

35 Year

Commitment to
Family Planning in
Indonesia



BKKBN and USAID's Historic Partnership



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Introduction by William M. Frej, Mission Director, USAID Indonesia

The United States Agency for International Development (USAID) is proud of the historic 35 Year Partnership with the National Family Planning Coordinating Board (BKKBN). Very few times in our lives will we participate in a collaborative effort that did so much to improve the lives of millions of people and in so doing – strengthened the development of a whole nation and its people.

For more than three decades, BKKBN and its partners have been the pioneers on the forefront of innovation and on the cutting edge of programmatic advancement. USAID credits the success of the partnership to the leaders and staff at BKKBN, Islamic organizations including Muhammadiyah and Nahdlatul Ulama, NGOs, the private sector, women’s groups, universities, and professional organizations. They have led the family planning movement with technical leadership, commitment and innovation.

Today, Indonesia is poised to provide even greater leadership on family planning, population and demographics both domestically and internationally. The successes can show other countries how to develop a quality family planning program.

This legacy document seeks to summarize the exceptional partnership between the US Government and BKKBN and identify the strategies and approaches that underpinned this family planning success story. We hope that this analysis will inform the international community about the Indonesian experience and assist other countries in developing their own sustainable and high quality family planning program.

USAID will be completing its funding and technical assistance for family planning in 2006, but population and family planning issues will remain critically important for future generations. Family planning remains a key component for poverty reduction, health and social welfare, and economic growth. We urge national and local governments, NGOs and civil society organizations to continue to advocate that every local government have a plan, budget, commodities, and services in place to meet the increasing demand for family planning.

USAID is honored to have worked so closely with the BKKBN on this internationally renowned family planning program. The friendships developed during this partnership and USAID’s respect for the National Family Planning Program will continue into the future.

Sincerely,

A handwritten signature in black ink that reads "W. M. Frej". The signature is written in a cursive style with a large initial "W" and a distinct "M".

William M. Frej
Mission Director
USAID Indonesia

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In addition, the publication benefited from numerous program reports and studies from USAID, BKKBN, and other organizations. Two recent books on the history of Indonesia's family planning program were particularly valuable and are recommended for further reading:

Two Is Enough. Family Planning in Indonesia under the New Order, 1968-1998. Edited by Anke Niehof and Firman Lubis. Leiden: KITLV Press, 2003. viii, 281 pages.

People, Population, and Policy in Indonesia. Edited by Terrence H. Hull. Publisher, Equinox, 2005. 208 pages.

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35 Years

an exceptional partnership



Chapter 1

The history of modern family planning in Indonesia is the story of how millions of Indonesians became motivated to change their behaviors, attitudes, and values about family size for the promise of a better future for themselves, their children, and future generations. It is also the story of how the Indonesian government, the private sector, faith-based organizations, the United States Agency for International Development (USAID), and other donors worked together to promote smaller, healthier families and to increase access to good-quality family planning services throughout the archipelago.

The Indonesian government embarked upon its family planning commitment in 1967, with a two-fold purpose. It regarded family planning both as a means of improving the health of its citizens and as a way of addressing the threat that over-population posed to economic progress. Over time, the government's commitment became one of the world's family planning success stories, and its investment in family planning paid off in improved health and economic development.

An important part of this story has been the remarkable partnership forged between Indonesia's National Family Planning Coordinating Board (Badan Koordinasi Keluarga Berencana Nasional, or BKKBN) and USAID. For over 35 years USAID played a major supporting role in Indonesia's success story. USAID provided over US\$340 million dollars of financial assistance and worked hand in hand with BKKBN and its other partners to develop the capacity of local organizations to promote family

planning, to enhance contraceptive security, to undertake effective social marketing, and to provide good-quality reproductive health services nationwide.

The BKKBN-USAID partnership acted much like a catalyst that helped drive the family planning program forward—with fresh insights, innovative approaches, research, and a supportive environment for evidence-based experimentation and risk-taking. The former and long-standing Chairperson of BKKBN, Dr. Haryono Suyono, acknowledged the dynamic character of this relationship and the intangibles of its contribution, in saying, “There is more here than just financial support; there is a spiritual and moral support to which we cannot attach a price tag.”

In due course, as strategic innovations unfolded, the family planning partnership came to incorporate elements of the private sector, professional associations such as the Indonesian Midwives Association and the Indonesian Society for Obstetricians and Gynecologists, and faith-based social welfare organizations such as the Islamic organizations Muhammadiyah and Nahdlatul Ulama. BKKBN, USAID, and the network of strong Indonesian partners had to overcome potential barriers to delivering family planning services—including a rural population dispersed across 13,000 islands, high levels of poverty and illiteracy, conservative social and religious attitudes, and a culture that valued large families.

Their efforts succeeded in changing fatalistic attitudes about childbearing and in empowering couples to embrace the “small, happy, prosperous family” as a new social norm. The program also managed to offer widespread access to a range of contraceptive methods and good-quality services across the country.

This publication seeks to summarize the innovative family planning strategies that BKKBN and USAID invested in during the 35-year partnership and the accomplishments that were achieved. Describing these successful strategies and approaches will leave

behind a legacy of understanding about a defining moment in Indonesia's social, demographic, and economic history; it will equally better inform the wider international community of health and population specialists about the Indonesian experience, components of which may serve as models of family planning strategies to continue to replicate in other national contexts. This publication also seeks to explain the remarkable relationship between BKKBN and USAID that has empowered many Indonesians to make informed decisions about the number of children they want and about the range of contraceptive methods available.

The Developmental Dividend

During the BKKBN and USAID partnership, the investment in family planning has paid developmental dividends, as Indonesia achieved an impressive increase in contraceptive prevalence and a dramatic decline in fertility. Use of modern contraceptive methods increased in prevalence from below 5% of married women in 1967 at the start of the program to almost 60% in 2006. Largely as a result, the Total Fertility Rate (TFR) fell by more than one-half—from over six children per woman to 2.6. In turn, this fertility decline—among the most rapid of any country over a similar period—dramatically reduced population growth (see Chapter 2, “Demographic Data Take the Measure of Change,” p. 13).

The decline in population growth was one of the original goals of the Indonesian government in adopting a family planning program and its achievement has brought substantial benefits by contributing to a reduction in poverty. Smaller families also enabled parents to better afford more educational opportunities for their children. Daughters appear to have been major beneficiaries of new family educational strategies, as there has been both a substantial increase in the percentage of girls receiving formal education and in the number of years that girls remain in school.

Widespread acceptance of family planning has also correlated with striking improvements in maternal and child health—another goal of the Indonesian government in its advocacy of national family planning. Increases in child spacing as a result of increased contraceptive use have been an important factor in the decline of maternal and child mortality. Infant mortality, for instance, declined four-fold over the past three decades, from an estimated 142 infant deaths per 1,000 live births in 1967 to 35 per 1,000 in 2003. Maternal health has also improved as contraceptive prevalence has risen. Maternal mortality rates have decreased as women had fewer pregnancies and spaced births longer.

Continuous Innovation

Over a 35-years period the architects of the USAID and BKKBN family planning partnership introduced a series of technical innovations, each designed to achieve a given set of objectives. Once one objective was accomplished, the program moved on to a new objective. A type of esprit de corps within the family planning leadership characterized by non-complacency and impassioned commitment fueled this strategic process, which resulted in a program that continuously expanded to meet people's family planning needs.

The program's major strategic innovations can be divided into four distinct steps—reaching the rural areas with grassroots participation; promoting smaller-family norms; building private sector self-reliance; and improving quality of care. Taken sequentially, these steps made efficient use of Indonesia's and USAID's human and financial resources. Taken together, they have expanded access to services, sparked widespread interest in family planning, and transformed reproductive attitudes and behavior.

1. Reaching the Rural Areas with Grassroots Participation. As the first step, BKKBN in the early 1970s decided to

focus on the rural areas of Java and Bali because these two islands accounted for two-thirds of the total population of the country. Since Indonesia's population lived largely in rural areas, program planners determined that the goal of significantly decreasing fertility rates could be accomplished only by substantially increasing levels of contraceptive use in the countryside.

To achieve its goal BKKBN mobilized members of rural communities to participate in program planning and in the provision of services. Since clinic-based services were inadequate in the countryside to reach a large number of people, the family planning program engaged in widespread outreach and community participation at the village level. This approach called for the establishment of a vast family planning network based on field workers and volunteers (see Chapter 4, "From Clinics to the Community," p. 25).

At its peak, the rural program included nearly 40,000 field workers and more than 100,000 volunteers. The rural family planning personnel typically would make home visits to discuss family planning methods, provide counseling, and make referrals to community health centers. BKKBN also trained around 29,000 of its volunteers and field workers to be able to distribute oral contraceptives (OCs) and other non-clinical contraceptives.

In the late 1970s the success of rural outreach and the community participation approach exceeded all expectations for increased contraceptive use. The USAID Mission reported in 1978 that OC acceptors accounted for 60% of all family planning acceptors and that overall contraceptive prevalence had increased from less than 5% at the start of the program to 27% in late 1977—with East Java and Bali having the highest prevalence of modern family planning use. By 2006 modern contraceptive prevalence had reached about 60%, with more than 75% of family planning clients using hormonal methods, including OCs and injectables. The

program's rural outreach and emphasis on community participation were instrumental in laying the groundwork for this strong demand for and use of modern methods.

2. Promoting Smaller-Family Norms. As family planning services became more available, the program launched an innovative multi-pronged and long-term communication component to introduce more couples to the idea of family planning and to promote the small family as a new social norm. BKKBN officials recognized that in addition to expanding access to contraception, widespread and pervasive beliefs about family size would necessarily have to change for the program to reach its objectives. Indonesia would have to move from a culture that accepted the number of children in a family as a matter of fate to an awareness that couples could make informed choices about the number and spacing of their children.

BKKBN also recognized that the social norm that valued large families would have to be replaced by one that viewed fewer children as desirable for the betterment of couples, families, and national welfare. To promote the value of fewer children, raise knowledge about family planning, and generate demand for contraceptive use, BKKBN launched large-scale behavior-change communication programs. These campaigns were to remain a key element in the program's strategy throughout most of its history (see Chapter 3, "Key Strategies," p. 19).

The program's communication campaigns have managed to achieve an almost universal awareness of family planning. In a recent survey the survey firm ACNielsen found almost 100% awareness of the top two family planning methods in use in Indonesia (the pill and the injectable) and over 90% awareness of condoms, implants, and IUDs. Research also indicated that the strategically conceived and creatively designed communication campaigns had succeeded in implanting the "small, happy and

prosperous family” as the dominant social norm in Indonesia.

3. Building Private Sector Self-Reliance. As levels of contraceptive use rose, it became apparent to planners that the public sector alone could not wield the resources needed to continue meeting the quickly growing demand for family planning services and supplies. As Dr. Haryono said in 1986, “I want to see an Indonesia 20 years from now in which 80% of family planning services are provided by the private sector...with government serving only those who are poor or cannot afford to pay.”

USAID helped its partners shift the already successful public sector program into one of the most remarkable private sector and self-sustaining family planning programs in the world, to the extent that by 2006 Dr. Haryono’s vision of private sector dominance in family planning had been surpassed by the reality of the achievements. Today, nearly 90% of family planning users pay for their services, whether they obtain them from private or public sources.

With strong technical assistance from USAID, the new emphasis on private sector services became known as self-reliant family planning (KB Mandiri). This program was first launched in the cities, where residents both were better able to afford the cost of services and generally preferred to seek health services from private providers. The self-reliance campaign aimed to increase the contraceptive prevalence rates in the cities that had fallen behind those in rural Java and Bali, where the family planning program was first established.

After its urban debut, the private sector program then was extended to the countryside, using private sector midwives. In response, the percentage of family planning clients who obtain their contraception from the private sector grew from less than 18% in the early 1980s to an estimated 66% in 2006. Even during the economic crisis years of 1997-2000, when a sharp drop in fam-

ily planning use was predicted, the private sector family planning program proved resilient.

To stimulate private sector use and achieve self-reliance, BKKBN and USAID launched various marketing initiatives (see Chapter 5, “Toward Self-Reliance: Involving the Private Sector,” p. 29). One of the largest of these was the Lingkaran Biru (Blue Circle) program—a public-private sector partnership that a private sector newsletter for foreign investors heralded as possibly “the most ambitious privatization program a country has ever attempted.” This program created an attractive identity for high-quality private sector midwives, doctors, and pharmacies and promoted their services, with the result that many urban residents began to use family planning offered through Blue Circle outlets.

To encourage self-reliance in rural areas, the program built up the role of private sector midwives, described at the time as the “the lynchpin of a successful rural KB Mandiri effort.” The initiative trained 50,000 village midwives (Bidan di Desa) who provided family planning services and supported the Posyandu—for Pos Pelayanan Terpadu (Integrated Service Post) program. In this program, midwives both provided contraceptive services to clients and offered nutritional outreach for children under the age of five. The costs of the services provided by these midwives were both subsidized by the government and derived from fees charged to their clients.

4. Improving Quality of Care. As more and more people became family planning clients, the program focused increasingly on improving the quality of care and service delivery. Quality is the cornerstone of USAID’s family planning program worldwide. By the 1990s family planning leaders, the Indonesian government, and professional associations emphasized that improvements in the quality of services could make the program more responsive to client needs.

Clients can be better served in making informed choices about the range and choice of contraceptive methods with good counseling and the support of trained providers. This initiative also encourages clients to seek out high-quality service providers, to know what to expect, and to be more active participants in their interactions with providers. The goal is to give clients reliable information and the confidence that they need to make informed family planning choices for themselves (see Chapter 6, “A Mature Program,” p. 33).

BKKBN, USAID, and other partners also have developed tools, standards, and systems that enable district-level decision-makers to offer sustainable family planning programs that meet international standards for quality of care (see Chapter 7, “Sustaining Success,” p. 37). One example is the publication of the Family Planning Service Delivery Guidelines, the first comprehensive manual for clinicians, which professional organizations have readily adopted. In addition to the Blue Circle initiative designed to provide quality services, USAID also supported the pioneering BKKBN initiative, Bidan Delima, a branded network of trained high-quality midwives working in the private sector (see p. 31).

Lessons And Challenges

Many lessons learned in the Indonesia program can help programs in other countries. These include BKKBN’s ability to gain support from political leaders, USAID and BKKBN investments in education and training, the flexible management and funding styles, emphasis on promoting the role of the private sector, and other aspects of an effective approach (see Chapter 8, “Lessons Learned,” p. 41).

Looking to the future, BKKBN faces many challenges. As population grows and contraceptive use increases, millions more people will need family planning information and services

(see Chapter 9, “Meeting Future Challenges,” p. 45). To meet its goals for contraceptive prevalence, BKKBN will need to revitalize the small-family ideal and to continue its emphasis on providing a range of contraceptive methods and good quality of care, now and into the future.



In 2005, over 300 representatives from Indonesia’s district, provincial, and national levels of government joined together with USAID and other partners to highlight the importance of providing good-quality reproductive health services.

35 Years



demographic data take the
measure of change

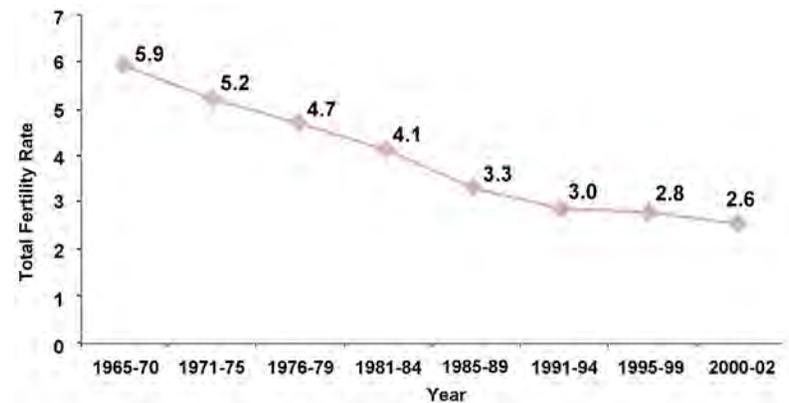
Chapter 2

The story of reproductive health in Indonesia “is a remarkable example of just how drastically behavior, attitudes, and values can change in a short period of time with relatively little social conflict,” say Terrence and Valerie Hull, demographers who have been tracking Indonesian population issues for three decades. Before Indonesia’s national family planning movement began in the late 1960s, large families were the norm, and many couples believed that the number of births they had was a matter of fate, not of choice. Only about 1 married woman in every 10 used contraception. The average woman gave birth to more than five children over her reproductive lifetime.

In contrast, “by 2000 most Indonesians had been born into a world where the whole community accepted family planning,” the demographers write. In about 30 years fertility fell by over 50%, among the most rapid fertility declines in any country over a similar period. In 2003 the Indonesian Demographic and Health Survey (IDHS) found that the TFR was 2.6 children per woman compared with 5.9 in the late 1960s—a reduction of over three children per woman (see Figure 1)¹. Almost 60% of married Indonesian women are currently using a modern contraceptive method, while 80% have used family planning at one time or another.

¹ Since 1987 a series of five large-scale surveys have documented Indonesia’s changes in fertility levels, contraceptive use, and attitudes toward childbearing. These surveys include the 1987 Contraceptive Prevalence Survey (CPS) and the IDHS of 1991, 1994, 1997, and 2002-2003. The surveys represent a cooperative effort between BKKBN, Indonesia’s Central Bureau of Statistics, The Ministry of Health, other donors, and USAID, which has provided technical and financial assistance in data collection, processing, analysis, and use for program planning and evaluation.

Figure 1: Long Term Decline in Total Fertility Rate



These dramatic demographic shifts did not happen by chance. They reflect widespread changes in Indonesia’s economy and society. They also reflect the success of the national family planning program. The program not only has supplied contraception but also has promoted the small-family norm, delayed marriage, and family welfare. In response, most Indonesians today, regardless of residence, education, or economic status, want to have fewer children than did previous generations, and they are increasingly able to have the smaller families they desire.

In developing countries the transition to lower fertility typically begins with educated women who live in cities. They are the most interested in limiting or spacing their births and best able to obtain family planning methods to do so. Rising contraceptive use and lower fertility then spread to other groups and eventually become the norm throughout society.

In Indonesia, however, this transition has been more rapid and more rural than in many countries. In part the difference reflects the fact that from the beginning the family planning program

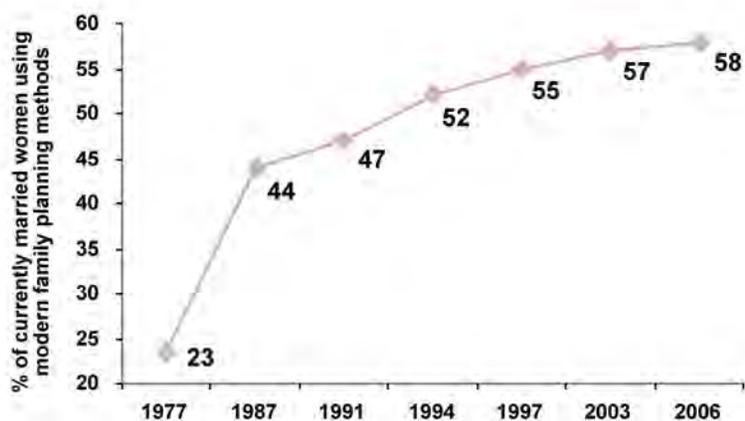
gave priority to lower-access rural areas and presented family planning as a widespread social movement for the benefit of all Indonesian couples.

Sustained lower fertility rates have slowed Indonesia's population growth and have reduced the country's total population size compared with projected levels. The national population growth rate fell from over 2.5% per year before 1970 to 1.5% in 1990-2000. If population growth had remained at 2.5%, Indonesia's total population in 2005 would have been nearly 300 million, instead of about 220 million—a difference of 80 million people, or approximately the total population of Vietnam.

Explaining Fertility Declines

The primary direct reason that fertility rates have declined is that the percentage of married women of reproductive age using modern contraception (contraceptive prevalence) has increased substantially (see Figure 2).

Figure 2: Growing Modern Contraceptive Prevalence



Source: IDHS, CPS, World Fertility Survey

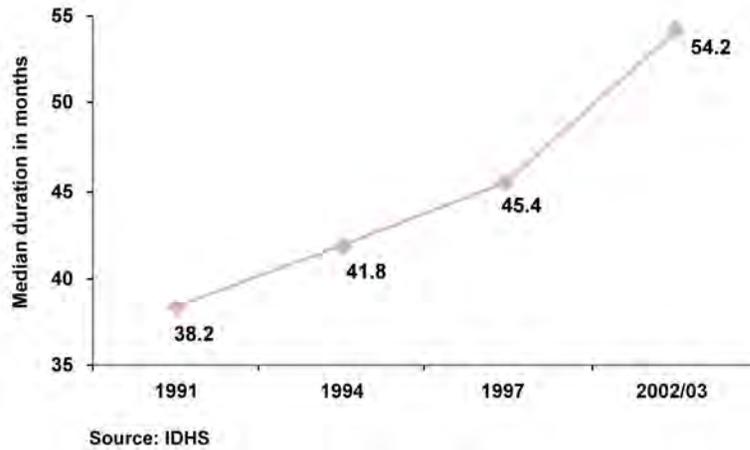
According to the 1971 Indonesia Census, fewer than 10% of married women aged 15-49 used modern contraception. In 2003, 57% did so, according to the 2002/2003 IDHS. Today, the prevalence of modern contraceptive use is about the same among both urban and rural women, at about 57%, and contraceptive knowledge and approval are virtually universal. Fewer than 8% of women surveyed report access or affordability as a reason for non-use. Differences remain among groups and regions, reflecting differences in cultural beliefs, women's status, and access to family planning. Nonetheless, differences by women's level of schooling and other status have narrowed.

Increasingly, Indonesians purchase modern contraceptive supplies and services in the private sector, rather than relying on the government. Nearly 90% of clients currently pay for their contraceptives, and the private sector now provides about two-thirds of family planning services. The public sector's share has dropped from 43% in 1997 to 28% in 2002-2003, according to the IDHS. USAID's technical assistance on the private sector has allowed BKKBN to focus their commodity assistance on the poor and most vulnerable groups.

Rising contraceptive prevalence also reflects rising levels of schooling and improvements in status among women. Overall, women remain in school longer and marry later than they used to. Within marriage, women are more likely to delay having their first child and to wait longer between births. For instance, in the 1987 IDHS 55% of women reported birth intervals of less than three years. By 2003 the percentage had dropped to 29%, and the percentage with birth intervals of less than two years was only 15%.

Indonesia's median time between births has risen sharply, from about 38 months in 1991 to 54 months in 2003 (see Figure 3)—among the greatest increases anywhere. Today, Indonesia's median birth interval is among the longest of any developing country. In Bangladesh, where birth intervals also have risen substantially, the median is about 49 months. In the Philippines, however, it is about 27 months, only half the length in Indonesia.

Figure 3: Trends in Median Duration of Interval Since the Preceding Birth



Desire For Smaller Families

Behind rising contraceptive prevalence and falling fertility rates are dramatic changes in people's attitudes toward childbearing over the past four decades. Survey findings demonstrate the success that Indonesia's family planning program has had in promoting a small-family norm and in enabling women to have the smaller families they want.²

In the 2002-2003 IDHS half of Indonesian women surveyed (50%) responded that they do not want to have any more children. About one-quarter (24%) wanted to delay having another child for at least two years. Only 13% wanted to have a child within two years or were currently pregnant. Reflecting widespread acceptance of the small-family norm through rural areas of In-

² Surveys collect two kinds of data that point to changes in attitudes about family planning. These are: ideal family size—the number of children respondents say they would like to have (regardless of their actual family size); and reproductive intentions—whether respondents say they want to have another child right away, later, or not at all. Survey data on ideal family size reflect broad social norms. Data on reproductive intentions are a more accurate indicator of a couple's actual childbearing behavior and indicate potential demand for family planning.

onesia, the proportion of rural women who do not want to have more children is now nearly equal that of urban women.

On average, the number of children that women consider to be ideal fell from about four children in the late 1960s to 2.9 children in 1994. Ideal family size has remained at about this level since 1994. Fertility levels have continued to fall, however.

Before the 1990s, actual fertility was much higher than ideal family size. The 1991 IDHS found that actual fertility was the same as the ideal number of children women said they preferred. Since then, fertility has fallen even below women's stated ideal and has remained lower. "The lesson from this success story is that once the small ideal family size is individualized and practiced, fertility will decline," observes Sri Moertiningsih Adioetomo, a prominent Indonesian demographer and special ministerial advisor.

Nonetheless, ideal family size remains well above replacement-level fertility. USAID advocates that, as well as offering a range of contraceptive choices, BKKBN should continue to reinforce the small-family ideal, particularly where levels of family planning use are lowest. "Individual family size preferences, and more importantly the prevailing community norms regarding family size, strongly influence a couple's decision to adopt family planning," USAID has noted.

Meeting The Unmet Need

Not all women who say they want to delay or end childbearing are using contraception. The gap between what survey respondents say and what they actually do is defined as the unmet need for family planning. In Indonesia the level of unmet need narrowed in the 15 years between the 1987 Contraceptive Prevalence Survey (CPS) and the 2002-2003 IDHS, suggesting that more women who said they wanted to control their fertility were actually doing so. In 1987 about 16% of women were considered to have an unmet need—about one woman in every six. In 2002-2003 the figure had dropped to 8.6%, almost half the level 15 years earlier.

Nonetheless, the fact that today nearly 9% of Indonesians want to postpone or end childbearing but are not using a family



planning method suggests the scope for further increases in contraceptive prevalence and declines in fertility. If all potential demand for family planning were met, contraceptive prevalence would rise to nearly 70%—on a par with most developed countries.

The Continuing Challenge

Despite the dramatic decline in Indonesia's fertility levels since the start of the family planning movement, the pace of

decline has slowed since 1990, as it has in some other countries. Indonesia's TFR remains above the replacement level of 2.1 children per woman. A projection, based on current trends, is that replacement-level fertility will not be reached until at least 2016, and possibly later. Before the TFR reaches replacement level, at least 35 million more people would be added to Indonesia's population. The population would not stop growing until around 2050. By then Indonesia would contain over 300 million people.

Sharing family planning. Ibu Efa and Pak Donyi, one child, age 3.

Ibu Efa and Pak Donyi have been married for five years. Both of them completed three years of education after high school and now hold management positions. They want to have only one more child. Their decision to have only two children is based partly on financial considerations. Efa is concerned that if she has more than two children, she would become too tired to keep working and this would mean a drop in the family's income.

Donyi says that he always makes a point of attending the family planning sessions because he wants to help take care of his family and to know about the choices that he and Efa have. Both of them also talk to friends about family planning. They say that their parents originally introduced them to the idea of child spacing and reproductive health, so they have learned how beneficial it can be when people share useful information.

Efa and Donyi chose not to use family planning for the first two years of their marriage because they wanted a child. Then as part of Efa's postpartum follow-up, a midwife counseled Efa on four contraceptive methods—OCs, injectables, the IUD, and implants. Efa was concerned about forgetting to take the pill and did not want to use an IUD, so she and her husband decided on injectables as their preferred contraceptive method. Efa, who has not experienced any noticeable side effects, says she is happy with her decision to use injectables.

35 Years

key strategies



Chapter 3

From the start, BKKBN and USAID recognized that family planning could flourish in Indonesia only with a strong enabling environment—that is, with a well trained and highly qualified staff, new social norms about family planning, cooperation from religious leaders, and government and political support. Just as crucial, a close working relationship between USAID and BKKBN ensured flexibility and responsiveness to keep pace with the program’s rapid development and growth.

Training and Education

“Unprecedented investments in training” are one of the key reasons for program success, said USAID population officer William Johnson. USAID and BKKBN made a major commitment to training and education, strengthening the program’s ability to lead and innovate.

Especially in the beginning, overseas graduate school training for key BKKBN staff helped to create a cadre of program leaders who were equipped to lead a national family planning effort. USAID—the only donor to provide significant financing for overseas graduate training—supported 209 master’s degree students and 33 doctoral students among its Indonesian colleagues. This education “enhanced our professional stature, gave us better skills, and created a level playing field for relating to other international donors,” said one BKKBN official. A deliberate strategy on the part of BKKBN was to include candidates from other sectors and ministries in order to expand the network of population advocates across many sectors and agencies.

Later, BKKBN created the International Training Program to help transfer its own family planning experience and skills to



Bidan Delima midwives work together in a training exercise. The Bidan Delima program is a network of about 3,500 high-quality private sector midwives, with nearly 3,000 more in training. “Unprecedented investments in training” are among the main reasons for Indonesia’s family planning program success, USAID believes.

colleagues elsewhere. The training program has become so well regarded that USAID missions in other countries have sent participants of their own to Indonesia for training. The International Training Program has had over 4,000 participants from 92 countries, and 500 from Bangladesh alone (see next page, “How the International Training Program Helped Bangladesh”).

HOW THE INTERNATIONAL TRAINING PROGRAM HELPED BANGLADESH

BKKBN's International Training Program (ITP) made the Indonesian family planning experience available as training tools to help other countries. Notably, among the 4,000 people that ITP trained were over 500 participants from Bangladesh. Ten years after training, more than 90% of these alumni reported in a qualitative evaluation that their training in Indonesia had led to improvements in the availability and quality of services in Bangladesh.

The Bangladesh participants came from national, district, and community levels. They included government officials, religious leaders, NGO managers, and community health service providers. They represented over 50 Bangladesh thanas, sub-district administrative units responsible for community development plans.

During their three-week training, they learned the roles, professional relationships, and activities of their Indonesian counterparts. They accompanied family planning field workers on house-to-house visits and observed field operations, as well as studying other subjects. Topics included adolescent reproductive health, Muslim leadership in family planning, and women and reproductive health.

The Bangladesh alumni credited their Indonesian training with improvements in the Bangladesh family planning program, including increased use of female volunteers, greater participation of community leaders, and more involvement of the political and government infrastructure. Other Bangladesh family planning staff agreed. They reported better performance in program activities and management in thanas where staff had been trained in Indonesia compared with other thanas.

BKKBN was a founding member of the National Clinical Training Network (NCTN). This network is responsible for ensuring high-quality reproductive health services in Indonesia through an

emphasis on clinical training. NCTN is now directed by the Indonesian Society for Obstetricians and Gynecologists (Perkumpulan Obstetri dan Ginekologi Indonesia, or POGI) and the Indonesian Midwives Association (IBI). As part of its training mission, NCTN has provided technical contributions to the family planning standards and tools developed with USAID funding and serves as a channel for their dissemination.

Midwives who have received NCTN training say that training has improved their skills, raised the quality of their services, and increased their self-confidence. NCTN training has enhanced midwives' clinical legitimacy in the eyes of their clients and has attracted many new clients.

Another strategy by BKKBN was to create a nationwide training system in 37 sites. This system provides short-term technical training in topics such as male involvement, interpersonal counseling skills, and contraceptive updates—with over 60,000 participants each year.

Behavior Change Communication

Behavior change communication is a hallmark of the Indonesian family planning program strategy. Throughout all phases of the program, communication has been a key element. BKKBN is also unique in that for decades it was headed by a leader, Dr. Haryono Suyono, who possesses a PhD in sociology with a focus on communication.

BKKBN launched strategically designed, large-scale, multi-pronged, and long-term communication campaigns designed to create a small-family social norm, to increase people's interest in having fewer children, and to generate demand for family planning services. The “small, happy, and prosperous family” campaign message became the unifying theme of all program communication materials at all levels.

These campaigns have succeeded in making discussion and use of family planning socially and culturally acceptable among all groups across the country. The campaign slogan “Dua anak cukup” (Two children are enough) became etched in stone—literally, as

bridges and mile posts on the major highways carried the slogan—and eventually became embedded in the national consciousness.

At the forefront of the strategy to promote family planning in rural areas was outreach through interpersonal communication that engaged communities through the combination of fieldworkers, health providers including village-based midwives, and community-based volunteers, supported by tools and materials to improve their effectiveness (see “Introducing Village Family Planning,” p. 24).

These interpersonal outreach and community mobilization efforts were augmented by creative use of the mass media—radio in the early days and later shifting to television—and in every district by extensive networks of mobile vans, billboards, wall markers, and an array of locally inspired and developed approaches and materials. The Indonesian press also has played a prominent role in covering population and family planning events. News media coverage helped promote an enabling environment and set the agenda of family planning’s crucial importance to Indonesia’s development aspirations.

Over the life of the program, communication programs have changed to reflect the changes in BKKBN’s focus. When BKKBN began to emphasize self-reliant family planning, the Blue Circle movement and communication campaign became the embodiment of this private sector initiative. As the program emphasized quality of care, communication campaigns promoted the range of family planning choices, stressed the clients’ right to make informed choices, and modeled desirable health provider behavior. When BKKBN’s mandate broadened, communication campaigns also included girls’ education, attributes of a quality family, and links between population and the environment.

Involving Religious Leaders

Indonesia is the world’s largest Muslim nation, with many Christians, Buddhists, and Hindus as well. Both of Indonesia’s large Islamic social welfare organizations, Nahdlatul Ulama (NU) and Muhammadiyah, have moved away from initial opposition to

family planning and now publicly support the goals of BKKBN. The tact and sensitivity of Indonesia’s political leadership and BKKBN have gone far to enable this change.

At the beginning of President Soeharto’s New Order regime in the late 1960s, private discussions were held with national religious leaders to reach a consensus on the national population policy and family planning program. As the well-known Indonesian family planning expert Firman Lubis has written, “the legitimizing power of religious leaders was consciously sought. BKKBN brought family planning studies to religious schools (Pesantren) and published newsletters that dealt with religious issues, ultimately reaching 2,700 institutions of learning.”

BKKBN informational materials for religious leaders included the health risks of early marriage and childbearing, since religious leaders perform wedding ceremonies and could encourage young people to postpone marriage and childbearing. BKKBN also funded the development of family planning materials to be used in Friday prayers and in women’s Koranic reading groups. If questions arose over whether a suggested family planning practice would be acceptable to Islam, the program would consult with the Majelis Ulama, the advisory council of leading Islamic clerics responsible for providing advice through interpretation of the Koran.

Whenever BKKBN would hear of religious leaders who opposed family planning, they would seek to meet and discuss family planning with the clerics in question. In conjunction with local clerics, the program tried such innovations as the Ramadhan pill, which would allow Muslim women to fulfill their religious obligations during the holy month of Ramadhan by preventing menstruation.

Eventually, NU itself created a population project to train family planning personnel. The organization has recently endorsed voluntary surgical contraception for its members under special circumstances and offers it in their clinics.



Dr. Haryono Suyono, the former and long-standing Chairperson of BKKBN, stands with district and local officials to witness health workers giving a service pledge. All levels of BKKBN know the importance of working closely with government and community leaders in a spirit of collaboration and cooperation.

Many of the successful negotiations between BKKBN and religious leaders were codified in a 1983 international meeting of Islamic nations on family planning; these were further confirmed in a 1990 seminar, which concluded with a declaration by Islamic leaders that family planning was of direct benefit to families, that clerics ought actively to promote the program, and that Islamic teaching justifies the use of family planning.

During a recent visit to the US by four of its leaders, Muhammadiyah—a 25-million member, 80-year-old Islamic social welfare organization—and its affiliate 'Aisyiyah, the world's first major Islamic women's social activist organization, were recognized by USAID Washington for their long contribution to family planning. "Indonesia is home to one of the most successful family planning programs in the developing world, and the promotion of family planning by leading Islamic organizations, like Muhammadiyah, has been critical to the success of the program," USAID declared.

Political and Government Support

President Soeharto supported family planning programs

unwaveringly for over 30 years, from December 1967 when he signed the World Leaders' Declaration on Population until the day he stepped down in May 1998. His approval of family planning was repeated at all levels, from province governors to village heads. The four presidents who succeeded him have given varying degrees of public support to family planning. Recently, President Susilo Bambang Yudhoyono has made several public statements that emphasize family planning as a development priority.

A culture of collaboration and cooperation has helped the program expand by gaining priority for family planning at national, regional, and local levels. Senior members of the BKKBN staff, many of whom have been with the agency since the 1970s, have created an extensive network of effective program alliances. Positive working relationships with successive governors in key provinces, as well as close coordination with Bupatis (district leaders), camats (sub-district leaders), and lurah (village chiefs) have contributed to political support for family planning.

All levels of BKKBN, from top management to front-line providers, recognize the importance of working closely with government and community leaders. Even fieldworkers know the value of harnessing the political machine, "Help from the lurah... is extremely important," as one said. "If we don't have this, it's just us, the workers of BKKBN."

Inside the USAID-BKKBN Partnership

Testifying before the US Congress, Dr. Haryono said that one reason the USAID-BKKBN relationship was so effective was that the USAID staff "has always been willing to listen and to learn, to stay in step with the Indonesia pace. AID has worked closely with us to identify problems and constraints and then seek local solutions." Charles Johnson, an early population officer said, "We at USAID never referred to the 'USAID family planning program.' We spoke of our contributions to the Indonesian family planning program.... We considered our staff to be partners with BKKBN staff."

USAID provided financial assistance via loans and grants.

Often, USAID funding was seed money for innovation. Dr. Jarrett Clinton, the first population officer, said that USAID paid the costs of a new program for the first year. “If BKKBN liked the ideas and demonstrated performance, then BKKBN placed this innovation in their own budget.”

USAID usually took less than six weeks from the time of proposal to provide BKKBN with funds. BKKBN valued this quick turnaround time because it allowed for “real-time” programming instead of enduring waits of over a year, as with other donors. By the early 1990s, however, the program had become too large and complex to continue the close collaboration that characterized the earlier relationship. Instead, expert agencies funded

by USAID provided technical assistance and assumed more of the daily interactions with BKKBN staff (see Table 1).

BKKBN officers mention the value of this close collaboration between experts and their BKKBN counterparts in solving program problems, transmitting skills, and building institutional capacity. Indeed, providing BKKBN with access to international experts in population and demography, logistics, research, and communication has been one of USAID’s most durable strategies. The global experience they have brought to bear on Indonesia’s family planning program has gone far to develop the country’s institutional capacity.

Table 1. Technical Agencies and Areas of Technical Assistance Provided

AGENCY

The Centre for Development and
Population Activities (CEDPA)
Deloitte Touche Tohmatsu
EngenderHealth
Constella Futures
JHPIEGO
Johns Hopkins Bloomberg School of Public Health/
Center for Communication Programs
John Snow Inc.
Macro International Inc.
Management Sciences for Health
PATH
Pathfinder International
The Population Council
University Research Co., LLC

TECHNICAL EXPERTISE

Adolescent Reproductive Health, Training for
Women Managers
Private Sector Financing
Voluntary Surgical Contraception
Social Marketing
Clinical Training, Standards, and Manuals
Behavior Change, Advocacy, Public Private Partnership
and Research
Contraceptive Security
Demographic and Health Surveys (DHS)
KB Mandiri, Decentralization Management
Community Mobilization, Midwifery Training
Management, Midwife Support
Research
Private Sector Mobilization and Research

35 Years



from clinics
to the community

Chapter 4

*A*s the partnership between USAID and BKKBN got underway in the early 1970s, it was clear that services would have to reach out to people in the rural villages in order to expand use of family planning. The clinical model for delivering family planning services would never achieve the national reach or impact needed. Public health facilities were too unevenly distributed and poorly staffed. Thus the program began community-based contraception at the village level.

Introducing Village Family Planning

At first, the national family planning program used already established clinics of PKBI (Perkumpulan Keluarga Berencana Indonesia, the Indonesian Family Planning Association, an IPPF affiliate), which had developed an extensive clinic network. The program then added extensive community services in an effort that became known as the village family planning program.

“Village family planning, simply stated, is an information, motivation, and contraceptive services program centered on the village level and run by village residents,” said David Piet, a former USAID health officer. The concept was originally proposed by a provincial BKKBN office and, in the face of initial opposition from the BKKBN central level, was effectively supported by USAID—demonstrating the openness of USAID management to new ideas.

Because Bali and Java were the most populated islands, program leaders concentrated activities there. Bali and Java also had the most developed village and community social structures on which the family planning program could rely to reach community residents. In Bali BKKBN embedded its program within the

Banjar—the traditional community organization for managing village labor to maintain the ancient and complex rice irrigation system and to manage religious and community festivals and celebrations. The program enlisted the support of village leaders, the Klian, to the new cause of family planning.

In both Bali and Java the outreach program relied upon family planning field workers (Petugas Lapangan Keluarga Berencana, PLKB) and local family planning volunteers (Pembantu Pembina Keluarga Berencana Desa, PPKBD), commonly referred to as kaders. PLKB eventually became BKKBN paid staff, while kaders remained volunteers. Although complementary, the PLKB and the kaders had different functions. PLKB, with non-medical backgrounds and middle-school education, went from house to house promoting family planning methods, interesting residents in using contraception, and making referrals to private providers. Kaders, who in Java were often wives of local officials and family planning users themselves, or who in Bali were wives of the head of the Banjar, promoted long-term methods, provided counseling, and managed community contraceptive funds.

The results of the program’s field-worker approach were encouraging. Of village women interviewed in one study, 30% had been offered contraceptives for a small fee by a field worker, while more than 40% said that a field worker had referred them to a private provider.

Once the program gained success on Bali and Java, BKKBN expanded to 10 other provinces, and ultimately nationally. Expansion had its challenges. Logistic systems were harder to manage. Personnel were stretched across a wider area. On the outer islands the population to be served was more dispersed, and village organizational structures were looser than on Java or Bali. Nonetheless, BKKBN and USAID overcame these challenges.

In West Sumatra, for example, after a field visit between Tom Reese, a USAID population officer and Dr. Mayhuddin, the BKKBN provincial chairman for West Sumatra, USAID took only two months to provide funding for expanding the village-level

family planning approach to over 1,000 villages in West Sumatra. As one report noted, “USAID support to village family planning has played a major facilitating role in the development and spread of this highly effective concept.”

Expanding Oral Contraceptives

The launch of Indonesia’s village-based program coincided with a global effort by USAID to increase access to oral contraceptives in developing countries. OCs were advantageous because they could be obtained in the absence of clinics and could be distributed by field workers in rural villages. During USAID discussions in the early 1970s with Dr. Judono, a founding member of PKBI, a decision was reached to support widespread distribution of OCs throughout Indonesia. The decision reflected recognition that there could never be sufficient trained personnel to support an extensive IUD program alone, and the program needed more diversity in its contraceptive method mix.

Ultimately, Indonesia would account for over 75% of USAID’s entire supply of OCs. In the late 1970s USAID Indonesia estimated that they were importing 35 million cycles of pills in a year. These were distributed via two ports, 16 provinces, 221 regency warehouses, 3,330 village clinics, and 25,000

new village re-supply centers—part of the 53,000 community outlets that BKKBN had established with USAID support.

Establishing effective reporting and logistic systems became a key priority. Central procurement of OCs allowed for large cost savings, although to procure centrally USAID had to anticipate its supply needs at least two and a half years in advance. USAID Washington was able to provide pills at only 13 US cents per monthly cycle compared with an average of 85 cents among

other government agencies and commercial wholesalers. In addition to using supplies from USAID, BKKBN in the 1980s built and equipped a factory in West Java to provide a local supply of OCs. This decision contributed to keeping OC costs low and provided BKKBN with more flexibility in assuring adequate supplies as demand for OCs continued to increase.

A drawback of central procurement was that the brand of OC could change at any time. Once, when Indonesia received a shipment of a new brand of pill, many existing family planning clients were unhappy because they experienced breakthrough bleeding and other side effects. BKKBN

responded by going to the field and reassuring clients and service providers that the side effects would diminish within a few months. Because BKKBN responded actively, brand changes did not

Making Informed Choices. Ibu Supriyati, age 43, three children, ages 16, 19, and 21.

Ibu Supriyati had relied on natural planning and breastfeeding to space her births. Then, after the birth of her third child, she decided to explore her options by consulting a midwife.

“I began considering family planning because the health insurance from my husband’s job at the Department of Religion will only cover three children. I didn’t think we could afford more children, and also after my third baby was born deaf, I was afraid that my other babies might have this problem too.

“I spoke with a midwife, and she also spoke with my husband, encouraging him to practice family planning. Then, my husband and I discussed our options, and we decided the IUD would be best for us. I was concerned that if I missed one of my daily pills, I might get pregnant. I’ve used the IUD for 16 years now, and I am grateful that I had the option to do so.”

adversely affect OC use in Indonesia. This experience was in contrast to other Southeast Asian country programs, where changes in the pill supply created problems for clients.

Development Communication

In the mid-1970s President Soeharto and his advisors, concerned about rapid population growth and its negative effects on Indonesia's development, began to advocate a demographic rationale for family planning in addition to its health benefits, which previously had been the rationale for government involvement. They argued that the program should adopt messages about the key role that family planning plays in slowing population growth, as a major contribution to Indonesia's development.

USAID believed that it was vital to explore what kind of messages would resonate best with potential family planning clients and how these messages should be delivered. USAID funded research to look at alternative ways of increasing popular interest in family planning. One approach adopted was to improve the quality of health education in the national program. The program focused on teaching providers how to communicate better with clients about the advantages of adopting family planning and other modern health practices. This investment in health education represented a major change from the approach USAID had adopted in 1968, which was to focus on the clinical and medical aspects of the national program.

As a demographic rationale for family planning took precedence in response to governmental concerns about rapid population growth, the program's communication materials reflected this change. Notably, the BKKBN family planning logo, which had depicted a family with four children, changed to show a two-child family.

Challenges for the 1980s

Toward the end of the first decade of collaboration, in the late 1970s BKKBN came to realize that relying on public funding



A group of men learn about family planning in this community education session. USAID has supported studies to find the best ways of increasing popular interest in family planning, and the family planning program has focused on helping providers to communicate better with clients.

to provide contraceptives to the existing 22 million family planning users, plus the anticipated 1 million new users each year, could not be sustained indefinitely. At the same time, their data showed that urban areas lagged behind rural areas in contraceptive prevalence.

Program planners had assumed that because urban couples had better education, more exposure to modern concepts, and more participation in the cash economy compared with rural people, they would be more likely to want family planning. But the limited family planning services available in urban areas were no match for the widespread access in rural areas that the village family planning program was providing. Thus as the 1980s began, USAID and BKKBN decided to respond to the twin challenges of building self-sufficiency and meeting urban needs.

35 Years



toward self-reliance:
involving the private sector

Chapter 5

To increase access to family planning services in urban areas and at the same time reduce dependence on public-sector services, BKKBN and USAID determined to expand the role of the private sector dramatically. They conducted research to examine new market-oriented approaches in urban areas and tried pilot projects in contraceptive social marketing. They addressed how to use the mass media in combination with social marketing to reach potential family planning clients in the urban areas.

The new urban strategy became synonymous with expanded private sector initiatives. As these initiatives succeeded, the family planning program became increasingly self-reliant and sustainable.

Condom Social Marketing

The private sector initiative began with contraceptive social marketing. The most accepted brand of condom for social marketing turned out to be Dua Lima (Two Five). This was the first condom in Indonesia positioned as a “family planning” condom. Distributed in pharmacies, drugstores, supermarkets, market stalls, and cigarette stands, over 8 million Dua Lima condoms were sold per year.

The program’s initial research found that the name Dua Lima could be easily remembered. (Other products in Indonesia, including cigarettes, also are marketed by using numbers in their names.) Clients at sales outlets could request the Dua Lima condom using “two-five” sign language (showing one hand with two extended fingers and the other fully open). Sign language could mitigate consumer shyness about asking verbally for condoms. In fact, the “two-five” sign language also came to represent the BKKBN’s campaign theme “dua anak cukup” (two children

are enough) by showing the two fingers, for two children, and the extended hand as a “stop” sign.

A key lesson that BKKBN learned in this pilot project was to conduct social marketing not in the traditional way—that is, by selling a subsidized product below market price (meaning that the more products sold, the more costs to the program)—but rather by defining social marketing as a partnership between the public and private sectors. Thus BKKBN helped to create a large market for contraceptives, and private companies then continued on their own after being convinced that they could sell to the lower-income consumers and still make profits. This public-private sector partnership was the model for what became the largest private sector family planning program, the Blue Circle campaign.

The Blue Circle Campaign

In 1988 BKKBN and USAID launched the Blue Circle campaign as a major institutional branding and marketing program. This effort, directed to urban residents primarily in middle and lower socio-economic groups, used extensive mass media marketing to promote private sector delivery of family planning by doctors (general practitioners) and midwives. Blue Circle brand private service providers were promoted as offering professional, safe, reliable, and good-quality family planning services.

The image of the Blue Circle was intended to be distinct enough that consumers would distinguish private sector providers from both BKKBN and community health center services. Market research led to the creation of the Blue Circle logo and the program’s support materials. These included an outdoor logo sign bearing the blue circle announcing “KB”—Indonesian shorthand for *Keluarga Berencana* (family planning)—that attached to the practitioners, medical office sign, as well as a waiting-room poster, general family planning brochures, leaflets on specific contraceptive methods, and promotional radio spots, posters, and community-based promotional materials. Starting in four cities in the first year and expanding to 11 cities in year two, the demand expanded to over 300 cities in the third year, as a growing number of cities and districts bid to become Blue Circle participants.



This Family Planning Cooperative sign highlights the positive attributes of family planning—including that it is safe and valuable for the individual, socially acceptable, and a good practice. Extensive marketing and promotion characterized the Blue Circle campaign, which began in 1988, in its efforts to position private service providers as sources of professional, safe, reliable, and good-quality family planning services.

By the end of the first year of the Blue Circle campaign, 32% of doctors and 58% of midwives in the four cities reported that the marketing program had had a positive impact on their practices. More and more people were asking them about family planning, and private providers were gaining many new clients thanks to Blue Circle branding. Midwives participating in the Blue Circle campaign reported an average 36% increase in clients per week.

After the public had become familiar with the Blue Circle brand of private services, the program added branded Blue Circle products. Four contraceptive manufacturers were enlisted to participate. In return for Blue Circle branding and promotion, they offered discounted contraceptive products—an oral contraceptive brand, the injectable Depo-Provera, and an IUD, as well as the Dua Lima condom. By 1990 the Blue Circle program was reaching all of its intended consumer groups and was launched nationally.

KB Mandiri

The KB Mandiri (self-reliant family planning) initiative further developed the concept of clients paying something for their contraceptives. Its purpose was to encourage consumers who could afford to pay something for family planning to obtain services from the private sector—private hospitals and clinics, pharmacies and drugstores, and voluntary community groups. Also, clients who obtained family planning from government sources were encouraged to pay something, if they could afford to do so.

Because paying for contraceptives was a new concept for many Indonesians, BKKBN introduced it carefully. A pilot project took place in Bali, Yogyakarta, and North Sulawesi because these areas already had relatively high contraceptive prevalence and the project could try to shift some family planning clients from the public sector to the private sector, rather than focus on raising contraceptive prevalence further. Radio and television campaigns and other strategies increased public awareness of the need to pay for contraceptives and tried other ways to increase the consumer's financial contributions to their use of contraceptives.

Survey data confirm the dramatic achievements of KB Mandiri and the unique Blue Circle model of public-private sector partnership. According to the 2002-2003 Indonesia DHS, about two-thirds of all family planning users receive their services from the private sector, especially private midwives. A dramatic shift has occurred. The 2003 IDHS found that nearly 90% of Indonesian family planning users pay for their family planning services. In comparison, in 1986 only an estimated 18% paid. Virtually all users of injectables and OCs, the top two methods used in Indonesia, pay for their contraceptives whether they obtain them from the private sector or from the government. The differences in the costs of obtaining injectables and pills from private sources compared with government outlets have become negligible.

At the height of the Indonesian economic crisis in 1997-98 almost all donors and population experts predicted that the contraceptive prevalence would go down because economic hardship would make modern family planning methods unaffordable for

most people. Nonetheless, prevalence increased by five percentage points between 1998 and 2003. This remarkable performance has been attributed largely to the dominant presence of the private sector created by the Blue Circle campaign, the institutionalization of the small-family social norm, and people's strong demand for family planning.

Private Sector Midwives

During the Blue Circle campaign it became apparent that private sector midwives were crucial to the program's continued development. Midwives served 58% of private sector clients at that time and were the leading private sector providers of OCs, IUDs, injectables, and implants. After an evaluation found that midwives were so eager for training that some split their per-diem training payments to enable more of their colleagues to join the training, USAID and BKKBN trained 5,000 more midwives in family planning skills.

The renewed dynamism of midwives also led to increased support for their professional organization, the Indonesian Midwifery Association (IBI). Supporting IBI not only contributed to the program's success in promoting private sector services but also improved gender equity, since other professional organizations were overwhelmingly male. IBI continues in this active role today, implementing the Bidan Delima program, with its emphasis on high quality and responsiveness to client needs (see "Standards and Guidelines for Good Quality," p. 37).

In response to USAID funding, IBI created training manuals and developed master trainers. IBI further instituted a sustainable system in which it charged members for training and used the generated funds for program development. The association also developed a peer review system that was the first of its kind and that contributed substantially to improving the quality of services.

Posyandu

The Posyandu program focused on improving the health of children under the age of five together with meeting the family

planning needs of their mothers. Posyandu services reflect not only the urgent need for better infant and child health but also the link between child mortality and family planning. Many studies show that, as child survival rates improve, families are more likely to be interested in family planning because they can be more confident that their children will survive to adulthood.

The Posyandu program integrated nutrition services into the family planning program, using the village-based groups developed in the 1970s. While at first the program suffered from administrative and managerial difficulties, BKKBN worked to find a successful approach to integrated services, and eventually prevailed. A 1991 evaluation found that "Posyandu has enhanced village satisfaction with the family planning program, brought clinical services (IUD and injectables) closer to the village population, and increased contraceptive prevalence."



35 Years

a mature program



Chapter 6

*B*efore the 1994 UN International Conference on Population and Development, held in Cairo, Dr. Haryono said, “It is no longer acceptable to focus on quantitative targets in a mature family planning program like Indonesia’s. The quality of services being provided needs more attention, and it is incumbent on the donor agencies to participate in this effort.”

Others agree that an emphasis on good quality is a key to continued program success. Terrence Hull has said “what women need now is the range of services and knowledge to protect their health while they determine their own choices of childbearing.” To address quality of care the Indonesian family planning program is making its services more responsive to client preferences and assuring client satisfaction. For example, in Jakarta one hospital



At a private sector clinic a midwife counsels a couple on their contraceptive options. Indonesia’s family planning program promotes informed choice and is making its services more responsive to client preferences.

increased the number of family planning service delivery days per month and gave new mothers referral cards for family planning services. Others have improved their counseling practices.

The program is also promoting informed choice. In East Java and elsewhere studies have shown that, when clients receive their contraceptive method of choice, they are more likely to continue use. Thus communication messages urge clients to participate actively in making an informed family planning choice and that making contraceptive choices is not a one-way street but entails a partnership between client and provider.

Voluntary Surgical Contraception

Access to a range of family planning methods is a cornerstone of good-quality services. Indonesia faces a challenge in reaching its goals for quality of care, as well as for achieving higher contraceptive prevalence, unless voluntary surgical contraception can become a viable part of the family planning program. BKKBN has been unable to include voluntary surgical contraception as an “official” program method due to concerns over Islamic objections to the permanent nature of the method.

There has never been a mass media promotion campaign to make people aware of voluntary surgical contraception as a long-term method. Instead, BKKBN has relied upon provider counseling, local interest, and field workers to spread information about the method. Because referrals by BKKBN field staff were thought to encourage voluntary use of surgical contraception, USAID has conducted a refresher training program on the method for 17,000 BKKBN fieldworkers and 3,000 supervisors.

BKKBN has delegated program authority to the Indonesian NGO, Perkumpulan Kontrasepsi Mantap Indonesia (PKMI) (the Indonesian Association for Secure Contraception), to be the primary agent in providing voluntary surgical contraception. PKMI, which received financial support from USAID for 30 years, developed sites where providers could offer voluntary surgical contraception, gave providers training in surgical techniques, and evaluated the quality of care.



A pharmacist talks with customers interested in oral contraceptives. Even during the economic crisis of 1998, demand for family planning remained constant, largely because of the dominant role of Indonesia's private sector in providing services and people's continuing strong demand.

At times the program has seen substantial client interest in surgical contraception. For example, when the no-scalpel method was introduced in Central Java in 1988, clinicians performed 1,000 vasectomies in a two-month period. But services have not been sustained, largely because not enough providers had the necessary skills. At one point only 20% of 290 refurbished health centers reported performing vasectomies.

Since 1995 the prevalence of voluntary surgical contraception use in Indonesia has remained at an estimated 4%. After data showed that prevalence of its use was one-third lower in 1995 than at its peak in 1990, and that prevalence had declined for five consecutive years, USAID decided to act on an evaluation recommendation and cease funding voluntary surgical contraception efforts.

Economic Crisis: Weathering the Storm

In 1998 an economic crisis struck Indonesia and other Asian countries. In the face of the crisis, which was expected

to seriously disrupt poor people's access to family planning and other health care, USAID reversed its 1995 decision to phase out development assistance in the family planning sector by 2000 and decided to maintain its support.

Reflecting the crisis, USAID support shifted from development assistance to humanitarian response:

- Donating contraceptives,
- Paying short-term operational costs for family planning services,
- Continuing family planning training through the National Clinical Training Network,
- Supporting primary health care programs at the community level, which were run by local and international NGOs, and
- Supporting surveillance systems to report contraceptive use and supply.

In addition to the support from USAID, BKKBN also obtained increased support from other donors for contraceptive procurement and made contingency plans to ensure a continuous supply. The program suspended its efforts to encourage contraceptive users to pay a greater share of the cost. The rapid response of USAID and other donors and BKKBN's resilience in the face of this crisis made a significant contribution to weathering the crisis.

Contraceptive use remained constant, even as the surveillance systems reported widespread shortages of contraceptive commodities throughout the country as a result of the crisis. A report based on RAND survey data found "no statistically significant differences between 1997 and 1998 in overall levels of contraceptive prevalence, in unmet need, or in method mix." The report concluded that, "the stability of contraceptive prevalence and unmet need in the face of dramatic changes in both the economic and service environments suggests that in Indonesia couples' fertility plans and their preferences for small families are well-established and that they will continue to fuel a strong demand for family planning services."



PARTISIPASI PRIA/SUAMI DALAM KB



35 Years

sustaining success



Chapter 7

In 2003 USAID decided to develop a graduation strategy with input from all stakeholders and to complete a final phase of technical assistance to BKKBN, to be completed in 2006. A team from USAID/Washington and the Mission confirmed that BKKBN possessed the management and technical capacity to carry out the national family planning program now and into the future. USAID's assistance has always focused on capacity building and sustainability, and the strategy noted BKKBN's institutional maturity and the ability of the Ministry of Health, NGOs, and professional associations to offer high-quality family planning services.

One of the lasting legacies of USAID donor assistance will be the use of standards and guidelines in training and practice. These are valuable documents that Indonesian health providers have adopted as a way to increase family planning use and promote reproductive health and family development. These standards are Indonesia's first empirically based, locally adapted, widely distributed, and policy-supported family planning standards.

USAID also has supported BKKBN's efforts to meet the management, restructuring, and budgetary challenges posed by Indonesia's decentralization of governmental authority for resource allocation and decision-making. This new structure will call on all of BKKBN's ingenuity and ability to implement a nationwide family planning program in a decentralized structure. One optimistic note is that the decentralized districts all have agreed upon the use of the uniform standards and guidelines, providing continuity of care in the family planning program.

Standards and Guidelines for Good Quality

Starting from a field review that found nine different volumes of standards and dozens of memos from BKKBN and

Moving from traditional to modern family planning. Ibu Sri Salkiyah, age 48, three children, ages 12, 19, and 24.

Ibu Sri Salkiyah has a middle school education and works at home in a small town in Central Java. After giving birth to her first child, she did not use modern family planning methods, both because she was embarrassed at having only one child and because contraception was not readily available. Instead, she tried breastfeeding and the calendar method to keep from getting pregnant. Following her third birth, however, she did not want to have any more children.

Then Sri learned about family planning from a nearby community health center, and she decided to adopt a modern family planning method. A midwife at the health center counseled Sri on her options, and Sri chose the IUD, which was then inserted free of charge. The IUD appealed to her both because of its reliability and its convenience. Sri wanted a method that did not require frequent follow-ups at the center. She still retains that IUD today. She says that she is happy about her decision to use the IUD, and intends to urge her children to use modern family planning methods.

the Ministry of Health that identified proper practices for clinicians providing family planning, a consortium of stakeholders consolidated them into one succinct and practical manual. The guidelines, developed in collaboration with BKKBN, professional organizations in Indonesia, and USAID cooperating agencies, are evidence-based and reflect lessons from extensive field experience.

Forty thousand copies of the manual have been published and distributed, and its contents have been posted on the Internet and in other electronic media. Other donor agencies have incorpo-

 **BIDAN DELIMA**
LAMBANG KESUKSESAN ANDA 



rated the guidelines into their family planning assistance programs and have distributed them throughout the country. Additional clinical topics, such as infection prevention and counseling, with relevance to wider public health areas such as maternal health, have also been upgraded to reflect the information in these new family planning guidelines.

These standards and guidelines are being used in the certification process for private sector midwives in the Bidan Delima initiative—the branded network of highly qualified midwives in the private sector who have passed rigorous evaluations of their professional midwifery practices, including clinical and counseling practices for safe delivery, family planning, and prenatal and postnatal care. Their skills and use of standards, protocols, and evidence-based practices will become the benchmark against which future high-quality services are measured. In mid-2006 there were about 3,500 certified Bidan Delima and an estimated 2,900 candidates in the pipeline.

Decentralization

In 2001 the Indonesian government passed legislation that devolved substantial executive, legislative, and fiscal authority to district-level governments, effectively decentralizing many programs—including the family planning program—that previously were managed at the national level. Under the decentralization legislation the extensive vertical BKKBN network from the central level to provinces, districts, and villages is being replaced with administrative structures belonging to agencies other than BKKBN. Each district now has the authority to establish its own approach to family planning program management. Some districts have decided to place the district family planning office within the local Ministry of Health district health office (Dinas Kesehatan). Other districts have merged the family planning program into the office of Civil Registration, Population, and/or Women's Empowerment. Still others have kept the family planning office as a stand-alone agency.

BKKBN was granted a waiver until January 2004 to determine how best to deliver a national family planning pro-

gram within the context of the new decentralized governmental structure. BKKBN responded by studying key aspects of its own operations to determine the best way to revamp them. Working with USAID, the Ministry of Home Affairs, and the Ministry of Health, BKKBN has defined minimum standards for maintaining the quality of family planning services at the district level. USAID also has supported the development of a managers' tool kit designed to help district level officials and managers take on their new family planning program responsibilities more effectively. The tool kit includes guides that explain new functional responsibilities and regulations, and many local managers have received orientation in its use.

BKKBN will need to find creative ways to support good-quality family planning services throughout the country in order to ensure the availability of a range of contraceptive methods, to offer continuing training for providers in counseling that helps clients make informed choices, and to provide program assistance to district decision-makers. USAID has suggested that, to ensure that district authorities continue to provide the needed support to family planning, BKKBN managers will have to adopt a mix of leadership, personal persuasion, and training. USAID also has noted that new strategic approaches such as block grants probably will be needed to allow for more district-driven expansion of the family planning program.

With the advent of decentralization, advocacy has become increasingly important at the provincial and district levels, both as a way of keeping district and provincial leaders engaged and committed to a strong national family planning program and as a means of encouraging them to remain responsive to local needs and conditions. Because district decision-makers are now popularly elected rather than appointed, BKKBN must be prepared to adapt its strategy of developing close political alliances at district and provincial levels in anticipation of a more frequent turnover of district-level administrators.

35 Years

lessons learned



Chapter 8

Indonesia's family planning program has rightfully earned an international reputation as a success story. Family planning specialists have highlighted several important features of the program that may be worthy of emulation, notwithstanding the distinctive geographic and demographic character of the highly populated Indonesian archipelago.

These “lessons learned” have been categorized as: support from top political leaders, the administrative separation of family planning from other health programs, heavy investments in education and training, continuous and flexible funding, strong partnership with the private sector, research-based decision making, and the long-term effectiveness of USAID's mission—the program's major external donor.

Political Support

From the outset, Indonesia's family planning program benefited greatly from the strong support of President Soeharto during his long tenure and from the continuity of leadership that BKKBN enjoyed. While it may be impossible and even undesirable to replicate the conditions that guaranteed this political stability, there are key elements about the interaction between family planning authorities and political figures that may be modeled. Perhaps the most important of these is frequent consultation with political, community, and religious leaders to seek their cooperation and backing both at the national and local levels. BKKBN consistently cultivated its relationship with President Soeharto and other influ-

ential political and ministerial figures, and it encouraged its regional and local managers to adopt tactics of establishing similarly strong lateral relationships at the provincial and district levels.

These political links with permanent government staff and community leaders proved to be of paramount importance at district and province levels. BKKBN delegated decision-making to provincial and district level managers and accorded them wide latitude in the day-to-day running of the program, with the result that these managers became agile and effective in responding to changing local conditions. Bangladesh recognized the strength of this aspect of the Indonesian approach and adapted similar approaches under its thana system, and family planning programs in other countries also might consider such an approach.

A Stand-Alone Program

When Indonesia was first investigating how best to launch its family planning program, the World Health Organization (WHO) advised President Soeharto's government to establish an institution that would be administratively separate from the Ministry of Health and its clinically-based health programs. It was believed that an autonomous, more flexible administrative system could more rapidly move the program forward in accordance with the high national priority that President Soeharto had set for family planning.

As a result, BKKBN came to report directly to the president and was placed in a stronger political position in its coordination with other governmental agencies. BKKBN was thus in a position to champion its budget request directly with the president and his closest circle of advisors. A 1980 USAID report on lessons learned acknowledged the importance of this strategic decision as well as the necessity of a close relationship of cooperation and coordination with the Ministry of Health.

While the mechanisms for collaboration and coordination have changed over time, the directors of both BKKBN and the Ministry of Health have always had equal access to Indonesia's top decision makers. A lesson learned from the Indonesia experience is that family planning leaders must have the authority and responsibility to develop innovative strategies and approaches that can meet people's needs. They must also collaborate with a range of stakeholders to meet the program's objectives.

Investment in Education and Training

At the beginning of its family planning assistance program to Indonesia, USAID was the primary donor supporting long-term education and training for key civil servants from BKKBN and other ministries. The Indonesia government recognized its value and increased its own contributions to overseas education.

The investment in human capital helped create a community of planners capable of speaking a common professional language and facilitated good working relationships among themselves and with international agencies. The skills that such international training imparts to managers add to their credibility and help build networks of family planning professionals who can learn from each other. This approach also contributes to a core group of mentors in universities and government agencies who can pass on their knowledge to their colleagues.

BKKBN officials also established a practice of reviewing the family planning experiences of other countries both to learn of new successful techniques and to avoid the pitfalls experienced by others. USAID supported BKKBN officials on missions throughout Asia, and even to such diverse locations as a Vermont family planning clinic and a Brazilian factory, to observe how different programs worked.

Through its International Training Program, BKKBN

invited colleagues from other countries to learn from the Indonesia program. This outreach prevented insularity and helped BKKBN become an early adopter of family planning innovations, such as the use of Norplant, social marketing, community-based distribution, and family planning mass media campaigns. This experience suggests that, as much as possible, countries should seek opportunities for South-to-South exchanges of information and experience. International university exchanges, such as those between the University of Indonesia and Australia National University and the University of Hawaii, also serve as valuable sources of ideas and inspiration for family planning programs.

Consistent Funding and Flexible Financing

Adequate financial assistance and effective funding mechanisms are crucial to program success. USAID support for BKKBN remained stable over many years, and the Indonesian government steadily increased its own contributions. In 1975 USAID and the Indonesian government each provided 35% of the family planning program budget. By the early 1990s the government's share of the BKKBN budget had risen to over 70%. The Ministry of Health also has made a significant contribution, paying for the expense of many clinical sites and service providers.

The program also developed effective mechanisms for quick resource disbursement. On average, during the first two decades of the program it took only 45 days to go from a proposal to having funds available. By using flexible funding approaches, provincial field managers were able to try new service delivery approaches. For example, South Sulawesi was able to make effective use of fleets of small boats to deliver services to isolated areas. Even as budgets have tightened, BKKBN has received a special appropriation from the national budget and experienced increases in funding for some districts.

Private Sector Partnership

In Indonesia as in most countries, the universal provision of free contraceptive services is not sustainable, especially as the population increases and demand for services rises. To overcome the limitation of a public sector program, BKKBN successfully engaged the private sector as a partner in providing services and attracting new clients. BKKBN also has worked with professional organizations to increase the number of private providers and improve their skills.

While continuing to subsidize family planning for those who cannot afford to pay, many countries can identify opportunities to foster private sector interest in providing affordable family planning services—for example, promoting industry-based health services for workers and raising people’s awareness that the private sector can provide good-quality affordable services for most people.

Data Collection and Research

USAID and BKKBN created data and reporting systems and built research capacity so that program decisions could be based on evidence and scientific analysis. BKKBN was one of the first agencies within Indonesia to automate its management systems with extensive computer networks. BKKBN uses data to track trends in contraceptive use such as shifts in method mix, to identify problems in contraceptive supply, and to monitor consumer satisfaction with services. Extensive reliance on data allows BKKBN to make quick mid-course corrections and avoid wasting program resources.

Although the world is increasingly computerized, effective data collection does not have to rely on computers. Nor does the possession of computerized data guarantee that programs will analyze and use the information wisely. The most important lesson

that Indonesia’s experience offers is that, when analysis of information is shared on a systematic and timely basis with the program managers who gathered it, the program can base decisions on evidence—the foundation of rational planning.

USAID Mission Focus

Among the lessons learned from the Indonesian experience is the importance of technical staff at the USAID Mission. Various accounts attributed this factor as key both to the success of USAID’s partnership with BKKBN and to the family planning program itself. The careful selection of technically qualified staff and the long-term commitment of USAID allowed the partnership to develop strong and trusting relationships with BKKBN and to foster a collaborative and effective working style.

Another factor that promoted an effective partnership with BKKBN and the Indonesian government was the authority and decision-making that USAID accorded to its health and population officers. Their status gave the program greater visibility with Indonesian counterparts and sent a signal that USAID was deeply committed to working in partnership to develop a successful program. Other financial donors can learn from this experience by selecting key staff carefully, building their credibility, and endowing them with the resources and the authority to collaborate flexibly and creatively with the family planning program that they are supporting.

35 Years

meeting future challenges



Chapter 9

Indonesia has set ambitious family planning goals—the achievement of replacement-level fertility by 2015 and zero population growth by around 2050. To reach these goals the country will need to increase the supply of high-quality services and contraceptives and to respond to growing demand. Increases both in the absolute number and the percentage of individuals using contraception will drive up the demand for family planning.

Several factors, including a growing economy with higher living standards, anticipated continued improvements in women’s education and status, and a stable democratic political environment are expected to weigh in favor of reaching these targets. A number of remaining challenges will have to be addressed, however, if the country is to reach its goals. Some recent trends have created cause for concern:

- Increases in contraceptive prevalence have slowed recently.
- The number of children that the average woman considers to be the ideal has changed little during the past decade and is much higher than the replacement level.
- Although actual fertility (at a TFR of 2.6) has fallen below average ideal family size (at 2.9 children per woman), fertility remains above the replacement level (at a TFR of 2.1).

The country’s decrease in fertility since 1967 is largely attributable both to the widespread acceptance of the smaller family

as social norm and the availability of contraceptives to fulfill the desire for a “small happy prosperous family.” In remaining consistent with this successful strategy, the family planning program must continue to devise strategies to reach out to new users, while serving the growing number of continuing users, and to ensure that all of the effective contraceptive method choices are accessible and widely promoted. The family planning program must also revitalize the concept of the small-family norm.

To continue its progress the family planning program must find ways to expand the quality of care and to make family planning accessible to all. Providing a wider range of family planning methods—that is, broadening the contraceptive method mix—is a crucial need for the future. Indonesian family planning faces these challenges at a time when financial support for family planning is becoming more difficult.

Midwives: Ensuring Quality and Access

Although BKKBN has successfully engaged the private sector in providing family planning, the need to expand access to good-quality private sector services will remain high, and midwives, who provide most of the family planning services, will likely remain the center of this focus. BKKBN and the Indonesian Midwifery Association will need to sustain the improvements in quality that have been achieved through USAID’s investment in the Bidan Delima program.

To meet the growing demand for services, the country’s family planning leaders must address an array of issues affecting midwifery. The number of certified midwives working in rural settings remains a major challenge. Care will have to be taken to monitor fluctuations in the income levels of midwives that may come about as a result of the decentralization of family planning. The income of midwives derives both from client fees and as a stipend

from the national government. If decentralized district governments choose not to continue paying base salaries for midwives or cannot otherwise retain them, access to family planning could be compromised, and without incentives to practice in remote settings many experienced midwives may feel motivated to move elsewhere in search of better living conditions.

Contraceptive Prevalence and Method Mix

More Indonesians must adopt longer-term family planning methods if the country's family planning goals are to be met. Currently, more than 75% of the 25 million family planning users choose a hormonal contraceptive method—either OCs or injectables. The family planning program is highly dependent on short-term methods, which require more extensive supply chain management than long-term methods.

International research has shown that no country has been able to sustain a contraceptive prevalence rate of 60% or more unless at least 13% of married women of reproductive age use long-term family planning methods—the IUD, implants, and voluntary surgical contraception (including vasectomy). Indonesia's current use of voluntary surgical contraception stands at only about 4% of couples, and growth has been stagnant, increasing by only one percentage point in the past 10 years.

IUD use suffered an almost 50% decline in the same period. The use of implants nearly doubled in the last decade, but since 1999 implant use has also declined, dropping by almost two percentage points. The diminished use of implants is an apparent response to a decline in the availability of subsidized implants, as a combination of high procurement cost and budget constraints forced the family planning program to reduce the quantity of implants it could subsidize.

For contraceptive prevalence to continue rising, BKKBN and local family planning authorities will have to resolve the long standing barriers to the program's ability to offer long-term methods, particularly voluntary surgical contraception. They will also have to resolve service delivery bottlenecks that discourage clients from pursuing longer-term methods. In Central Java alone, for example, 30,000 people remain on the waiting list for voluntary surgical contraception.

Budgets and Programs

BKKBN has a long and successful history of both attracting donor support and securing adequate funding from the national government. In recent years, however, negotiating for its share of the national budget has become challenging, as other priorities compete for Indonesian government support. BKKBN leaders need to develop strong advocacy skills and messages at both the national and local levels.

Family planning is integrated into the Ministry of Health's Community and Family Health Division and it is highlighted as a critical component to reduce maternal and child mortality. Given competing priorities within the health sector, however, family planning does not always receive adequate financial and human resources. More attention is needed to ensure that the Ministry of Health has sufficient budget and strong leaders and experts to ensure high-quality family planning service delivery.

The restrictive budget environment will necessarily challenge BKKBN to practice greater fiscal restraint to stretch the budget, and it must continue to find innovative ways of re-invigorating its advocacy efforts at both the national and local levels. BKKBN will also need to explore other potential sources of support, including local district governments and private foundations.

A Final Thought

USAID is proud of supporting the 35-year partnership in family planning with BKKBN. The program has been successful because of the strong commitment of both partners. Indonesia's family planning program owes much to its leaders, who were creative and flexible agents of change. Their effective leadership style can serve as a model for a future generation of family planning leaders.

As BKKBN constructed and developed the national family planning program, the entire country has benefited from the dedication of its staff. Their positive collaboration with Indonesia's political leadership and with communities, as well as with USAID and other international donors, has allowed the country to achieve its stunning success in family planning.

Family planning remains a crucial development issue in Indonesia—and family planning success is a lynchpin for improving health, social welfare, and economic development. BKKBN's current and continued support to client-centered, high-quality family planning services mirrors changes in Indonesia, which has made the transition to a more open society. Now, as USAID completes its funding and technical assistance to BKKBN, it is vitally important for all partners to renew their commitment to family planning and to face the challenges of the future with confidence and vision.





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