and Kenneth Farr for their assistance in the course of this assignment.

The authors also wish to thank Dr. Haryono Suyono, chairman of BKKBN, and the many members of his staff who gave freely of their time and ideas.

### Economic and Demographic Indicators: Indonesia

Total Population	185 million (1992 est.)
Life Expectancy	61 years (1989)
Infant Mortality Rate	70/1,000 live births (1991)
Crude Birth Rate	25/1,000 (1991)
Maternal Mortality Rate	400-500/100,000 live births (1991)
Total Fertility Rate	3.0 (1991)
Contraceptive Prevalence Rate	49.7 percent (1991)
Percent of Population, Urban	30 percent (1989)
Per Capita Income	\$550 (1990)
Gross Domestic Product, Annual Growth Rates	7 percent (1965-1980), 5.3 percent (1980-1989)

# Indonesia's Family Planning Program: An Overview

## Introduction

A little over two decades ago, Indonesia appeared an unlikely setting for development of a successful national family planning program. A country peopled largely by poor (\$50 per capita income), illiterate, Muslim peasant farmers spread over thousands of islands, speaking many different languages and belonging to several hundred different cultural groups did not fit the pattern for the introduction and expansion of a family planning program. Nonetheless, with strong Presidential support, an ambitious family planning program was launched in 1970 with the creation of the Indonesia National Family Planning Coordinating Board (BKKBN), which was independent of any cabinet ministry and which reported directly to the president. This would develop into a powerful voice for family planning, unique in its governmental influence and its worldwide reputation.

## Demographic Progress

With the BKKBN in charge, the program progressed steadily and impressively. The total fertility rate (TFR) has dropped by nearly half in only two decades, from an average of 5.6 births per woman in 1971 to 3.0 births per woman in 1991. This has come about primarily as a result of the increase in the contraceptive prevalence rate (CPR), which has risen rapidly from less than 10 percent of married women aged 15 to 49 using contraception in 1971 to 49.7 percent in 1991. This places Indonesia in the handful of developing countries that have achieved a CPR in the range of 50 percent. As a result of the declining birth rate, Indonesia's rate of population growth has also dropped, from an estimated 2.5 percent in 1970 to an estimated 1.6 percent in 1991. If many Indonesians had not become seriously committed to having smaller families (and had the population growth rate between 1970-1990 remained constant at 2.5 percent), the total population in 1990 would have been 191.7 million rather than the actual 1990 figure of 179.3 million.

## Ingredients of Success

Indonesia has succeeded in overcoming the odds against its slowing population growth thanks to a combination of determination and commitment by its leadership and the ready support of international donors.

**Program Evolution.** One of the reasons for Indonesia's success in family planning lies in the way the program itself has evolved. It began in areas of greatest population density, the central provinces of Java and Bali, later expanding into less densely populated islands.

It began at the village level, an unusual approach, with the aim of extending family planning services into as many of Indonesia's 66,000 villages as possible. This was a daring departure from traditional reliance on fixed clinics. Not only did this approach put Indonesia's program in the unusual position of initially achieving higher prevalence in the countryside than in the urban areas; the energizing of community participation and use of village volunteers have made the program a model for the introduction of other social services into the villages.

A decade later, the program began to concentrate on the urban areas, and here, it switched from reliance on government services to placing a greater burden on the client. Few programs have set out this systematically or thoroughly to break the mold of free services, enlisting the private sector to increase coverage in urban areas. Few programs have succeeded as dramatically as Indonesia's in moving a large segment of users to the private sector in a short period of time — from 12 percent in 1987 to 22 percent in 1991.

**Role of A.I.D.** As the single largest donor, the U.S. Agency for International Development (A.I.D.) has played a key role, serving as a partner to the BKKBN along every step of the program's evolution. Since 1968, A.I.D. has supported family planning activities in Indonesia, providing nearly \$250 million for technical assistance, training, contraceptives, and funds for local support for every aspect of policy and program development. The funds provided by A.I.D. have been used for two major purposes: the expansion and improvement of family planning services and the strengthening of the institutional capability of BKKBN and other Indonesian institutions to organize, manage, and evaluate the family planning program.

A.I.D. assistance to the evolving rural and urban programs was primarily designed to stimulate service provision and succeeded remarkably well in ensuring the spread of services nearly country-wide. The provision of contraceptive supplies was also a critical part of A.I.D.'s assistance.

The second type of A.I.D. assistance, for institutional development, is important for long-term program sustainability. Thanks to training and technical assistance, BKKBN and other Indonesian institutions that support the national family planning program have become among the most effective family planning organizations in the developing world.

The inputs of A.I.D. have been synchronized with the dynamic growth of the program itself, particularly the major switch from a rural to an urban focus. Over the years, A.I.D. and BKKBN have enjoyed an unusual degree of cooperation, with both parties exchanging ideas on strategies that were best for the unique Indonesian setting. More important, A.I.D. has kept in mind that this was Indonesia's program and that eventually its own support would be reduced. Funds have therefore been provided to help install systems in the BKKBN and other organizations that would improve their capability to manage the program. As a result, in many areas, the BKKBN assumed

financial responsibility for parts of the program that initially could only operate with the assistance of outside financing.

**Indonesia: Its Unique Approach to Family Planning.** The fundamental reasons for the family planning program's success, however, are internal. In part, they stem from the socioeconomic and political setting, whose initial difficulties have been largely offset by the progress enjoyed in the country over the past 20 years. In addition, they reflect the determined way in which the government has pursued the goal of reducing population growth in the context of improving family welfare, consistently providing adequate resources and developing institutions with the strength to implement the program. Key ingredients of success include

### **Non-Program Factors**

- **Sustained Political Commitment.** Political commitment has been continuous, strong and open from the national to the local levels. No other developing country leader has given more public support to family planning than has President Soeharto over the past 25 years.
- **Political Stability.** The quarter century of political stability enjoyed by the people of Indonesia under a government dedicated to social and economic development has contributed to the relatively smooth implementation of the national family planning program.
- **Demand for Fertility Control.** One of the keys to the success of Indonesia's family planning program has been the strong latent demand for family planning services in the country, particularly on Java and Bali. In 1976, the number of children desired by couples in these islands was 4.2; by 1991, the mean ideal number was 2.8 children.
- **Socioeconomic Development.** Improved socioeconomic conditions, partly spurred by fertility declines, have reinforced trends in reduced fertility. Particularly important has been the emphasis placed on female education, which has resulted in a female literacy rate of 65 percent and a growing proportion of females in the work force.
- **Cohesive Village Structure.** BKKBN has capitalized on the tradition of mutual self-help (particularly strong in villages in Java and Bali) by enlisting the support of village councils in the family planning program. As occurs in other matters, once the council agrees on a course of action, the entire village will join in the activity.

### **Program Factors**

The Indonesia program has done an outstanding job in setting a steady course of action and marshalling the required resources, both human and financial.

- **Population Policy Development.** Since the program's establishment, the government has supported its family planning efforts in highly visible and concrete ways. The government adoption of a policy to promote the "small, happy, and prosperous family" struck a responsive chord among large segments of the Indonesian population. The slogan also incorporates many other national development policies in the areas of agriculture, literacy, and greater access to health care.
- **Strategic Planning.** The adoption of a highly visible and clear-cut population policy in support of the national family planning program has helped galvanize popular support for the program. That the policy is drawn in terms of quantitative goals is equally important, illustrating the sophistication of the Indonesian program; many developing countries have yet to incorporate targets into program management.
- **Creative Leadership.** Program leaders have not been afraid to try new strategies. Neither the revolutionary village family planning approach, using volunteers instead of fixed clinics, nor the urban initiatives, depending on clients' bearing some of the cost of services, would have been possible had not program leaders been willing to experiment with new approaches.
- **Information, Education, and Communication.** The BKKBN has excelled in the creative use of traditional and mass communications to promote family planning. Approaches have ranged from support at the presidential level to development of logos and slogans. The latter have achieved a national recognition that is the envy of commercial advertising and marketing companies.
- **Islam and the Indonesian Family Planning Program.** As the world's largest Muslim country, Indonesia might well have been a difficult environment for family planning. The BKKBN, however, has done a remarkable job in enlisting Muslim leadership as its ally in the effort to increase contraceptive prevalence throughout Indonesia.
- **Adequate Funding.** Political support has been translated into substantial domestic funding which, coupled with ample donor support, has facilitated rapid program expansion. Initially relying heavily on foreign donors to finance family planning activities, the government steadily increased its budget support so that by 1976, it was providing a majority of program funds. Today, donors provide funding for less than 30 percent of total program costs. The government's share of total family planning expenditures continues to grow, even as the total budget expands and as other social programs have faced funding cutbacks.

### **Organizational Strengths**

- **Institutional Collaboration.** The BKKBN, as an autonomous coordinating institution with its own budget line, has played a key role in mobilizing

and directing family planning resources. Coordinating organizations exist in many family planning programs, but BKKBN is unique in the authority it has been accorded and the effectiveness with which it has exercised that authority.

- **Strong Community Involvement in Family Planning.** BKKBN's village grassroots organizational efforts have translated into widespread community support for the Indonesian national family planning program. The staggering number of persons it has enlisted at the village level has enabled the program to make family planning an acceptable topic of public discussion, reduced fears and concerns, and provided information, contraceptives, and peer support to couples throughout the nation.
- **Variety of Service Delivery Mechanisms.** The family planning program operates through three major delivery mechanisms — Ministry of Health for clinical services, BKKBN for village distribution, and private providers. This variety of options for obtaining services ensures that family planning information and contraceptives are readily available throughout the country's 27 provinces in a variety of culturally acceptable settings.

## The Future

**Demographic Challenges.** In 1992, the program is at a critical juncture. Despite the successes achieved to date, a great challenge lies ahead. The current goal of the national program is to reach a two-child family size by the year 2005. This goal will require a 30 percent reduction in the total fertility rate over the next 14 years (from 3.0 in 1991 to 2.1 in 2005). In order to achieve the targeted TFR of 2.1, calculations suggest that the CPR must rise from 49.7 percent to at least 62.7 percent by the year 2005. When compared to demographic experience in other developing countries, however, a CPR of 62.7 seems low: Most countries do not achieve replacement fertility until around 70 percent of all married women aged 15 to 49 are using contraception.

### Service Delivery Challenges

- **Increasing Contraceptive Use.** The challenge for program managers is daunting. In the first place, the program seems to have hit a plateau. Over the four years between 1987 and 1991, contraceptive use rose a total of only two percentage points. Prior to 1987, the pace of growth was more like two percentage points *per year*. Moreover, the number of users needed to achieve a CPR of 62.7 percent is enormous. The total number of current users will need to increase from 15.6 million in 1991 to 25.4 million by 2005, or by nearly two-thirds. Achieving this rise will involve a tremendous program effort each year, for new users will have to be recruited not only to increase the overall total but also to replace those who drop out each year. Over the 13-year period between 1992 and 2005, it is estimated that around 85 million new acceptors would

need to be recruited in order to produce a net increase of 10 million users in the year 2005.

Program managers will be looking to the approximately 14 million women with unmet need for family planning to recruit these new users. About half are younger women with a need for spacing methods, while the rest are older women with a need to limit their family size.

- **The Use of Effective, Long-Term Methods.** Indonesia's contraceptive method mix is unbalanced in favor of temporary methods, with the three most popular methods being the pill, the IUD, and injectables. Voluntary sterilization is relatively low when compared with other Asian countries. In Indonesia, only 6.6 percent of all users are sterilization clients. Other Asian family planning programs generally have much higher levels, with sterilization accounting for between 25 and 50 percent of total use.

The low use of sterilization reflects the lower government priority and support for voluntary sterilization, which is due largely to religious opposition, and the resulting low level of knowledge of this method. Voluntary sterilization could make a significant contribution to the national family planning program, but policy changes and vigorous public promotion of this method are required.

The projection that a 62.7 percent CPR will lead to replacement fertility is based on a contraceptive method mix that is generally consistent with trends identified between 1987 and 1991. These include modest increases in injectables, implants, sterilization and traditional methods and a slight decline in the proportion of women using pills and IUDs. The only major change would be in condom use, which is projected to increase rapidly owing to an increasing awareness of the risk of HIV infection. An alternative scenario, more in line with the experience in other Asian countries, would place heavier emphasis on increasing utilization of voluntary sterilization and implants to meet the needs of older couples who have achieved desired family size and want to terminate future fertility. This scenario would perhaps be more cost effective but would require significant efforts by BKKBN and the Ministry of Health and vigorous promotion of long-lasting methods.

**Financial Requirements.** Budget requirements for a program that aims at increasing the number of current contraceptive users from 15 to 25 million over the next 13 years will be enormous. A rough estimate would suggest that if the size of the program is to grow by nearly two-thirds, the BKKBN budget will also need to increase by another \$50 million, and donor contributions will also have to expand by two-thirds.

Total program costs could rise at an even faster rate, however. It may be more costly to attract current non-users, who are generally among the lower socioeconomic groups and in harder-to-reach areas. In addition, if the

government decides to promote long-term methods, these are more expensive than pills, IUDs, and injectables, at least initially.

On the other hand, the possibility also exists that the expansion of the program could result in lower costs in the longer run. As contraceptive use becomes more widespread, recruitment may become less difficult: since many previously hesitant women may be convinced to join the majority of Indonesian women in spacing their children or limiting their family size. Likewise, although long-term methods are more costly at the start, these costs tend to be amortized over time. Finally, if the government is successful in continuing to increase the number of families who receive their services through the private sector, the financial burden will ease on BKKBN and on the donor community.

Even if costs become lower over time, a redoubled effort is needed now, as the program shifts from its current levels into the next phase. The population will continue to grow for decades even after replacement level fertility is achieved. The BKKBN, together with international donors, has provided the key inputs that have established the family planning program as an indispensable component of Indonesian family life. This partnership will continue to be essential, if the program is to achieve the high level of contraceptive use that will be required in the coming years.

# 1. Introduction

## Indonesia: An Unlikely Setting for Family Planning

On August 17, 1967 — the twenty-second anniversary of Indonesian independence — Acting President Soeharto established family planning as official government policy. Over the next 25 years, the Indonesian national family planning program expanded throughout the country, bringing freedom of reproductive choice to millions of Indonesian couples and spearheading a significant decline in fertility.

Critics said "it couldn't be done." A country peopled largely by poor (\$50 per capita in-

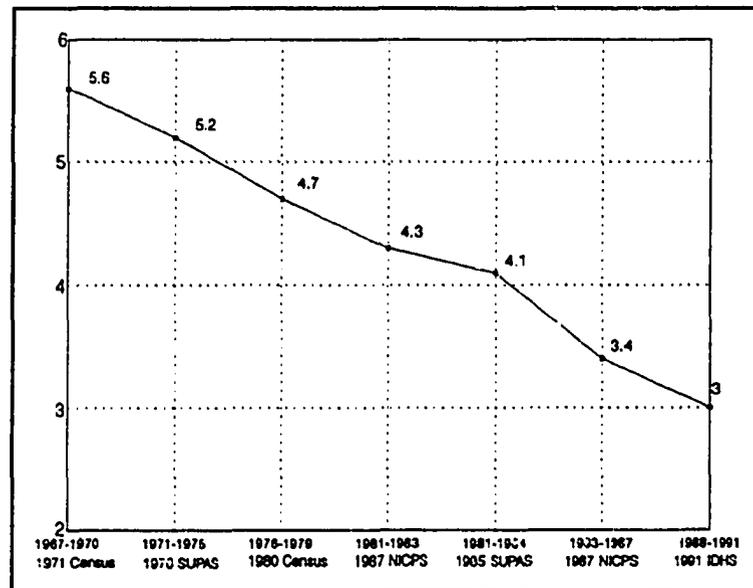
come), illiterate Muslim peasant farmers spread over thousands of islands, speaking many different languages and belonging to several hundred different cultural groups, did not fit the pattern for the introduction and expansion of a family planning program. But Indonesia proved the critics wrong. The national family planning program is now viewed as one of the most successful in the developing world and draws visitors from many countries to study and learn how the program developed and expanded.

## Demographic Achievements in Indonesia

### Total Fertility Drops

Since 1967, rapid population growth has been viewed as a major impediment to Indonesia's social and economic development prospects. Since 1971, the government has given strong support to the country's family planning program. This investment has nearly halved the total fertility rate (TFR) in a period of only 20 years. In the late 1960s, women were having an average of 5.6 births. By 1991 this figure had fallen to 3.0 births per women (a 46 percent decline in just over two decades — see Figure 1).

Figure 1  
Indonesia: Total Fertility Rates  
(1971-1991)



Source: Indonesia Demographic and Health Survey, 1991: Preliminary Report, (1991:24).

Note: 1971 Census, 1976 SUPAS, 1980 Census, and 1985 SUPAS estimated using the "own children" method. 1987 NICPS and 1991 IDHS calculated directly from birth history data. SUPAS = Inter-Censal Population Survey, NICPS = National Indonesian Contraceptive Prevalence Survey, IDHS = Indonesia Demographic and Health Survey

## Contraceptive Prevalence Rises

Although a gradual increase in the age at marriage has been a contributing factor, most of Indonesia's fertility decline can be attributed to the rapid rise in the percentage of married women aged 15 to 49 using contraception (from less than 10 percent in 1971 to 49.7 percent in 1991). Indonesia is only one of a handful of developing countries that have achieved a contraceptive prevalence rate (CPR) in the range of 50 percent. Among women using contraception in 1991, 95 percent were using modern methods (pills, IUDs, injectables, implants, vasectomy, tubectomy, and condoms) and 5 percent were employing

**Table 1**  
Percent of Currently Married Women Using Contraception by Region in Indonesia (1976, 1987, and 1991)

Region	IFS 1976	NICPS 1987	IDHS 1991
Java and Bali	26	50.9	53.4
Jakarta	28	54.0	56.0
West Java	16	45.8	51.0
Central Java	28	53.5	49.7
Yogyakarta	40	68.1	71.3
East Java	32	49.8	55.4
Bali	38	68.5	71.9
Outer Islands I	NA	41.7	43.5
Outer Islands II	NA	39.6 <sup>1</sup>	42.8
Indonesia Total	NA	47.7 <sup>1</sup>	49.7 <sup>2</sup>

Sources: Indonesian Fertility Survey (IFS) (1976), National Indonesian Contraceptive Prevalence Survey (NICPS), 1987, (1989:34) and Indonesia Demographic and Health Survey (IDHS), 1991 Preliminary Report, (1991:20).

<sup>1</sup>Excludes Jambi, East Nusa Tenggara, East Timor, Central Kalimantan, East Kalimantan, Maluku, Irian Jaya.

<sup>2</sup>The 1991 CPR, based upon the same regions that were sampled in the 1987 NICPS, is 50.3 percent.

traditional methods. Contraceptive use is considerably higher on Java and Bali than on the Outer Islands, but some Outer Island provinces have now attained levels of use that rival those of Java and Bali (see map on page 9 and Table 1).

Recently, the pace at which contraceptive use was growing has leveled off. Over the last four years, the CPR rose only two percentage points (from 47.7 in 1987 to 49.7 percent in 1991). This compares with an average growth rate since 1970 of about two percentage points *annually*.

This "plateau" effect may be encountered at any stage of program development, but it is more likely to occur when a substantial percentage of women are already using contraceptives. When it does occur, the key for program managers is to determine how to move to a higher stage of performance.

## Infant and Child Mortality Rates Decline

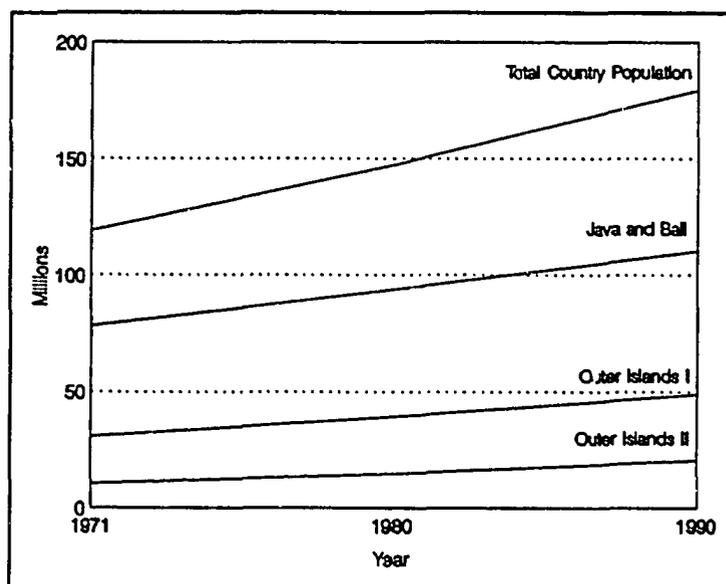
The rapid increase in contraceptive use between 1971 and 1991 has contributed to a near halving of the infant mortality rate. Nationally, in 1971, 13 percent of infants died before reaching their first birthdays; as of 1987, only 7 percent did not survive the first year. Although improved health services, rising educational attainment, and higher living standards also played a role, the importance of contraceptive use were clear in Java and Bali, where, between 1976 and 1987, births tended to be spaced farther apart and were less common among adolescent girls and older, high-parity women.

Maternal mortality is still high in Indonesia. Recent survey results from Central and West Java indicate that between 400 and 500 women die from maternal-related conditions per 100,000 live births. On the other hand, life expectancy had increased from around 45 years in the 1960s to 61 years in 1989.

## Rate of Population Growth Declines

Indonesia's rapid decline in fertility has considerably slowed the rate of population growth. Between 1971 and 1980, Indonesia's population grew at a rate of 2.33 percent per annum (a doubling time of 29.7 year.). Results from the 1990 Population Census indicate that the rate of population growth slowed substantially during the 1980s. Between 1980 and 1990, Indonesia's population grew from 147.4 to 179.3 million, which constitutes an annual population growth rate of 1.96 percent (a doubling time of 35.4 years — see Figure 2). Recent estimates based upon the 1991 Indonesia Demographic and Health Survey (IDHS) show that the annual population growth rate may have fallen to around 1.62 percent in 1991 (implying a doubling time of 43 years). If Indonesia's growth rate had remained at the level of 2.5 percent per annum estimated for 1970, Indonesia

Figure 2  
Total Population Growth  
for Indonesia and by Region  
(1971, 1980, and 1990)



Source: Terence H. Hull, "Population Growth Falling in Indonesia: Preliminary Results of the 1990 Census," *Bulletin of Indonesian Economic Studies*, Vol. 27, No. 2, August, 1991.

Note: Computed using the exponential growth rate formula of  $100 \cdot [\ln(P_t/P_0)]/t$ .

would have had an additional 12.4 million in 1990 — 191.7 million instead of the actual total of 179.3 million (see Figure 5 on page 28).

## How Indonesia's Family Planning Program Achieved Success

How has Indonesia succeeded in slowing population growth against the many odds it has faced? Taken together, the answers offer an unusual and fascinating family planning case history.

### Program Evolution

Part of the answer lies in the history of the program itself — the determined way in which the government has pursued the goal of reducing population growth in the context of improving family welfare, consistently pro-

viding adequate resources, and developing institutions with the strength to implement the program. Another aspect is how the program evolved — starting at the village level, with the main provider the government, and moving into the urban areas, where a greater burden was placed on the client to pay for services. Programs usually begin the other way, moving from the urban areas into rural regions where the people are more scattered and harder to reach. For Indonesia, this unusual route not only worked; it was probably one of the key reasons for the program's success.

## **Role of A.I.D.**

A second critical factor was the ready availability of international assistance. As the single largest donor, the U.S. Agency for International Development (A.I.D.) played a key role among the donors, serving as a partner to the BKKBN, the Indonesia National Family Planning Coordinating Board, at every step of the program's evolution. Its inputs allowed for the program to develop as it did: A.I.D. covered most of the initial costs of program expansion into rural areas and then it flexibly switched its support to the urban centers, helping put in place the mechanisms that would lead to greater privatization. Throughout this process, A.I.D. and BKKBN enjoyed an unusual degree of cooperation, with both parties exchanging ideas on what strategies would be best for the unique Indonesian setting. More important, A.I.D. always kept in mind that this was Indonesia's program and that eventually its own support would be reduced. Funds were therefore provided to help install systems in the BKKBN and other organizations that would improve their capability to manage the program. In many areas, the BKKBN has assumed financial responsibility for parts for the program that initially could only operate with the assistance

of outside financing. At this point, thanks in part to A.I.D. support, Indonesia has one of the most effective family planning programs in the developing world.

## **Indonesia: Its Unique Approach to Family Planning**

The fundamental reason for the family planning program's success, however, is internal. Indonesia offers a unique blend of political, socioeconomic, and program factors that are receptive to family planning. Not often found in developing country settings, particularly in combination, are the political commitment and stability, the explicit articulation of a population policy, the creative program leadership, and the funding that are the most important hallmarks of the Indonesia program. Other factors include the existence of latent demand for family planning, steady socioeconomic development, a cohesive village structure, the involvement of Muslim leaders, and a strong information, education, and communication (IEC) effort. Taken together, these factors have combined to allow the Indonesian family planning program to achieve a dramatic downturn in fertility and reduction in the rate of population growth over the past two decades.

## Country Profile

**Densely Populated** With 185 million inhabitants in 1992, Indonesia has the world's fourth largest population. This tropical archipelago of some 13,000 islands stretches over 3,000 miles from east to west and over 1,000 miles from north to south. Nearly two-thirds of the population (over 110 million persons) live on Java, which contains only 7 percent of the total land area. In contrast, the largest islands of the country, Kalimantan and Irian Jaya (the Indonesian provinces on Borneo and New Guinea), are sparsely inhabited.

Java's population density (835 persons per square kilometer) is one of the world's highest. Its 110 million people are compressed into an area the size of Wisconsin, a state that contains only 5 million people. If the continental United States were to have a population density similar to Java's, the earth's entire 5.5 billion people would be crowded within its borders.

**Ethnically and Linguistically Diverse** Indonesia is one of the most ethnically and linguistically diverse nations on earth, counting over 300 distinct ethnic groups speaking many different languages. Since independence, the government has promoted the adoption of a single national language. Indonesia is the world's largest Muslim nation, with nearly 165 million people (90 percent of the population) counted as Muslim. The remaining 15 to 20 million persons are Protestants, Roman Catholics, Hindus, and Buddhists.

**Economically Progressive** The end of Dutch rule in 1949 left a nearly destitute country with low literacy, limited infrastructure, and one of the lowest per capita incomes of any country in the world. The country has made impressive gains in the four decades since independence. Per capita income now stands at \$550 per year. By international standards, average annual growth rates in the gross domestic product have been high over the past 25 years (7.0 percent during the period 1965 through 1980 and 5.3 percent from 1980 through 1989). Consumption levels, especially the ownership of consumer durables, have increased dramatically. Due to favorable government policies, Indonesia is moving rapidly toward a free market economy.

The industrial sector is a major engine of economic development, and the agricultural sector provides enough food for both domestic and export purposes. The industrial and commercial sectors have grown substantially in the past decade. Major oil, gas, forest, and mineral resources provide most of the country's exports and government revenues. Fifty-six percent of the population still earns its livelihood from agriculture, and during the 1980s Indonesia achieved self-sufficiency in rice production. In addition, the Indonesian government has made substantial investments in the physical infrastructure of the country, building new roads, hydroelectric dams, port facilities, and telecommunications networks.

**Increasingly Urban** As agricultural employment declined and as more jobs became available in the non-agriculture sectors, there has been rapid internal migration to the cities. The percentage of Indonesia's urban population has increased from 16 percent in 1965 to 30 percent by 1989. The rate of urbanization has also increased. Between 1965 and 1980, the average annual growth of the urban population was 4.8 percent while from 1980 to 1989, this rate had risen to 5.4 percent (a doubling time of only 12.8 years). A near-term challenge for the country will be the development of new policies for managing urban population growth and the resulting congestion and strain on urban infrastructure.

## 2. The Indonesian National Family Planning Program: Two Decades of Growth

### Historical Overview

President Soeharto's 1967 announcement that the government was committed to family planning as an official development program reversed the earlier official pro-natalist policy. Initially, larger families had been considered an important element in the struggle of the newly independent countries for political and economic power.

During these early pro-natalist years, the private voluntary sector nonetheless took the initiative to provide some family planning services and to urge changes in official policy. In the 1950s, physicians had been trained abroad in family planning. In 1957, the Indonesian Family Planning Association (PKBI) was founded with financial and technical assistance from the International Planned Parenthood Federation (IPPF) and other private donor groups. The PKBI lobbied for changes in government policy, initiated small public information campaigns, and by the late 1960s had trained staff members and provided contraceptives through 70 health clinics in the major cities of Java and Bali. In 1967, the PKBI launched an urban pilot project in Jakarta with the official sanction and some budgetary support from the municipal government.

The efforts of non-governmental organizations (NGO) to alert the government to the problem and to spark and satisfy latent demand for family planning paved the way for the government to

launch its own major program to provide contraceptive services. It took about three years after President Soeharto's announcement, however, before the government set the new family planning policy into motion. The key event, in 1970, was the establishment of the BKKBN, which was independent of any cabinet ministry and which reported directly to the president.

#### BKKBN: A Unique Institution

The BKKBN today stands as a powerful voice for family planning, unique in its governmental influence and its worldwide reputation. It currently has offices in all 27 provinces and 301 regencies and a staff of 48,000, including over 33,000 paid family planning fieldworkers. It supports a network of 500,000 village family planning volunteers and 76,000 village contraceptive distribution centers (VCDC) blanketing the 66,000 villages and hamlets of Indonesia with information and contraceptives. In addition, family planning is promoted by some 300,000 village family planning acceptor groups and tens of thousands of volunteers who provide integrated nutrition and health services, organizations of wives of officials, and traditional and local elected officials.

The BKKBN rapidly expanded its staff and national organization. Free of some of the bureaucratic procedures and traditions that typically plague government agencies and embarking upon an exciting new program, the BKKBN was able to attract a cadre of creative and active young professionals willing to experiment and use research as a basis for developing policies and program activities. Offices and training facilities were constructed in many key locations, funded by World Bank loans. Today, BKKBN activities extend into almost all parts of the 3,000-mile-wide Indonesian archipelago.

## Stages of Family Planning Program Development

### Geographical Phasing

The BKKBN strategy for service expansion was to concentrate first on the most populous provinces and then to expand to the less crowded islands. The national family planning program was initially limited to the six provinces of Java and Bali, which contain 62 percent of Indonesia's population (see map on opposite page). Once a sound family planning program had been planned, introduced, and tested there, the BKKBN moved sequentially to provide family planning services to the remaining 21 provinces. In 1974, family planning programs were introduced in the 10 large provinces designated as Outer Islands I (27 percent of the population). In 1979, the remaining 11 provinces, Outer Islands II (11 percent of the population), were added to the national program.

In addition to absolute population size, there were other reasons to begin the family planning program in the six provinces of Java and Bali. The people were easier to reach because of comparatively more and better staffed health clinics, better transportation and communications infrastructures, a well-organized village structure, and high perceived demand for family planning services.

### Village Family Planning

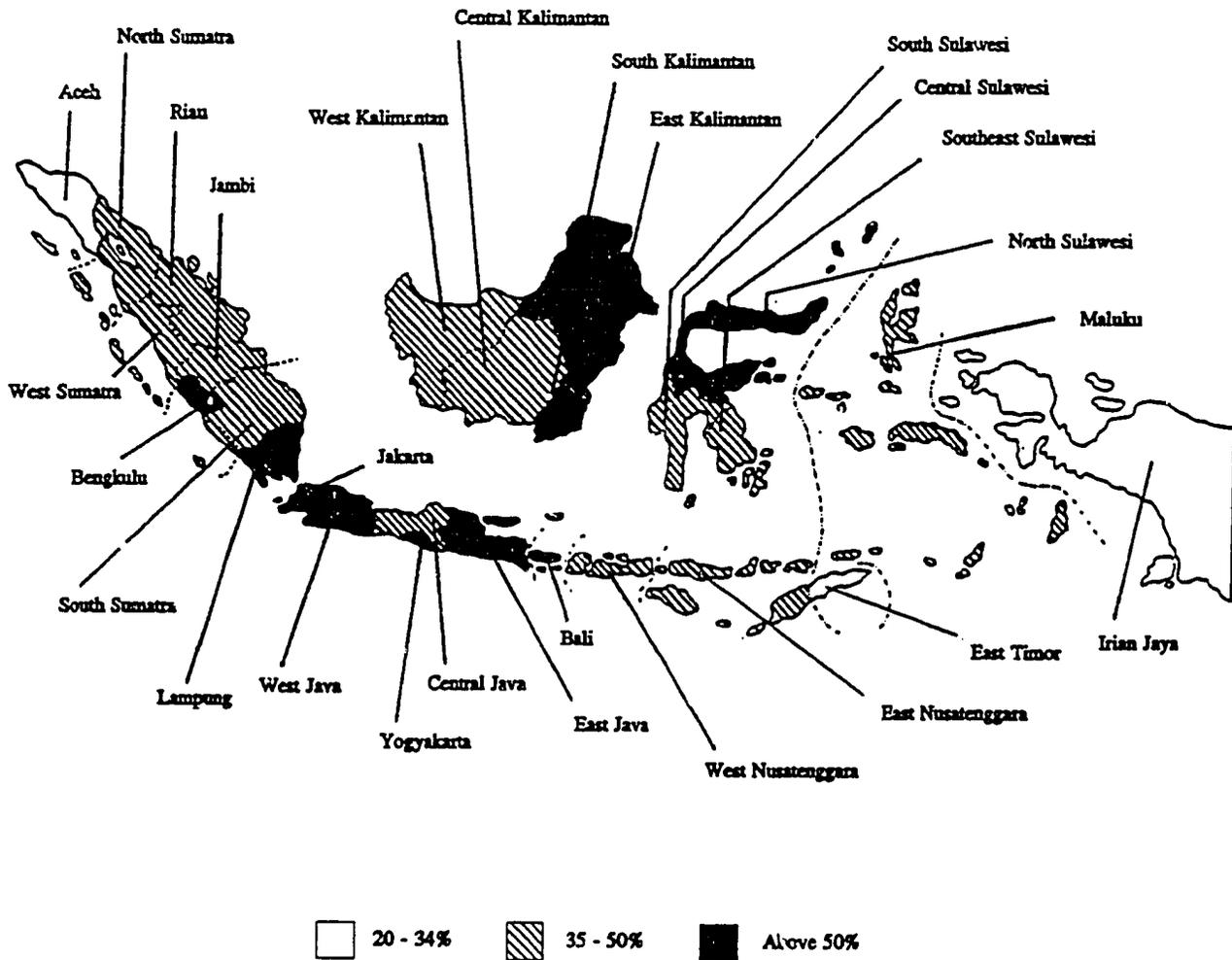
During the 1970s and 1980s, the BKKBN adopted its first major program initiative, "village family planning," as a national policy and program, designed to reach the majority of couples in rural areas who had limited access to fixed facilities. The program arose from the realization that there was little hope of reaching the great majority of Indonesian couples through the limited, existing Ministry of Health (MOH) network of health clinics. In many cases, the health clinics faced severe shortages of staff, especially physicians. Similarly, most clinics were in urban areas although over 80 percent of the population was rural.

In 1972, with support from A.I.D., the BKKBN began a pilot study in West Java to test the idea of using village volunteers with basic training to serve as community distribution agents for oral contraceptives and condoms and to refer clients for other methods to health clinics. The village volunteers were recruited, supervised and supported by the government network of family planning fieldworkers. Within a year, the results appeared so encouraging that the BKKBN decided to extend the approach throughout the country, this time using A.I.D. technical assistance. A guarantee by A.I.D. officials to provide all the contraceptives needed allowed BKKBN officials to plan confidently for phased geographical expansion.

The BKKBN's coordinating role grew as it galvanized other ministries to take actions that would support the program. The MOH provided staff at its hospitals and health centers for clinical contraceptive methods (IUDs and later injectables, implants, and both male and female sterilization). The Ministry of Information made time available on radio and television to advertise the program. Many other ministries, including the Ministries of Religious Affairs, Education, Agriculture, and Youth and Sports, participated in national, provincial, regency, and sub-district coordinating committees to focus attention and resources on the expanding family planning program.

In the late 1970s, recognizing that family planning is only one element in improving family welfare, the BKKBN initiated programs to provide basic health and nutrition information and services through its vast village network and to provide funds for income-generating activities by members of the village family planning groups. Beginning in 1980, funds from A.I.D. supported these activities in three provinces and other donors contributed other funds to expand the program nationally.

## Contraceptive Prevalence Rates in the 27 Provinces of Indonesia (Modern and Traditional Methods)



**CPR by Region and Province**  
(Country Total 49.7%)

**Java - Bali 53.4%**

- Bali 71.9%
- Yogyakarta 71.3%
- Jakarta 56.0%
- East Java 55.4%
- West Java 51.0%
- Central Java 49.7%

**Outer Islands I 43.5%**

- North Sulawesi 68.5%
- Lampung 53.8%
- South Kalimantan 51.9%
- South Sumatra 47.1%
- West Kalimantan 44.0%
- West Sumatra 40.3%
- West Nusatenggara 39.0%
- North Sumatra 37.2%
- South Sulawesi 37.1%
- Aceh 28.9%

**Outer Islands II 42.8%**

- Bengkulu 58.3%
- East Kalimantan 57.9%
- Central Sulawesi 50.4%
- Jambi 47.9%
- Central Kalimantan 44.6%
- Maluku 43.2%
- Southeast Sulawesi 41.9%
- Riau 39.8%
- East Nusatenggara 39.2%
- East Timor 25.1%
- Irian Jaya 20.6%

Source: 1991 IDHS

The success of this approach was already clear by 1980, when the census of that year revealed that contraceptive use was higher in rural areas than in urban centers. This was exactly the opposite of the experience in most other developing countries, but not a surprising result given the BKKBN emphasis on village distribution.

The village family planning program was the government's first social program to reach effectively into all of Indonesia's 66,000 villages and hamlets. Extensive community participation and use of village volunteers have made the program a model for the introduction of other social services.

### **A.I.D.'s Role: A Partnership Village Family Planning**

The pattern of partnership between A.I.D. and BKKBN was established at the start in the village family planning program. The two organizations agreed on needs that could not be funded internally and A.I.D. responded quickly. For example,

- A.I.D.'s funding for the pilot study in West Java proved that the innovative concept of using village volunteers to provide family planning would work. The technique continues to be used successfully today, more than 20 years later.
- A.I.D. technical assistance, A.I.D.'s guarantee of adequate contraceptive supplies, and A.I.D. funds for training fieldworkers and village volunteers allowed BKKBN leaders to plan with confidence the national expansion of the village family planning initiative. The costs of introducing a program were covered by A.I.D. funds but BKKBN covered recurrent costs. This pattern continues to this day, with other donors continuing to cover costs of program expansion and BKKBN financing an ever-growing basic program.
- One social service project that was modeled after the family planning program linked nutrition and health services with ongoing family planning operations. This was developed in response to family planning users' increasing concerns about improving the health and nutrition of their families, especially their children. Once again, the A.I.D. funds served as seed money but when the usefulness and success of the program were established, other ministries and donor organizations provided additional funds to expand to other villages. The project provided initial support for 7,500 villages in East Java and Bali. The MOH later provided funds for 10,000 villages and UNICEF supported activities in 25,000 villages.

Had the village family planning program not had early support from A.I.D. to test innovative concepts, technical assistance to expand the program, and a guaranteed supply of contraceptives, it might not have unfolded so convincingly, and the government might not have been persuaded eventually to take over nearly full support of the program.

## Urban Family Planning

Although the earliest family planning programs had started in urban areas, the heavy demands of the village family planning program consumed most of the time and resources of BKKBN throughout the 1970s. With the encouragement and urging of President Soeharto, in 1980 the BKKBN undertook its second major program initiative, developing an urban strategy to meet the needs of the rapidly increasing urban population. These needs were somewhat different from those of villagers; A.I.D.-funded studies of 3,000 men and women in Jakarta indicated that clients in the cities preferred receiving information and contraceptives from private doctors, midwives, and pharmacies.

These findings appeared at a time when the economic and policy climate were changing. In the early 1980s, government of Indonesia (GOI) revenues had begun to drop in line with a rapid decline in world oil prices. As a result, government budgets were substantially reduced, including, for the first time, the BKKBN budget. This in turn led to a change in government policy, with the focus shifting to increasing private sector involvement in all sectors of the economy. A.I.D.'s policies were also beginning to promote privatization, a new emphasis combined with an increased concern with equity and efficiency in public sector resource allocation. These new policies, in conjunction with the apparent receptivity of the urban population to paying for contraceptive services, led the BKKBN to explore options for shifting part of the financial burden of family planning to consumers.

An initial effort to learn whether this would occur was made by Yayasan Kusuma Buana (YKB), an Indonesian NGO devoted to family planning. YKB established several fee-for-service urban family planning clinics in Jakarta in an attempt to determine whether lower-middle income urban families would pay for family planning services.

### A.I.D.'s Role: Key Support Urban Family Planning and Private Sector Promotion

In the 1980s, as the BKKBN launched its second major initiative, urban family planning, A.I.D. shifted its technical experts and funds to this new activity and provided support at each crucial step, testing innovative concepts and stimulating involvement of the private sector.

- A.I.D. funded the initial survey of men and women in Jakarta that established that urban clients preferred to get their contraceptives from doctors, midwives, and pharmacies.
- A.I.D., along with the United Nations Population Fund (UNFPA), provided the technical assistance and financial support that made possible YKB's experiment to establish fee-for-service clinics in moderate-income neighborhoods of Jakarta.
- A.I.D.-funded technical experts in 1987 helped develop the special Blue Circle logo to identify private doctors, midwives, and pharmacists who would participate in the program. Subsequently (after BKKBN provided free contraceptives to these private providers to sell cheaply), A.I.D. provided specialists and funds to strengthen the professional associations of doctors, midwives, and pharmacists, to train their members, and to organize advertising and promotional activities.
- A.I.D. expanded its support in 1988 for promotion, advertising, and marketing of locally produced contraceptives under the Blue Circle logo, including oral contraceptives, IUDs, injectables, and condoms.
- A.I.D. financed research to investigate various approaches to move to community financing of family planning in urban and rural areas. It also financed studies to analyze the feasibility of providing health and family planning services to low- and middle-income clients through Indonesian health insurance organizations. These studies demonstrated that donor funds could leverage considerable private sector investments in family planning.

This A.I.D. support has been critical in allowing for the substantial shift to private sector delivery of contraceptives. Even in a favorable policy climate promoting privatization, it is unlikely that the shift could have occurred without increased consumer awareness of private outlets, reasonably priced and widely available contraceptives, and private providers motivated and trained to offer family planning services.

The pilot effort looked promising. As a result, a commercial contraceptive supply program was developed to sell contraceptives at discounted prices in retail outlets. The program uses private Indonesian companies to advertise, distribute, and market a variety of contraceptives at prices that are lower than for other commercially available brands. It also broadly promotes clients' use of private doctors, midwives, and pharmacies. Beginning with the "Dua Lima condom" program, it expanded from initial efforts in Indonesia's 11 largest cities to 37 cities, then 301 cities throughout the country, and finally to many rural areas as well. By 1989, the Dua Lima condom had become the market leader, overall condom sales had increased, and the project had achieved financial self-sufficiency.

The success of this condom sales program encouraged BKKBN to expand the program to

include a broad range of contraceptive products to be introduced into the commercial market under the Blue Circle label and sold at competi-

tive prices. This second phase is known as the "Blue Circle" program. The 1991 IDHS indicates that 22 percent of couples now pay for family planning services through the private sector, up from 12 percent in 1987.

In mid-1992, BKKBN announced the introduction of a "Gold Circle" line of contraceptives, another creative step in the evolution of contraceptive social marketing in Indonesia.

Gold Circle products are to be sold at commercial prices in urban areas. They will also be sold at subsidized prices, through BKKBN distribution if necessary, to reach rural areas through a new cadre of 60,000 village midwives. It is too early to predict the impact of this newly announced program on Blue Circle products and on increasing contraceptive use.

#### KB Mandiri

The BKKBN has developed a strategy of family planning self-reliance (*KB Mandiri*), which encourages individuals and communities to assume greater responsibility for family planning, including paying for services. *KB Mandiri* is a concept related to consumers' assuming the costs of family planning services in relation to their ability to pay. Under full *KB Mandiri*, the couple takes responsibility for all costs of services; partial *KB Mandiri* is for couples whose limited income permits them to pay only part of the costs of services; and pre-*KB Mandiri* is for couples whose economic status is so low that paying for services would create an economic hardship. *KB Mandiri* is closely related to a traditional Javanese concept of *gotong royong*, or mutual self-help, which unites individual villagers to act for the social good of the community.

### 3. A.I.D. Support

Donor support has been critically important for the functioning of the Indonesia family planning program. A.I.D. has led the way, with total funding of nearly \$250 million and with special emphasis on technical assistance, training, contraceptives, and funds for local support for policy and program development. Significant

support has also come from many other donors, in particular the World Bank (\$226 million, including projected funding) and UNFPA (\$83 million). Other donors include the IPPF, the government of the Netherlands, the World Health Organization (WHO), and the Japanese assistance program.

#### The Impact of A.I.D. Assistance in Population Program Development

Over the past 25 years, A.I.D. has been the largest donor to the BKKBN and other Indonesian family planning organizations. It provided intellectual and conceptual stimulation in the initial development of both the rural and the urban phases of the program. Over time, it continued to provide the technical assistance and substantial financial resources to assist the GOI to develop and expand its national family planning program. Since 1968, A.I.D. has provided nearly \$250 million in both bilateral and central funds through projects with both governmental and private organizations. Funds have been combined with a strong in-country technical presence complemented by numerous resident and short-term experts. Their close collaboration with BKKBN colleagues has enabled A.I.D. staff and advisers to marshal resources quickly to meet program changes and provide rapid support for new program initiatives.

Specifically, A.I.D. has contributed a total of \$187 million in bilateral funds, including \$167 million through five bilateral population projects and \$20 million through a bilateral health project which promoted the integration of family planning, health, nutrition, and income-generating activities. Funds for procurement of contraceptives have been the single largest element of A.I.D.'s bilateral assistance.

The Office of Population has provided an additional \$66 million in funding, including \$40

million through Cooperating Agencies and \$22 million in contraceptives. Among the Cooperating Agencies, the Association for Voluntary Surgical Contraception (AVSC) has provided most of its support to the Indonesia Association for Secure Contraception (PKMI), which promotes voluntary sterilization. The Pathfinder Fund has supported NGOs in a number of innovative activities including training of religious leaders and provision, by boat, of services to persons along rivers and islands. The Social Marketing for Change (SOMARC) project supported efforts to design and introduce the Dua Lima and Blue Circle contraceptive social marketing programs, and the Population Communication Services project provided technical assistance to develop the Blue Circle logo. The Population Council has played a seminal role in the introduction of the implant, NORPLANT®. Family Health International supported local contraceptive research through grants to the Indonesian Fertility Research Program.

Although A.I.D. provided funds through projects with specific goals and objectives, the A.I.D. funds were always viewed by BKKBN and A.I.D. officials as contributions to the Indonesian national family planning program, not as discrete A.I.D. projects. The strong government involvement, in combination with the program's many achievements, has stimulated continued and expanded financial commitment not only by the government, but on the part of other donors as well.

## **Key A.I.D. Inputs into Indonesia's Family Planning Program**

### **For the expansion and improvement of family planning services:**

- Continuous supply of adequate contraceptives (\$80 million) and development of computerized logistics and management information systems.
- Technical expertise and equipment to establish local production of oral pills and IUDs.
- Financial and technical support, medical equipment, and training for the expansion of voluntary sterilization services throughout Indonesia.
- Vehicles to enable field supervisors to monitor family planning programs.
- Financial support for the introduction of the village family planning program.
- Financial support for advertising and technical assistance to promote the use of private doctors, nurses, and midwives to expand family planning, primarily in urban areas.

### **For strengthening the institutional capability of BKKBN and other Indonesian institutions to organize, manage, and evaluate their family planning programs:**

- Extensive long- and short-term training in the U.S. and locally to provide over 1,300 Indonesians with advanced management and technical skills in family planning. In-country training for tens of thousands of Indonesians involved in the field operations of village and urban family planning.
- Assistance in developing the computerized logistics system to manage contraceptive distribution.
- Assistance to BKKBN in management information systems and data processing for improvement of its operational, financial, and administrative management systems.
- Key operations research and national Demographic and Health Surveys to measure program performance and impact.

The funds provided by A.I.D. have been used for two major purposes: the expansion and improvement of family planning services and the strengthening of the institutional capability of BKKBN and other Indonesian institutions to organize, manage, and evaluate the family planning program. The A.I.D. assistance to the evolving rural and urban programs was primarily designed to stimulate service provision, and succeeded remarkably well in ensuring the spread of services nearly country-wide. As shown in the box on the preceding page, the provision of contraceptive supplies was also a critical part

of A.I.D.'s assistance. Thus, for service delivery, donor support has been available at critical formative stages of program development, providing the inputs needed to launch and initially sustain activities whose costs were subsequently assumed by the government. The second type of A.I.D. assistance, for institutional development, is equally important for long-term program sustainability. This has included key support for training and technical assistance to BKKBN and the many other Indonesian institutions that support the national family planning program.

## The Expansion and Improvement of Family Planning Services

### Support for Wide Choice of Methods: Key to an Effective Service Delivery Program

Without an adequate supply of contraceptives, a family planning program cannot operate. Particularly during the early stages of the program, A.I.D. helped assure the viability of the Indonesia program by providing significant quantities of oral contraceptives, condoms, and IUDs. Without a choice of methods, particularly longer-term, more effective methods, a program may lose much of its effectiveness. Here again, A.I.D. has played a pivotal role by making sterilization available in the country.

### Contraceptive Supplies

Indonesia stands nearly alone among developing countries in having moved from reliance on donors for its contraceptives to near self-sufficiency. In supporting this move, A.I.D. employed the same strategy it used in the village and urban family planning programs. It began by carrying the full burden: Between 1968 and continuing through the mid-1980s, A.I.D. expended over \$80 million for contraceptives. (The World Bank, UNFPA, IPPF, and the Dutch government also provided limited supplies of contraceptives over this period.) At the same time, as it became apparent that donors would not

be able to meet the increasing demand from the expanding village family planning program, A.I.D. agreed with BKKBN that the answer was developing the domestic capacity to produce contraceptives. A.I.D. therefore provided the support that was needed to begin production. It provided technical expertise, specialized production and packaging equipment, training for Indonesian staff, and an initial supply of raw materials for the domestic manufacture of oral contraceptives.

### Indonesia: Success in Local Contraceptive Production

In 1978, the state-owned pharmaceutical producer, Kimia Farma, began planning for an oral contraceptives factory in Bandung. When it began operations in 1980, the BKKBN purchased the entire production. The plant now provides most of BKKBN's oral contraceptive requirements and the BKKBN has included funds for procurement within its regular budget. Local manufacture has since expanded to include IUDs, condoms, and injectable contraceptives. The IUD manufacturer received support from A.I.D., the condom factory from the Japanese, and the injectable is produced by a private pharmaceutical company.

## Voluntary Sterilization

Voluntary sterilization is considered a medical procedure and is available through MOH facilities. Because of potential religious opposition, voluntary sterilization has not been widely promoted, although the number of procedures has increased steadily each year. A.I.D. has provided medical equipment and supplies to the MOH to support this method.

A.I.D. encouraged the founding of PKMI in 1974 to publicize and promote voluntary sterilization, to train physicians and nurses, to establish medical standards, to monitor the quality of services, and to establish 11 PKMI training centers. A.I.D. continues to support PKMI, a national organization that includes many leading obstetricians and gynecologists, especially in its

### **Sterilization: Limited Role in Indonesia Family Planning Program**

In 1974, some 9,000 voluntary sterilizations were performed in Indonesia. By 1991, the number performed annually had grown to nearly 146,000. During the past 17 years, a total of over 1.4 million voluntary sterilization procedures have been performed. Despite this impressive increase, voluntary sterilization represents only 6.6 percent of all users — a figure far below that of other countries with similar or higher overall contraceptive prevalence.

efforts to improve quality of services and to make this important fertility control method widely available throughout the country. PKMI works under the policy direction of BKKBN and the MOH.

With A.I.D. funds, AVSC has provided \$7 million to the program. Its efforts have included a wide range of activities: training doctors, paramedics, and counselors; offering professional education for medical personnel; developing standards and guidelines for voluntary sterilization services; providing sterilization services in government facilities; introducing the no-scalpel vasectomy technique; and providing technical assistance to the national family planning program.

## Implants

When the new contraceptive implant, NORPLANT<sup>®</sup>, became available for clinical and field trials, Indonesia eagerly accepted the opportunity to test the first new contraceptive method to be introduced since the 1960s. Technical and financial support for the clinical introductory efforts were provided by the Population Council with substantial A.I.D. funds. The method, which provides up to five years of protection, proved highly acceptable to Indonesian women, an encouraging development in view of the relatively low use of voluntary sterilization in the country. NORPLANT<sup>®</sup> was formally introduced into the national program in 1986. Since then the number of annual NORPLANT<sup>®</sup> insertions has increased rapidly. By the end of 1991, over 1 million insertions had been reported, making Indonesia's the largest NORPLANT<sup>®</sup> program in the world.

## Institutional Development

When BKKBN was created in 1970, its fledgling staff needed help in organizing to meet the challenge of developing a national family planning program. A.I.D. provided much of that help, particularly by training BKKBN staff, providing technical expertise to develop the logistics and management information systems and strengthen-

ing research and evaluation capabilities. In recent years, A.I.D. has encouraged BKKBN staff to share its expertise with other developing countries by supporting the BKKBN's International Training Program, which has become a well-known resource for training visiting population experts.

## Training

A.I.D.-funded training has had a powerful influence on an entire generation of Indonesians involved in family planning and public health policy and program management. Over 1,000 Indonesians have gained technical and managerial skills and have been exposed to new ideas through long-term graduate education in the U.S. and short-term technical training in the U.S. and other countries. An additional 300 Indonesians received undergraduate or graduate training at Indonesian institutions with A.I.D. financial support.

Such training was critical for program development. At the program's start in 1970, few Indonesians had been trained in family planning, mainly the physicians and support staff working in the health clinics supported by the PKBI. With the creation of the BKKBN came an immediate need for staff who understood both the technology and management of family planning. The far-reaching effects of A.I.D.'s training are demonstrated by the current BKKBN senior leadership; the chairman, vice-chairman, all of the deputies, many of the bureau chiefs, and many of the provincial BKKBN chiefs have received either graduate education or technical training with A.I.D. support. In addition, A.I.D. provided scholarships for the research and teaching staffs of leading Indonesian institutions which support the national family planning program. These include the MOH, the Central Bureau of Statistics, and demographic research centers at the University of Indonesia and at Gadjah Mada University. Also, A.I.D. supported the development of all five schools of public health and trained many of their faculty members.

Tens of thousands of Indonesians involved in the field operations of village and urban family planning programs have received training with funds provided by A.I.D. These include village leaders, government officials at all levels, physicians, midwives, pharmacists, and fieldworkers. Most important, A.I.D. supported BKKBN's efforts to train the 25,000 volunteers

annually who serve as village contraceptive distributors.

In 1988, A.I.D. provided substantial financial and technical support to the BKKBN for the organization of the International Training Program, which conducts courses on planning and managing family planning programs. These courses include field visits to provide participants first-hand experience with community participation and village organization.

## Contraceptive Supplies and Logistics

Assistance in the 1970s from A.I.D. staff to BKKBN was important in the development of the computerized logistics system essential for managing the immense contraceptive supplies and distribution envisioned for the rapid expansion of the village family planning program. This system continues to distribute large quantities of contraceptives with few problems of stock shortages — no small feat for a program encompassing a large geographical area with many remote areas to be served.

## Management Information System and Computerization

A.I.D. has provided substantial funding for the development of BKKBN's management information system and data processing facilities. In the early 1970s, A.I.D. provided the first computer and software at BKKBN headquarters. In the 1980s, A.I.D. funds enabled BKKBN to equip headquarters offices and 21 of the 27 provinces with the latest computer technology and staff training. This technology has enabled BKKBN to improve its operational, financial, and administrative management systems. A special A.I.D. grant provided funds to equip all regencies in West Java with computers and to provide software and staff training to determine the utility of computer technology at this administrative level. This innovative A.I.D. pilot project has led BKKBN and the World Bank to finance similar computer technology throughout the rest of the country.

## Research and Evaluation

Over the past two decades, A.I.D. has committed considerable resources to improve the BKKBN's research and evaluation capabilities. During the 1970s, the development of BKKBN's service statistics system received primary attention because research and evaluation studies conducted during this period were most often based upon these data. There was little systematic investigation of new program initiatives. BKKBN tended to rely upon the observations of field-based program managers in evaluating the effectiveness of new program strategies. In recent years, BKKBN has given greater attention to the development of its research and evaluation programs. A.I.D. has been a major contributor in this effort by providing technical assistance and funds to BKKBN's three main research centers.

Both the 1987 National Indonesia Contraceptive Prevalence Survey (NICPS) and the 1991 Indonesia Demographic and Health Survey

(IDHS) have been supported by A.I.D. These national surveys provided BKKBN with reliable independent program performance measures, including estimates of fertility, infant and child mortality, contraceptive prevalence, unmet need for family planning, the cost and source of family planning services, and treatment and coverage rates for major maternal and child health interventions. BKKBN research staff participated in the analysis of these surveys and have acquired greater skills in analyzing large data sets and preparing policy-relevant reports.

A.I.D. also provided assistance for developing operations research capability within BKKBN. Operations research studies proved especially useful in demonstrating the feasibility of expanding family planning services through the private sector, planning more effective integration of family planning and health services in the sub-district health centers (*puskesmas*) and village health posts (*posyandu*), and developing new safe motherhood initiatives.

## Other Donors

Other donors have also made major contributions to the Indonesia family planning program.

**World Bank** The World Bank made its first population loan to Indonesia in 1972. In a total of five loans, the Bank has or will provide \$226 million in program support. World Bank funds have concentrated on infrastructure development, as well as substantial purchases of vehicles, equipment and training materials, international and local training, and contraceptives. In the current (fifth) loan, the World Bank will also support the training and deployment of 16,000 village midwives to serve as the new frontline of family planning service delivery at the village level.

**United Nations Population Fund** The UNFPA has been supporting population assistance programs in Indonesia since 1972. In four country programs totaling \$83 million, UNFPA has supported family planning service expansion, physical infrastructure development, training, family planning promotion, and a wide variety of other population and family planning activities.

**Other Donors** IPPF supported the creation and development of the PKBI. The Government of the Netherlands has provided some contraceptives and limited sums for field programs and training activities to BKKBN. WHO has contributed funds for contraceptive clinical trials and other research activities. The Japanese assistance program has cooperated in the development of a condom factory and also provided audio-visual equipment.

## 4. Ingredients of Success: Indonesia's Family Planning Program

Although A.I.D. has contributed in an exemplary way to program success, the critical actor in this partnership — Indonesia — must receive the major credit for the fine performance of its national family planning program. Part of the reason for the program's effectiveness lies in the political and socioeconomic conditions found in the country. Equally, or even more important, however, have been the government's policy support, the creative leadership, the financial support, and the innovative program strategies that have combined to make this a program worth studying and emulating. Indeed, as the Indonesian na-

tional family planning program has expanded and improved, it has achieved international recognition. Today, family planning policymakers, program managers, and researchers come from throughout the developing world to learn from Indonesia's experiences. Indonesia now trains senior-level policymakers and program managers from Nigeria and Senegal, Bangladesh and India, Vietnam and Egypt.

Below is an effort to offer to a wider audience lessons about ingredients for success that can be distilled from a close look at the Indonesia experience.

### Non-Program Factors

#### Political Factors

**Sustained Political Commitment** No developing country leader has given more public support to family planning than has President Soeharto. His powerful leadership and guidance for the national family planning program has not wavered since he announced, in 1967, that family planning would be included as part of the national development program. In 1968, he joined other

*No developing country leader has given more public support to family planning than has President Soeharto.*

world leaders in signing the United Nations Declaration on Population, the first international recognition that rapid population growth was a major problem in achieving economic growth. Having the BKKBN report directly to him reinforced the importance President Soeharto placed on rapid population growth.

The president's support of family planning has produced a strong trickle-down effect through-

out the government bureaucracy. Promotion of family planning is one measure used to assess the annual performance of government officials at every level. Performance awards based on competition among provinces, regencies, and sub-districts have helped to expand the family planning program.

**Political Stability** The quarter century of political stability enjoyed by the people of Indonesia under a government dedicated to social and economic development has contributed to the relatively smooth implementation of the national family planning program. The country has avoided frequent changes of government leadership and policies which often delay implementation of such efforts. Since 1970, the BKKBN has had only two chairmen. The first chairman served for 13 years, and the second chairman has served since 1983. Similar continuity appears at lower levels in the organization. This uninterrupted succession of staff has given the BKKBN unusual bureaucratic strength and cohesion.

## Socioeconomic Factors

**Demand for Fertility Control** A strong latent demand for reducing family size provided a receptive environment for the national family planning program. The supply-driven program strategy adopted by the government helped bring about a dramatic fall in the number of children desired by many Indonesian families. In 1976, couples on Java and Bali wanted 4.2 children

*The national family planning program has been able to raise the level of contraceptive use rapidly over the past 20 years by serving many families who were acting upon lower fertility preferences.*

program has been able to raise the level of contraceptive use rapidly over the past 20 years by serving many families who were acting upon lower fertility preferences. Future growth in the program is predicated on mobilizing demand from the 50 percent of couples not presently using family planning, especially among those who express a desire to space or limit their family size.

**Socioeconomic Development** Improved socioeconomic conditions, partly spurred by the decline in fertility, have helped to accelerate Indonesia's demographic transition. Particularly important has been the government's strong commitment to education. Primary education is now mandatory and secondary and university education facilities are expanding rapidly throughout the country. Indonesia now has a high literacy rate of 74 percent, and — significant for fertility decline — this includes 65 percent of females over the age of 10. Women now also constitute more than one-third of the labor force, according to the 1990 Population Census. Numerous studies

have shown that use of family planning tends to increase as women are better educated and become integrated into the formal work force.

**Cohesive Village Structure** Villages on Java and Bali have a long tradition of mutual self-help (*gotong royong*), working together to improve conditions in the village. Decision-making for many important village activities, from the proper times to plant crops or divide irrigation water to the planning of cultural and religious festivals, is in the hands of village councils. Once a council discusses and comes to an agreement, the entire village will join in the activity.

The BKKBN has capitalized on this tradition, winning the cooperation of villagers by enlisting the support of the councils and their elected or informal village leaders in the family planning program. BKKBN staff have participated in village-level discussions with council members and have provided training for the various cadres of villagers. These discussions often lead to selection of persons to serve as village contraceptive distributors and to maintain village records of contraceptive use.

Co-opting village leadership played a critical role in the early expansion of family planning and continues to be an important element in village family planning today.

Although the outer island provinces have much lower population densities and the influence of village leadership is not considered as powerful as on Java and Bali, the village family planning system pioneered on these islands seems to be an effective mechanism for delivery of family planning services on the outer islands as well.

*The BKKBN has capitalized on this tradition [of mutual self-help], winning the cooperation of villagers by enlisting the support of the councils and their elected or informal village leaders in the family planning program.*

## Program Factors

**Population Policy Development** From the program's inception, the government has supported its family planning efforts in highly visible and concrete ways. Although during the 1960s, the PKBI had begun to introduce the topic

*The government adopted a policy to promote the "small, happy, and prosperous family."*

of family planning and smaller families as a legitimate issue for public discussion, it was not until the national program began that these ideas gained national recognition. The government adopted a policy to promote the "small, happy, and prosperous family." This struck a responsive chord among large segments of the Indonesian population. It also incorporated many other national development policies: increased agricultural development for national food self-sufficiency and greater rural employment; reduced illiteracy through expanded educational opportunities, especially for women; and greater access to health care throughout the country, with special attention to reducing infant mortality through preventive public health services.

**Strategic Planning** The adoption of a highly visible and clear-cut population policy in support of the national family planning program has helped galvanize popular support for the program. That the policy is drawn in terms of quantitative goals is equally important, illustrating the sophistication of the Indonesian program. Use of targets is characteristic of a committed, well-managed program. Many developing countries have yet to incorporate targets into program management.

The magnitude of the initial target adopted (halving of the birth rate over the 30-year period 1970 to 2000) was a daunting challenge for a program that was only in its organizational stages. Because the policy was part of a larger effort, including the BKKBN, the president, and government resource support, the goal appears

to be achievable and the practice of marking progress by five-year incremental targets continues to keep the Indonesian program on track. More recently, a new target has been set — to achieve replacement fertility (a TFR of 2.1) by the year 2005.

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**Creative Leadership** The BKKBN has been fortunate in having leaders who have been willing to test original approaches to expanding services and who continue to seek innovations and ways of improving the program. In the early 1970s, the concept of village family planning represented a daring departure from the traditional reliance on fixed health centers for services. When early tests provided evidence of the soundness of using village volunteers, the BKKBN made this a national policy and began steps to expand the program nationally. Similarly, in the early 1980s, the urban approaches were new in the Indonesian setting, relying on a fee-for-service concept rather than free distribution of contraceptives. Likewise, the BKKBN's move to initiate related health, nutrition, and income-generating activities in villages was creative and far-sighted, serving to reinforce the effectiveness and acceptability of the family planning program.

*The BKKBN has . . . leaders who . . . test original approaches to expanding services . . .*

**Information, Education, and Communication** The BKKBN has excelled in the creative use of traditional and mass communications to promote family planning. The president has willingly and frequently addressed the country on the importance of reducing the rapid rate of population growth for the good of the country and for the health and welfare of each family. The family planning slogan, the "small, happy,

and prosperous family," and its accompanying logo, have achieved a national recognition that is the envy of commercial advertising and marketing companies.

*The BKKBN has excelled in the creative use of traditional and mass communications to promote family planning.*

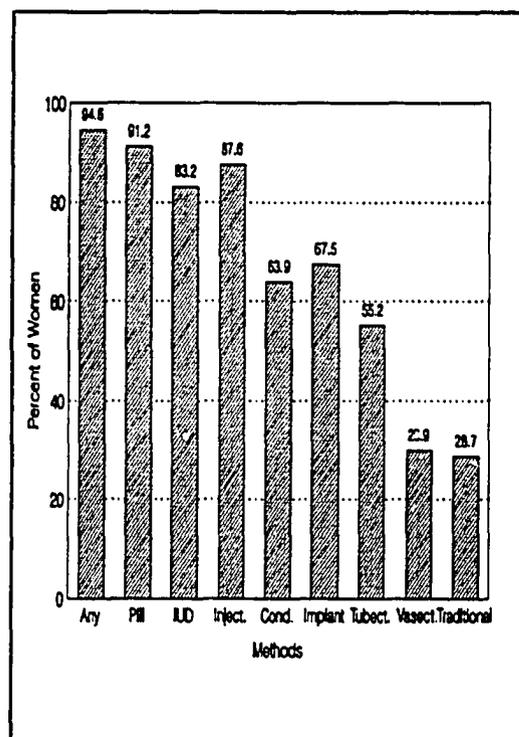
Likewise, the Blue Circle logo is a familiar reminder to many Indonesians of the availability of family planning. The current BKKBN chairman is a master of public relations and has easy access to the mass media organizations.

Soon after the creation of the national family planning program, the BKKBN began to mount massive publicity campaigns relying on the technical resources of the Ministry of Information and mass media institutions. Successive surveys have shown the increase in public knowledge of family planning and contraceptive methods. The preliminary results from the 1991 IDHS indicate that 95 percent of women of reproductive age know at least one contraceptive method and 93 percent know at least one source of information and contraceptives (see Figure 3).

**Islam and the Indonesian Family Planning Program** The BKKBN has been effective in enlisting Muslim leadership as an ally in promoting family planning throughout Indonesia. As the world's largest Muslim country, Indonesia might well have proved to be a difficult environment for family planning. Islam, however, also has a strong emphasis on the family and its welfare — values that fit well with the goals of family planning.

BKKBN has worked effectively to enlist the support of the Islamic community. It has focused both on influential public sector groups, such as the Ministry of Religious Affairs, and on leading independent Islamic organizations, which provide a wide range of social services, primarily in the areas of secular education and health. Over time, BKKBN has actively encouraged the involvement of respected Islamic organizations and religious community leaders in all aspects of program development and implementation.

**Figure 3**  
Indonesia  
Currently Married Women (ages 15 to 49):  
Knowledge of Particular Methods



Source: 1991 IDHS

It has offered orientation courses to help religious organizations and local-level Islamic leaders (*ulamas*) to understand and accept family planning. It has provided motivational activities in over 2,700 institutions

*Indonesia might well have proved to be a difficult environment for family planning, [but] BKKBN has worked effectively to enlist the support of the Islamic community.*

of learning, included family planning in women's Koran reading groups, brought family planning studies to religious schools, and supported the publication of newsletters that deal with religious issues. In addition, family planning services have been provided in over 800 health facilities operated by the Islamic Muhammadiyah organization and its women's branch, Aisiyiyah.

**Adequate Funding** Political support has been translated into substantial domestic funding which, coupled with ample donor support, has facilitated the rapid expansion of the Indonesian

national family planning program. At the start, the program was almost entirely donor funded, and external funding was critically important in enabling the BKKBN to initiate new programs. Today, donors provide less than 30 percent of total program costs, and the GOI has provided sustained levels of budget support to family planning, even when other social programs have faced funding cutbacks.

Donor assistance for family planning typically is designed with the goal of leveraging domestic resources. The remarkable aspect of the Indonesia experience is the consistent willingness and

*At the start, the program was almost entirely donor funded . . . Today, donors provide less than 30 percent of total program costs, and the GOI has provided sustained levels of budget support to family planning, even when other social programs have faced funding cutbacks.*

ability of the government to mobilize domestic spending for family planning program maintenance and expansion. The total budget for family planning, and the GOI share, have both increased steadily over the past 20 years, growing from \$1.2 million in fiscal

year 1970/71 to \$56.2 million in FY 1980/81 to \$74.2 million in FY 1990/91 (see Figure 4).

The MOH also has a budget line for family planning services, supplemented by cost reimbursement from BKKBN for voluntary sterilization services.

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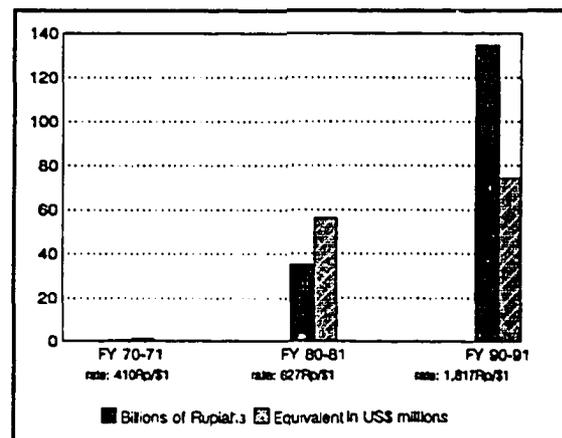
\$1.2 million in fiscal

## Organizational Strengths

**BKKBN as an Autonomous Coordinating Institution** The BKKBN as an autonomous coordinating institution, with its own budget line, has played a key role in mobilizing and directing family planning resources. Coordinating organizations exist in many family planning programs, but BKKBN is unique in the authority it has been accorded and the effectiveness with which it has exercised that authority.

The BKKBN's coordinating role assures that each ministry or private organization contributes to the program without duplication of effort. Coordinating mechanisms have been established at each level of government: national, provincial, regency, sub-district, and

Figure 4  
BKKBN Budget 1970-1991



Source: USAID

In recent years, the BKKBN budget increased more rapidly than the budgets of other governmental ministries. Even when oil prices decreased sharply in the early 1980s, the BKKBN budget was largely protected.

Indonesia is one of the few developing countries to have moved from total dependence on donor funds for commodities to nearly complete domestic production and domestic resource allocation to pay for needed contraceptives. In fiscal year 1991/92, the BKKBN purchased approximately \$27 million of contraceptives, a sum that represented nearly one-third of its budget.

*BKKBN is unique in the authority it has been accorded and the effectiveness with which it has exercised that authority.*

village. Periodic meetings, chaired by BKKBN officials, provide opportunities to discuss new policies, programs, implementation strategies, and problems.

**Strong Community Involvement in Family Planning** BKKBN's grassroots village organizational efforts have translated into widespread community support for the Indonesian national family planning program. The staggering number of persons it has enlisted to promote family planning at the village and sub-village level has enabled the program to make family planning an acceptable topic of public discussion, reduce fears and concerns, and

provide information, contraceptives, and peer support to couples throughout the nation. The involvement of community religious and political leaders has contributed considerably to the acceptability of family planning at the local level.

**Variety in Service Delivery** The BKKBN's adoption of three major delivery mechanisms — fixed MOH public services, village volunteers, and private providers — has increased the available options for Indonesians to obtain services, ensuring that family planning information and contraceptives are readily available throughout much of the country.

## Who Provides Services in the Indonesia Family Planning Program

**Government Services** The MOH is the most important implementing unit for clinical family planning services. Services offered through government agencies account for 78 percent of all contraceptive users. The Ministry provides a nationwide system of health services and employs 90 percent of all doctors and 80 percent of all nurses and midwives through a network of hospitals, health centers, and clinics. These are financed in part through a subsidy from BKKBN. The MOH also provides strong budgetary and technical support for public health programs, immunizations, and maternal and child survival services. The Ministry's hospitals and clinics provide the government's clinic-based contraceptive services (IUDs, injections, and implants), offer voluntary sterilization services in many facilities, and prescribe and provide most of the initial supplies of pills. MOH staff provide patient counseling and medical backup for contraceptive-related problems. Other GOI clinics and hospitals operated by the military and the Ministry of Interior are also important providers.

**BKKBN: Community Service Provision** As well as providing policy guidance and program coordination, the BKKBN serves as an implementing unit with a village-level staff of 33,000 family planning fieldworkers to promote and monitor the village family planning activities. These fieldworkers complement the MOH network and are the key link in maintaining and expanding the village family planning network throughout the islands. They recruit, train, and supply a vast number of village volunteer contraceptive distributors who provide door-to-door services. BKKBN also involves informal groups of community religious and political leaders who participate in the program throughout the country.

**Private Sector** In only four years, the proportion of couples who pay for family planning services has nearly doubled, rising from 12 percent to 22 percent of all users. Pills are still provided primarily through the public sector, although this is a method ideally suited for private sector provision. The GOI has set a goal of increasing the private provision of services to 50 percent of couples by the year 2000.

**Non-Governmental Organizations** Although NGOs were critical to the family planning program in the early days when the government was pro-natalist, today the NGOs serve mainly to supplement the national program. For example, NGOs target specific groups, specialize in clinic-based methods such as implants and voluntary sterilization, and test new approaches to service delivery. The major organizations are involved as follows:

- The PKBI focuses mainly on providing information and services to young people and the urban poor.
- PKMI promotes voluntary sterilization within the medical norms of the MOH.
- Yayasan Kusuma Buana (YKB) provides a non-governmental mechanism to support financially viable family planning and health clinics in lower-middle income urban neighborhoods.
- Other NGOs, such as religious organizations of Muslims and Christians, women's organizations, and village development organizations, have been encouraged by the BKKBN to become more active in providing information, counseling, and some contraceptive services to members.
- The Indonesian Medical, Midwives, and Pharmaceutical Associations are currently encouraging members to become active family planning providers through the Blue Circle contraceptive social marketing program.

## 5. The Future: Challenges and Opportunities

### Demographic Challenges

#### Total Fertility Rate

The current goal of the national family planning program is to reach a two-child family size (replacement level fertility of approximately 2.1) by the year 2005. This goal will entail an additional 30 percent reduction in the TFR over the next decade and a half (from 3.0 in 1991 to 2.1 in 2005), a seemingly realistic target given that fertility dropped by nearly 50 percent over the first 20 years of the program. Desired family size, however, is presently 3.0 births.

#### Contraceptive Prevalence Rate

In order to achieve a TFR of 2.1, the CPR must rise from 49.7 percent to at least 62.7 percent by the year 2005 (see Table 2 for the assumed method mix on which this projection is based). In comparison with other countries, a CPR of 62.7 seems low: Most countries do not achieve replacement fertility until about 70 percent of all married women aged 15 to 49 are using contraception. Indonesia, however, may be a special case. High divorce and low remarriage rates, low coital frequency, and high infecundity are other factors in Indonesia that are working to contribute to low fertility.

On the other hand, fertility may be under-reported in Indonesia. If this is the case, the future program performance needed to attain replacement fertility could be greater than 62.7. For example, if Indonesia's 1991 TFR were actually 3.5 rather than 3.0, then a contraceptive use rate of 66.3 percent in 2005 would be required to reach replacement fertility.

Table 2  
Current CPR and Projected CPR by Method  
Required to Reach TFR of 2.1 by 2005

Method	1991	1995	2000	2005
Pills	14.8	15.5	16.2	16.9
IUD	13.3	13.6	13.7	13.8
Injectables	11.7	12.8	14.2	15.7
Implants	3.1	3.6	4.3	5.0
Condoms	.8	1.2	1.8	2.5
Vasectomy	.6	.8	1.0	1.3
Tubectomy	2.7	3.0	3.4	3.8
Traditional	2.6	2.9	3.3	3.8
<b>Total</b>	<b>49.7*</b>	<b>53.3*</b>	<b>57.9</b>	<b>62.7*</b>

Source: 1991 IDHS

\*Discrepancy between the CPR by method and the totals is due to rounding.

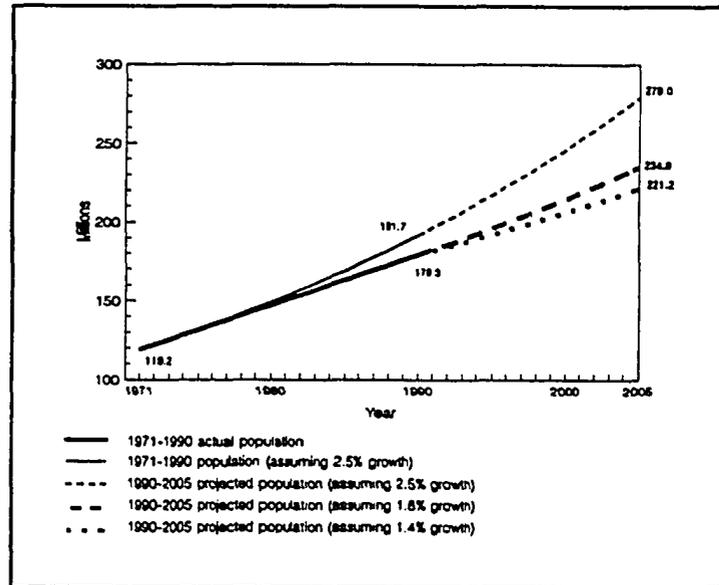
#### Rate of Population Growth

If there is a reduction in the TFR to 2.1 by 2005, Indonesia will have nearly 12 million fewer people than it would if the TFR were to remain at 3. Specifically, the total population would have grown to 234 million if the TFR remained at 3, not the current estimate of 221.2 million. This demographic dividend should enhance Indonesia's prospects for rapid and sustained prosperity in the coming century.

The magnitude of the dividend becomes more impressive, however, when viewed from the perspective of the entire program life. As noted in Chapter 1, the decrease in the annual

Figure 5  
Indonesia's Population Size by Year  
Assuming Different Growth Rates  
(1971-2005)

growth rate from 2.5 percent to the most recent estimate of 1.62 percent meant that Indonesia's total population in 1990 was 12.4 million persons smaller than it would have been had the growth rate remained constant. If, over the full 35-year period from 1970 to 2005, there were to be a constant 2.5 percent growth rate, Indonesia's population would expand by the year 2005 to 279 million people, or 57 million people more than the current projection (221.2 million). Fifty-seven million people is the equivalent of the population of France, or Turkey, or Thailand (see Figure 5).



Source: 1991 IDHS and team calculations

## Service Delivery Challenges

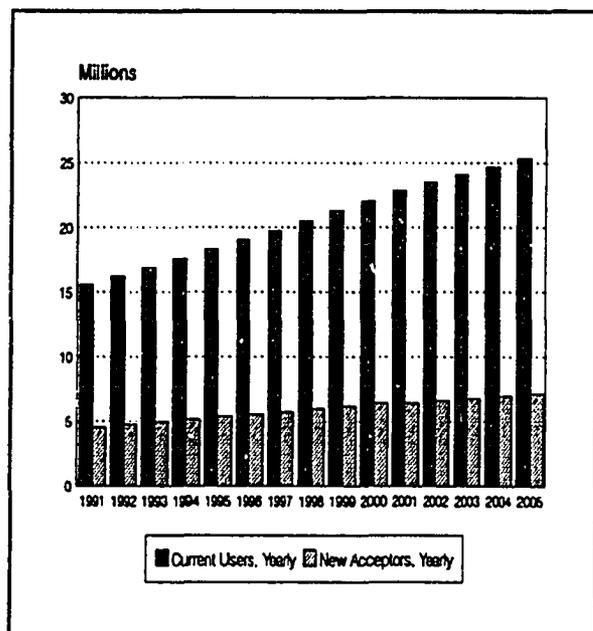
### Attracting Users

To achieve a CPR of 62.7 percent (the minimum rate projected to be needed to reach a TFR of 2.1 by the year 2005), the total number of current users must increase from 15.6 million in 1991 to 25.4 million by 2005. This represents an increase of nearly two-thirds over the present level of program performance. The sheer magnitude of 10 million users is daunting: This projected increase is larger than all of the current contraceptive users in sub-Saharan Africa.

From the perspective of program managers, the challenge is even greater than that number

would suggest. To achieve an increase of 10 million current users, over eight times that number would have to be recruited over the 13-year period. Not only do new acceptors need to be added to the total annually to increase the total volume of users; they must also be recruited to replace the large number of women who stop using contraceptives each year. (These two groups of new acceptors typically represent nearly 30 percent of the full complement of users in any given year.) In Indonesia, the total number of new acceptors needed from 1991 to 2005 would increase gradually from 4.6 million per year to 7.2 million annually (see Figure 6). The *cumulative* total of new acceptors would be around 85 million.

**Figure 6**  
**Current Users and New Acceptors by Year,**  
**to Achieve a CPR of 62.7 by 2005**



Source: 1991 IDHS and team calculations

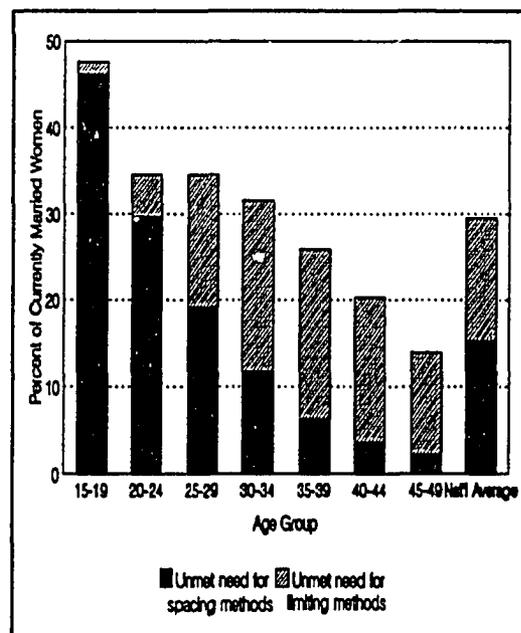
Of additional concern is the plateau that the program appears to have reached. If the CPR is to increase by more than 12 percentage points (50 percent to 62.7 percent) over a period of 14 years (1991 to 2005), the rate of growth will need to accelerate in comparison to the slow rate of growth over the past four years.

Program managers in Indonesia will be looking to the vast pool of women with unmet need for family planning to recruit the new acceptors needed to increase contraceptive prevalence. According to the 1991 IDHS, a total of nearly 14 million currently married women between the ages of 15 and 49 — or approximately three out of every ten (29.6 percent) — have unmet need. This includes (a) those women who have stated that they want either to space children or to limit their family size; and (b) those women who have reproductive goals that are not consistent with the demographic goals of Indonesia's national family planning program, which are limiting family

size to two children and encouraging couples to space births.

More than half of the women with unmet need are aware of the need for family planning services and therefore would tend to be receptive to program efforts to provide a method. Of those who are aware of this need, slightly over half require spacing methods, with the remainder requiring limiting methods. Overall, about half the unmet need (15.4 percent representing some 7.2 million women) is for spacing methods and the other half (14.2 percent representing 6.7 million women) is for limiting methods (see Figure 7).

**Figure 7**  
**Unmet Need for Family Planning among**  
**Married Women of Reproductive Age**  
**(Ages 15 to 49)**



Source: 1991 IDHS

Spacing need is concentrated primarily among women aged 15 to 24 whereas limiting need is most common among women aged 30 to 49 years. Unmet need is higher in the outer islands than in Java and Bali, but because the number of women of reproductive age is

considerably higher on Java and Bali, the absolute number of women with unmet need is still higher on Java and Bali than on the outer islands.

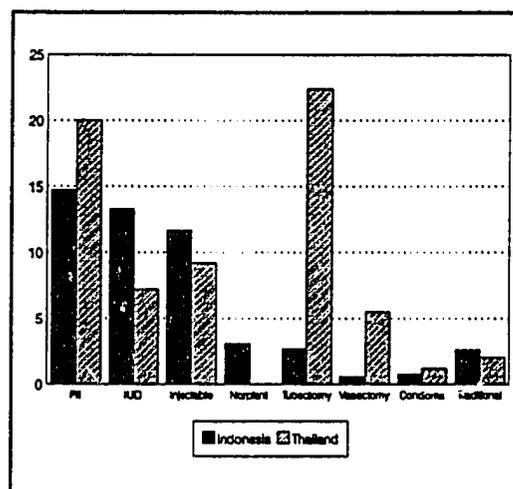
BKKBN program managers are focusing efforts on recruiting not only older couples with completed families but also greater numbers of young, low-parity women. This is an essential strategy if replacement fertility is to be achieved with a CPR of only 62.7 percent. Managers will also need to attract couples who still have high family size preferences and low motivation to use birth control. Reaching both these populations will require additional outreach, particularly to clients from poor urban neighborhoods, couples living in outlying rural areas, and women with lower levels of education.

#### Use of Effective, Long-Term Methods

Indonesia's contraceptive method mix is unbalanced in favor of temporary methods. In 1991, the most popular method was the pill (29.8 percent of total use), followed closely by the IUD (26.8 percent) and injectables (23.5 percent). The use of implants has increased rapidly in Indonesia in recent years but still constitutes only 6.2 percent of the total method mix. Sterilization use is relatively low when compared with other Asian countries. (see Table 2 on page 27.) In Indonesia, only 6.6 percent of all users were sterilization clients whereas in Thailand (which has nearly reached replacement fertility), the most commonly used method has been sterilization (see Figure 8).

Other Asian family planning programs generally have much higher levels of sterilization use than Indonesia, with sterilization generally accounting for between 25 and 50 percent of total use (e.g., Korea 48 percent, Sri Lanka 40 percent, and Thailand 25 percent). Even in countries that are far from attaining replacement fertility, sterilization use is often higher than in Indonesia (e.g., Bangladesh 31 percent, Nepal 45 percent, and the Philippines 24 percent).

Figure 8  
Comparative Method Mix:  
Indonesia and Thailand<sup>1</sup>



Sources: 1991 IDHS and 1987 Thailand Demographic and Health Survey

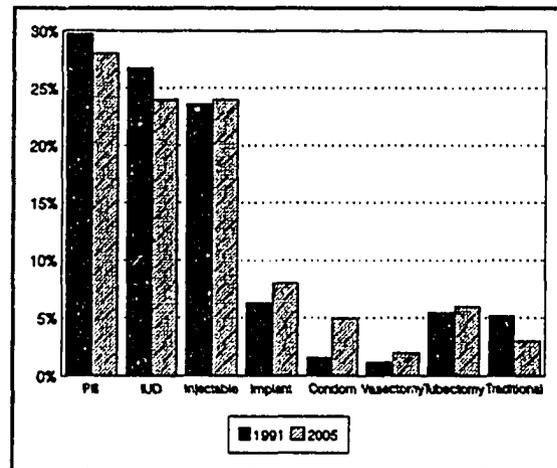
<sup>1</sup>Total CPR in Indonesia is 49.7 percent compared with Thailand's 67.5 percent.

The low use of sterilization reflects the low government priority and support for voluntary sterilization and the resulting low level of knowledge of effective methods, particularly in comparison with the nearly universal knowledge of "any" method. (These in turn are primarily a result of religious opposition to sterilization.) Just over half of all currently married women aged 15 to 49 had heard of tubectomy whereas not quite 30 percent had heard of vasectomy. The contraceptive implant was not much better known, with only two-thirds having any knowledge of the method (see Figure 3 on page 22). Voluntary sterilization could make a significant contribution to the national family planning program, but policy changes and vigorous public promotion of this method would be required.

The projection that a 62.7 percent CPR will lead to replacement fertility is based on a contraceptive method mix that is generally consistent with trends identified between 1987 and 1991. These include modest increases in injectables, implants, sterilization and traditional methods and a slight decline in the proportion of women using pills and IUDs. The only

Figure 9  
**Contraceptive Method Mix**  
 Comparison of 1991 and Projected for 2005

major change would be in condom use, which is projected to increase rapidly owing to an increasing awareness of the risk of HIV infection (see Figure 9). An alternative scenario, more in keeping with the experience in other Asian countries, would place heavier emphasis on increasing utilization of voluntary sterilization and implants to meet the needs of older couples who have achieved desired family size and want to terminate future fertility. This scenario would perhaps be more cost effective but would require significant effort by BKKBN and MOH and the vigorous promotion of long-lasting methods.



Source: 1991 IDHS and team calculations

## Financial Requirements

Budget requirements for a program that aims at increasing the number of current contraceptive users from 15 to 25 million over the next 14 years will be enormous. A rough estimate would suggest that if the size of the program is to grow by nearly two-thirds, the BKKBN budget will also need to increase by another \$50 million, and donor contributions will also have to expand by two-thirds.

Total program costs could rise at an even faster rate than program growth would suggest. It may be more costly to attract current non-users, who tend to be among the lower socioeconomic groups and in harder-to-reach areas. If the government decides to promote long-term methods, these are more expensive than pills, IUDs, and injectables, at least initially.

On the other hand, the possibility also exists that the expansion of the program could result in lower costs in the longer run. As contraceptive use becomes more widespread, recruitment may become less difficult since many pre-

viously hesitant women may be convinced to join the majority of Indonesian women in spacing their children or limiting their family size. Likewise, although long-term methods are more costly at the start, these costs tend to be amortized over time. Finally, if the government is successful in continuing to increase the number of families who receive their services through the private sector, the burden will ease on BKKBN and on the donor community.

Even if costs become lower over time, a redoubled effort is needed now, as the program shifts from its current levels into the next phase. The population will continue to grow for decades even after replacement level fertility is achieved. The BKKBN, together with international donors, has provided the key inputs that have established the family planning program as an indispensable component of Indonesian family life. This partnership will continue to be essential, if the program is to achieve the high level of contraceptive use that will be required in the coming years.

## Glossary

A.I.D.	U.S. Agency for International Development
AVSC	Association for Voluntary Surgical Contraception
BKKBN	Indonesia National Family Planning Coordinating Board
CA	Cooperating Agency
CPR	contraceptive prevalence rate
GOI	government of Indonesia
HIV	human immunodeficiency virus
IDHS	Indonesia Demographic and Health Survey
IEC	information, education, and communication
IFS	Indonesian Fertility Survey
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
MOH	Ministry of Health
NICPS	National Indonesian Contraceptive Prevalence Survey
NGO	non-governmental organizations
PKBI	Indonesian Family Planning Association
PKMI	Indonesian Association for Secure Contraception
Rp.	rupiah
SOMARC	Social Marketing for Change (project)
SUPAS	Inter-Censal Population Survey
TFR	total fertility rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development (mission)
VCDC	village contraception distribution center
WHO	World Health Organization
YKB	Yayasan Kusuma Buana

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