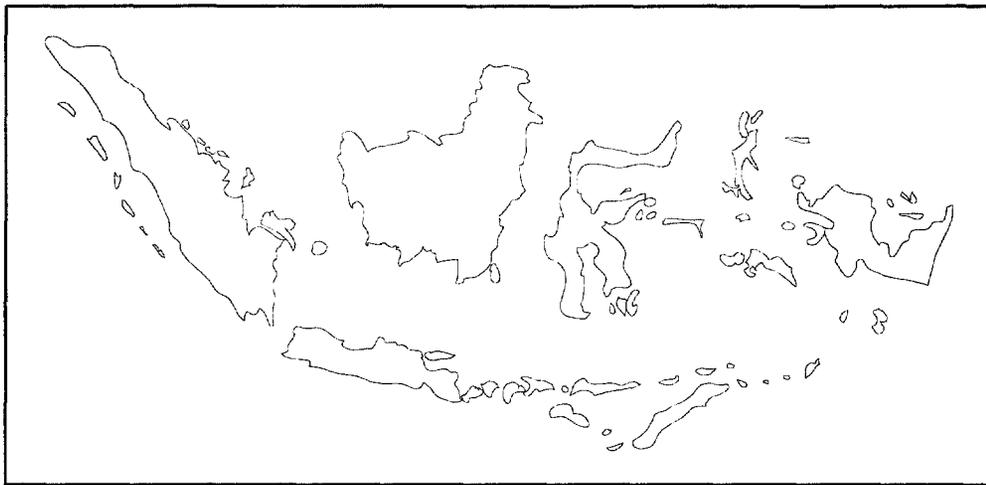
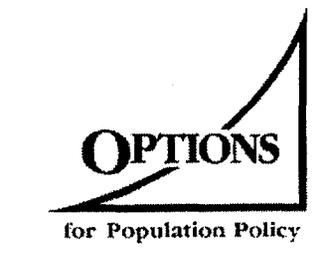


Creating Demand for Family Planning in Indonesia



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OPTIONS II Project



CREATING DEMAND FOR FAMILY PLANNING IN INDONESIA

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EXECUTIVE SUMMARY

Creating Demand for Family Planning in Indonesia

The Government of Indonesia is committed to reducing population growth by reducing fertility and has set as its target to achieve replacement level fertility. Although Indonesia has achieved significant progress toward reaching this goal, important problems still remain. The purpose of this paper is to explore the following questions:

- Which route to replacement level fertility is Indonesia most likely to take;
- Which individual characteristics and/or geographic areas are most associated with “excess” fertility; and
- What are the possible reasons for high fertility preferences.

Achieving replacement level fertility will require an enormous change in fertility patterns. Using data from three national surveys (conducted in 1987, 1991 and 1994), current and replacement levels of fertility were analyzed using parity progression. Results showed that in 1994, 68 percent of all women age 30-34 who had two births had already gone on to a third birth, and 55 percent of those with three births had already progressed to a fourth. Achieving replacement level fertility would require reducing the parity progression ratio from two to three births to approximately 26 percent and from three to four births to approximately 13 percent, declines of 62 and 76 percent, respectively, from current levels.

What distinguishes women who stop at two or three births from those who go on to have more children? Analysis of the survey showed that there are regional differences in patterns of parity progression. For example, ratios fell consistently over time only in East Java, DKI Jakarta, and Outer Java-Bali II. Women's education is not strongly related to parity progression. Current employment is related to parity progression, but the direction of causality is not clear.

To determine why the preference for high fertility remains pervasive, this paper also looks at motivation to limit childbearing. These results suggest that reproductive preferences are not well internalized for many Indonesian women, and that only a minority can be said to be highly motivated to limit childbearing to a two-child family. Comparisons across surveys suggest that lack of internalization of reproductive preferences and low motivation to limit childbearing persist across socioeconomic and regional groups, despite continuing government educational and promotional efforts.

Creating Demand for Family Planning in Indonesia

I. INTRODUCTION

The Government of Indonesia is committed to reducing population growth by reducing fertility and has set as its target to achieve replacement level fertility. This would translate into a Total Fertility Rate (TFR) of 2.1 births per woman. While support of the national family planning program remains high, performance targets have been shifted from demographic (fertility-driven) to satisfying couples' unmet need for contraception. It has been pointed out that Indonesia's *Demand Fulfillment Policy* will be inadequate to achieve replacement level fertility unless and until couples reduce their ideal family size. Therefore, a *Family Planning Demand Creation Policy* has been proposed to complement the Demand Fulfillment Policy, which would marshal other development efforts to encourage parents' desire to have few children (Galway, September 1995).

By all accounts, Indonesia has achieved significant progress toward attainment of its population goal. Over the last 25 years, fertility has declined by half, from a TFR of 5.6 births/woman in 1967-70, to 2.9 births in 1991-94 (DHS, 1994). However, important problems remain, including the following:

- persistent urban-rural differences;
- slowing of the rate of decline, especially in rural areas; and
- the mean children ever born to women at the end of their reproductive years is still considerably higher than the computed TFR. In the 1994 DHS, the mean children ever born to women age 30-34 (who still had some 15 years of reproductive life left) was 2.9.

There are basically two routes to achieving true replacement fertility (i.e., when both TFR and mean children ever born to women age 45-49 equal 2.1): all women have exactly two births; or higher parity women are offset by childlessness and women with only one birth.

The purpose of this paper is to explore the following questions:

- Which route to replacement fertility is Indonesia most likely to take;
- Which individual characteristics and/or geographic areas are most associated with "excess" fertility; and
- What are the possible reasons for high fertility preferences.

The paper includes findings and secondary analyses from three national surveys: the 1987 National Contraceptive Prevalence Survey (NCPS); the 1991 Demographic and Health Survey (DHS); and the 1994 Demographic and Health Survey.

II. FINDINGS

A. Current Fertility Patterns

1. Childbearing in Indonesia is universal and most women will have at least two children.

Virtually all women in Indonesia will be married at some time during their lifetimes: in 1994, 97 percent of women age 35-39 had been or were currently married, unchanged from the 98 percent level of marriage reported in the 1980 census (1987 NCPS). Once married, almost all women will have children at some point during their marriage. As a result, only 11 percent of all women can expect to reach menopause with no or only one live birth. Rates of childlessness among women age 45-49 have declined slightly from 1987 to 1994 (6.1 percent in 1987 vs. 4.7 percent in 1994). The percentage of women age 45-49 with one live birth has risen slightly. *Therefore, to reach replacement fertility, Indonesia cannot rely on childless women to offset women who will have more than two children.*

There is some indication that women are delaying marriage and - consequently - their first birth. While women who marry later will have somewhat fewer children, this in and of itself will not be sufficient to achieve replacement level fertility. However, as the pace of early childbearing slows down, an increasingly large portion of total fertility is accounted for by older women (over age 35).

2. High levels of delayed fertility will ensure that three of every four women will go on to have three or more births in their lifetime.

Table 1 presents the percentage of all women by age group who already had three or more live births by the time of the survey.

Table 1 Percentage of Women with Three or More Births by Woman's Age at Time of Survey			
Woman's age	Survey		
	1987	1991	1994
20-24	8.6	5.6	4.3
25-29	39.6	32.5	26.8
30-34	67.2	61.0	55.6
35-39	74.5	74.7	72.2
40-44	81.6	87.3	77.4
45-49	81.8	80.3	79.7

It seems safe to assume that extremely low parity (women who have 0-1 births during their lifetimes) will continue at the historical level of approximately 11 percent for at least the foreseeable future. In order to achieve a mean of 2.1 births per woman, most women will have to stop childbearing after their second birth, and fewer than 25 percent can go on to have three or more births. This is not likely to happen in the near future. As shown above in Table 1, even as recently as 1994, 27 percent of women age 25-29 had already exceeded two births, and at prevailing age-specific fertility rates, a 30-year old woman could expect to have one more birth before reaching menopause. Even under the best circumstances, it will take at least one more generation to achieve true replacement level fertility, as only the cohorts born after 1970 have not already exceeded two births.

3. Achieving replacement level fertility will require an enormous change in fertility patterns.

Table 2 introduces the concept of **parity progression**, the principal analytic tool used in this paper. The first column presents the percent distribution of all women age 30-34 in the 1994 survey by number of children ever born. The second column presents a simulated distribution which would achieve replacement level fertility. The third and fourth columns present parity progression ratios, that is, the probability that a woman who has achieved a certain fertility level will go on to have at least one more birth in her lifetime (i.e., the 2-3 parity progression ratio is the proportion of women with two children who go on to have three; the 3-4 progression ratio is the proportion of those who have three children who go on to have four, etc.)

Table 2 Current and Replacement Level Parity Progressions				
Total children ever born	Percent distribution		Parity progression ratio	
	Women 30-34	Simulation	Women 30-34	Simulation
0	8.6	5.0		
1	9.6	6.0		
2	26.2	66.0		
3	25.0	20.0	.68	.26
4	14.7	3.0	.55	.13
5+	15.9	0.0	.52	.00
Total fertility	2.9	2.1		

In 1994, 68 percent of all women age 30-34 who had two births had already gone on to a third birth, and 55 percent of those with three births had already progressed to a fourth. Achieving replacement level fertility would require reducing the parity progression ratio from two to three births to approximately 26 percent and from three to four births to approximately 13 percent, declines of 62 and 76 percent, respectively, from current levels.

4. There are regional differences in patterns of parity progression. Women's education is not strongly related to parity progression. Current employment is related to parity progression, but the direction of causality is not clear.

What distinguishes women who stop at two or three births from those who go on to have more children? To answer this question, we compared the 1987, 1991, and 1994 surveys. Analyses were confined to ever-married women ages 20-34 at the time of the survey who, five years prior to the survey date, had had either two or three births. The variable of interest was whether or not the woman had another live birth during the five-year period prior to the survey. Because we are interested only in transitions from 2-3 and from 3-4 births, we will call this "intermediate" progression. (Women over age 35 were not included to control for subfecundity).

Tables 3 and 4 present parity progression ratios from 2-3 and from 3-4 births by region across the three surveys. (Two regions are not included because of small sample size.)

Table 3 Parity Progression Ratios (2-3 Births) by Region and Survey						
Survey	Region					
	DKI Jakarta	West Java	Central Java	East Java	Outer I	Outer II
1987	*.61	.58	.55	.46	.71	*.73
1991	.50	.63	.48	.44	.68	.66
1994	.48	.55	.55	.34	.64	.61

Table 4 Parity Progression Ratios (3-4 births) by Region and Survey						
Survey	Region					
	DKI Jakarta	West Java	Central Java	East Java	Outer I	Outer II
1987	*.46	.57	.43	.46	.57	*.72
1991	*.40	.57	.50	.42	.64	.68
1994	.30	.50	.48	.21	.56	.59

Note: * ratios based on fewer than 100 observations

These tables show regional differences in levels and across time. Parity progression ratios fell consistently over time only in East Java, DKI Jakarta, and Outer Java-Bali II. West Java showed a consistent time trend in the 3-4 birth transition (but not in 2-3) and Outer Java-Bali I in the 2-3 birth transition (but not in 3-4). East Java showed the lowest progression ratios and Outer Java-Bali I and II the highest. By 1994, DKI Jakarta ranked second to East Java, and West and Central Java fell between the two extremes. Only East Java is close to the intermediate parity progression ratios necessary to achieve replacement fertility.

These parity progression groupings correspond generally to regional differences in computed TFR, but not exactly. The TFR in DKI Jakarta in 1994 was 0.3 births lower than in East Java, while the latter had lower parity progression ratios. It is possible that recent in-migration of large numbers of young unmarried women into the capital city has temporarily lowered that TFR.

Women's education showed little consistent effect on intermediate parity progression. Women with no education showed slightly lower progression from 2-3 births than other groups, while women with senior high school or more showed lower progression from 3-4 births.

Women's employment was related to parity progression. In all surveys, women employed at the time of the survey showed lower parity progression ratios than women who were not employed. (There is probably mutual feedback between employment and fertility, since women with a recent birth may have a harder time finding employment). Comparing the 1987 and 1994 surveys, we see only small declines in parity progression ratios over time. The percentage of women who were employed increased between the first and last surveys. Thus, it is likely that lower parity progression ratios among employed women coupled with increasing female employment accelerated the rate of fertility decline. Table 5 presents women's employment and parity progression ratios by employment across the three surveys.¹

Survey	Percent employed Parity 2	Progression 2-3 births		Percent employed Parity 3	Progression 3-4 births	
		Employed	Unemployed		Employed	Unemployed
1987	52.1	.51	.64	55.6	.45	.56
1991	44.5	.52	.60	43.8	.53	.52
1994	60.6	.45	.61	62.2	.41	.54

B. Internal Consistency Among Fertility Preferences

Why are high intermediate parity progression ratios so pervasive? To address this question, we will look at motivation to limit childbearing. The DHS questionnaire includes several questions on fertility preferences: ideal family size (number of children), future reproductive preferences (want more children), and wantedness of births in the last five years (wanted then, wanted later, did not want). It also includes a question on the number of living children at the time of the interview.

To be internally consistent, a woman who has the same or more living children than she would consider to be ideal would state that she wants no more children in the future. Similarly, a woman who has more living children than she would consider ideal would also state that her last birth was unwanted. In some countries with low ideal family size and higher fertility, such as Peru, we observe this kind of internal consistency.

1. Preference for a two-child family in Indonesia is low.

¹ The difficulty of ascertaining clear time trends in women's employment across surveys may be due, in part, to variations in question wording and skip patterns from survey to survey.

The percentage of ever-married women who declare their ideal family size to be two children has increased only slightly over time. In the 1994 survey, equal proportions of women declared a preference for two children (36 percent) and for between three and five children (37 percent).

2. A small but sizable proportion of ever-married women cannot clearly state their fertility preferences.

More than one in ten women either gave a non-numerical answer (e.g., "Up to God") when asked how many children they would like to have or have liked to have had for themselves, or responded that they did not know. The proportion of these responses actually increased in the 1994 survey, perhaps due to different interviewer training. Table 6 presents the percent distribution of ever-married women by stated ideal number of children across the three surveys.

Table 6 Changes in Stated Ideal Number of Children			
Ideal number of children	Survey		
	1987	1991	1994
2	31%	35%	36%
3	23%	22%	19%
4	19%	17%	14%
5	7%	5%	4%
Non-numeric/ Don't know	13%	15%	22%

3. Even among women who can state their ideal number of children, there is a measurable degree of internal inconsistency.

In 1994, 5 percent of women who had more living children than their stated ideal answered that they wanted more children (compared to 3 percent in 1991), as did 9 percent of women whose number of living children was equal to their stated ideal (7 percent in 1991). Only 38 percent of women with more living children than they considered would be ideal stated that their last birth was "unwanted" (32 percent in 1991), while 52 percent stated that their last birth was "wanted then" (50 percent in 1991).

4. Few women are strongly motivated to limit childbearing after the second child.

Using living children, ideal family size, and future reproductive preferences, we can calculate a scale of fertility motivation, from very strongly motivated to have more children (women who currently have fewer living children than they consider ideal and who want more children) to motivated to limit (women who do not want more children).

Strong motivation to have more children steadily decreased from 1987 to 1994. Nevertheless, in 1994, 27 percent of all women with two living children and 6 percent of those with three living children strongly wanted at least one more child. Motivation to limit childbearing also increased from 1987 to 1994. However, even by 1994, only 49 percent of women with two living children and 75 percent of those with three living children declared they wanted no more children.

5. Motivation to limit childbearing is related to contraceptive method mix and shows regional variation.

Will motivation for more children or to limit childbearing influence future fertility? This is difficult to answer with retrospective data. While total contraceptive prevalence in 1994 was unaffected by motivation, method mix was quite different between women who strongly wanted more children and those who wanted to limit. Women who wanted more children were more likely to use supply methods (pill, injectable) that could be discontinued at any time, while women motivated to limit were more likely to use long-term clinical methods (IUD, voluntary surgical contraception) with lower failure rates. Table 7 presents contraceptive use for the two groups.

Contraceptive method	Fertility motivation	
	Want more children	Limit childbearing
No method	24.3	22.6
Pill	26.9	21.5
Injectable	27.0	17.2
Implant	7.5	6.3
IUD	10.3	17.5
Sterilization	0.0	9.2

It is also interesting to note that the regional rankings on parity progression ratios are maintained for fertility motivation: in 1994, East Java showed least motivation for more children and greatest motivation to limit, while Outer Java-Bali I and II showed the reverse. In addition, a clear difference emerged between East Java and DKI Jakarta among women with two living children, and DKI Jakarta more closely resembled Central and West Java for these women. Table 8 presents these results.

Region	Two living children		Three living children	
	Want more children	Want to limit	Want more children	Want to limit
East Java	19.3	64.3	3.2	82.3
DKI Jakarta	24.4	49.4	3.3	82.5
Central Java	25.4	55.0	5.9	83.8
West Java	27.7	41.8	5.0	72.8
Outer Java-Bali I	35.2	34.9	8.6	68.7
Outer Java-Bali II	36.2	35.9	8.3	68.0

These results suggest that reproductive preferences are not well internalized for many Indonesian women, and that only a minority can be said to be highly motivated to limit childbearing to a two-child family. Comparisons across surveys suggest that lack of internalization of reproductive preferences and low motivation to limit childbearing persist across socioeconomic and regional groups, despite continuing government educational and promotional efforts.

The apparent inconsistencies among the fertility preference questions may be due to a number of factors, including weakly internalized ideal family size coupled with perceived social pressure to respond with a low number; and/or unwillingness or social pressure not to term a child who has already been born as unwanted.

III. CONCLUSIONS AND RECOMMENDATIONS

Because of established population momentum, it will be many years before low period fertility rates are translated into low completed family size. The first cohort that has any chance of achieving a two-child family are women born after 1970 (and it is probable that many of these women will have three or more children before reaching menopause). Nevertheless, a number of encouraging findings emerged from the analyses:

1. *Motivation to limit childbearing to a three-child family is widespread.* Even in the highest fertility provinces, two-thirds of young women with three living children say they want no more, and this percentage increases to over 80 percent in Jakarta, East, and Central Java. The national family planning program should target these women to encourage them to adopt effective, long-lasting contraceptive methods, especially IUDs and voluntary surgical contraception. Widespread adoption of these methods by these women could have significant impact on over age-30 fertility rates and potentially reduce TFR by as much as half a birth.
2. *Motivation to limit childbearing to a two-child family is weak at best, and many women with two living children strongly desire another child.* Internalization of a two-child norm may ultimately depend on other development factors, such as women's employment opportunity, which are outside the control of the national family planning program, but are being addressed through Indonesia's other social and economic development policies.
3. *East Java is fairly close to achieving the two-child family,* both in terms of observed intermediate parity progression rates and in terms of women's stated motivation to limit fertility. Further analysis of the East Java case may shed light on historical, social, and development factors associated with East Java's rapid progress toward replacement level fertility.