

Indonesia Looks Toward Continued Fertility Decline*

Rapid population growth on the island of Java was recognized as a problem as early as 1800 by Indonesia's Dutch colonial rulers. Pressures were particularly acute in the crowded city of Jakarta. Java's carrying capacity had become seriously threatened by 1900, when a policy of redistribution or "transmigration" was begun, in which individuals and families were moved from this densely populated region to the sparsely inhabited outer islands of the archipelago nation.

Yet official recognition of Indonesia's high growth and birth rates as constraints to national well-being was slow in coming. In 1964, measures to reduce birth rates were not considered to be in keeping with Muslim customs and morals, and the administration of then-President Soekarno felt that the nation's population pressures could be adequately eased by transmigration, which could also provide the means to develop an economic and agricultural base on the outer islands.

The first advocates of family planning in Indonesia were private groups that provided services and information in the early 1950's to an educated and highly motivated urban middle class. These small groups later merged to form the voluntary Indonesian Planned Parenthood Association, which set the stage for eventual governmental initiatives. The first official government action took place in 1968 when Soeharto assumed the presidency and was one of 20 heads of state to sign a U.N. declaration on population which stated that "the number and spacing of children is a basic human right." An ad hoc advisory committee then recommended the establishment of a national family planning program for Java and Bali, which was initiated in 1969. REPELITA I (1969-73) was the first National Development Plan to include a family planning component and set a target (3 million) for new contraceptive users. In 1969-70 the National Family Planning Board was established, and

"Family planning program efforts have had a remarkable impact on the island nation of Indonesia, where fertility rates have fallen significantly in recent years. In Kenya, by contrast, high birth rates persist despite substantial population assistance efforts. The following brief overviews by David Cantor of activities in these two countries indicate the wide range of sociocultural influences to be considered in the development of family planning programs in LDCs and the importance of country-specific approaches to the provision of fertility planning services.



Photo credit: Agency for International Development

Indonesian mother and baby participating in Indonesian maternal and child health care program

the groundwork laid for what was to become one of the world's most successful family planning programs.

REPELITA II (1974-78) cited rapid population growth as the country's most important problem and family planning as the major focus of its population policy. This plan called for 8 million to 12 million new users in Java and Bali and 1 million new users in the outer islands within the 5-year period. These goals were supported by strong statements urging the adoption of a small family norm through intensive information, education, communication/motivation activities, and innovative approaches toward the delivery of family planning services.

The current population policy of REPELITA III calls for further expansion of family planning efforts to all regions of the country, stresses the need for developing the outer regions through planned and voluntary transmigration, and recommends a national demographic policy aimed at slowed population growth, reduced infant mortality, and more even distribution of the population.

International population assistance to Indonesia began in 1968, when the government initiated official support of family planning. At that time the

country provided a very small amount (4 percent—see table B-1) of the total dollars spent on its population activities. AID was the major foreign donor and has continued to be a major source of assistance over the 12-year period. During the period 1968-78 AID contributed \$43.2 million in grants and \$14.3 million in loans. Total funds provided to the Indonesia family planning program through 1978 totaled \$208 million; of this amount, 50 percent was provided by the Indonesian government, 28 percent by AID (which includes AID intermediaries as well as donations to multilateral), and 22 percent by other foreign donors. The trends outlined in table B-1 reveal the government's growing willingness to provide support for its own program (61 percent in 1978). At the same time the kinds of assistance provided by major donors have shifted. AID, for example, had historically delivered its assistance in the form of contraceptive commodities and funds for developing and supporting family planning service activities. In keeping with an overall government policy shift to promote self-sufficiency, AID is now—along with UNFPA—providing raw materials for the local production of contraceptives. The government's goal is self-reliance in the production of oral contraceptives by the years 1985-90. The main focus of assistance for AID and most international donors, however, continues to be the provision of commodities to and support for Indonesia's village family planning program.

The National Family Planning Coordinating Board, the semiautonomous government agency responsible for family planning, began a clinic-based operation in 1969. This became a broad-based community distribution system known as the Village Family Planning Program in 1974 and has within the last 2 years begun to reach beyond the Java-Bali region to the outer islands.

The initial clinic approach to family planning was well received because government leaders viewed the issue as primarily one of health care. Numbers of new contraceptive users grew through this approach by some 50,000 each year. Their numbers were increasing by more than 1.6 million per year by 1974; condoms and pills were the main methods of choice. The government felt that although the clinic program was successful, achieving the kind of fertility decline outlined in REPELITA II—a 50 percent drop in fertility by the year 2000—called for an intensive outreach effort to bring family planning services to the people.

An important aspect of the present Village Family Planning Program is the way in which the distribution network is organized. Like the Indonesian political structure, the services delivery network has a hierarchically organized, top-to-bottom organizational approach (see table B-2). The Ministry of Health clinics provide basic services and supplies to subdistricts and to village outpost points or contraceptive supply depots. These depots in turn service several village user or family planning groups which are the basic units of the distribution system. The contraceptive supply depots are staffed by volunteer village leaders who are responsible for registering eligible couples and maintaining contraceptive records.

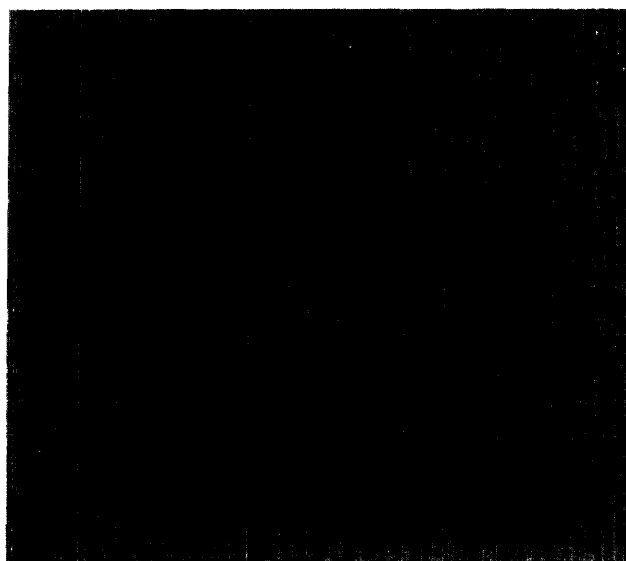
These influential village leaders include such figures as chiefs, religious leaders, and school teachers, who are recruited and trained to both establish and monitor the contraceptive supply depots at the village level. They in turn form village subgroups that consist of current contraceptive users among whom individuals are chosen to recruit new contraceptive users. These village subgroups also serve as forums for promoting such other activities as nutrition education and overall family welfare.

Table B-1.—Indonesian Population and Family Planning Program Financial Resources, Government of Indonesia (GOI), and Foreign Donor, 1968-78

	1968	1969	1970	1971	1972	1973	1974	1975	1976 ^a	1977 ^a	1978 ^a	1980 ^a
GOI family planning:												
In thousands.....	\$75	\$300	\$1,323	\$2,300	\$5,134	\$5,885	\$8,400	\$12,500	\$15,600	\$20,700	\$33,100	\$49,700
Percent.....	4	19	29	44	53	41	40	49	48	54	61	65
Foreign donor inputs:												
In thousands.....	\$2,051	\$1,288	\$3,319	\$2,913	\$4,600	\$8,552	\$12,636	\$13,000	\$16,600	\$17,700	\$20,800	\$26,914
Percent.....	96	81	71	56	47	59	60	51	52	46	37	35
Total GOI and foreign donor inputs:												
In thousands.....	\$2,126	\$1,588	\$4,642	\$5,213	\$9,735	\$14,437	\$21,036	\$25,500	\$32,200	\$38,400	\$53,900	\$76,614
Total per capita.....	\$0.028	\$0.021	\$0.060	\$0.076	\$0.120	\$0.177	\$0.263	\$0.297	\$0.272	\$0.324	\$0.395	—
Total per acceptor.....	\$80.90	\$29.90	\$25.61	\$10.04	\$9.02	\$11.02	\$14.26	\$15.40	\$14.55	\$16.64	\$21.22	—

^aIncludes Java and Bali plus 10 Outer Island Provinces. Prior year figures for Java and Bali only.

SOURCE: AID estimates from various sources.

Table B-2 Flow of Conception Services and Supplies

The Village Family Planning Program has been operating in Java-Bali since 1975, and in parts of the outer islands since 1977.

In 10 years (1968-78) the programs of the National Family Planning Board have recruited 13 million new contraceptive users. In March of 1979 current contraceptive users totaled 5.5 million (see table B-3). In Java and Bali this represents 30 percent of all married (or cohabiting) fecund couples.

A different perspective of this program success is provided by a summary of the impacts of these interventions since their inception. In 1970 the rate of population growth in Indonesia was about 2.5; today it is estimated to be between 1.9 and 2.0. In Java and Bali, where the impact can best be measured, a 15 percent drop in fertility occurred during the 10-year period from 1969 to 1979. The crude birth rate during this period fell from 45 per 1,000 to 33 per 1,000—a drop of more than 25 percent.

Effects of family planning program

How much has Indonesia's comprehensive program contributed to reducing the country's fertility rate? How much population growth would have occurred had there been no family planning program? How much and to what extent have such natural phenomena as later age at marriage or economic growth contributed to this reduction?

A demographic analysis designed to quantify the change in fertility rates in Java and Bali due to family planning interventions was carried out by the Community and Family Study Center, University of Chicago, using 1971-76 data (see table B-4). The first column measures the fertility rate changes that would have occurred naturally due to various social and economic phenomena. The second column is based on very optimistic assumptions of contraceptive use; the third column uses a more conservative projection. Actual rates are reliably considered to fall between the second and third columns.

Substantial fertility declines due to family planning program efforts are particularly noticeable on East Java and Bali. By lowering crude birth rates to more closely correspond to previous reductions in death rates, Java and Bali are undergoing their own demographic transition as growth rates, based on either high or low program estimates, fall substantially. According to these figures, family planning measures are largely responsible for slowing the population growth rate between 1971 and 1976.

Influence of political, cultural, religious factors

What has brought about the apparently overwhelming success of family planning interventions in Indonesia (particularly Java and Bali) in lowering birth rates? The general consensus points to a fortuitous combination of circumstances, events, timing, and dedicated people. The replication of these conditions in other LDC cultures is considered highly unlikely.

Table B-3.—Contraceptive Use Rates by Method, 1978

	IUD	Percent	Pill	Percent	Other	Percent	Total
Java-Bali	1,413	28	3,197	64	392	8	5,002
Outer Islands.....	81	15	373	69	85	16	540
Indonesia total.	1,494	27	3,569	64	478	9	5,542

NOTE: Figures may not add due to rounding

Table B-4.—Annual Growth Rates Under Various Assumptions for Java-Bali

Annual growth rate				Annual growth rate			
Province	No family planning	High program	Low program	Province	No family planning	High program	Low program
Jakarta:				Yogyakarta;			
1971	2.9	2.9	2.9	1971	1.5	1.5	1.5
1972	2.9	2.8	2.8	1972	1.5	1.4	1.5
1973	2.9	2.7	2.7	1973	1.5	1.3	1.3
1974	2.9	2.6	2.7	1974	1.5	1.1	1.1
1975	3.0	2.5	2.6	1975	1.5	1.0	1.0
1976	3.0	2.4	2.6	1976	1.5	0.9	1.0
West Java:				East Java:			
1971	2.8	2.8	2.8	1971	2.0	2.0	2.0
1972	2.7	2.7	2.7	1972	2.0	1.9	1.9
1973	2.7	2.5	2.5	1973	1.9	1.6	1.7
1974	2.6	2.3	2.3	1974	1.9	1.3	1.4
1975	2.5	2.1	2.2	1975	1.8	1.0	1.2
1976	2.5	1.9	2.0	1976	1.8	0.9	1.1
Central Java:				Bali:			
1971	2.1	2.1	2.1	1971	2.4	2.4	2.4
1972	2.1	2.0	2.0	1972	2.4	2.2	2.3
1973	2.1	1.9	2.0	1973	2.4	1.9	2.0
1974	2.1	1.8	1.9	1974	2.4	1.5	1.7
1975	2.1	1.6	1.8	1975	2.4	1.2	1.5
1976	2.1	1.5	1.6	1976	2.3	1.0	1.5

President Soeharto, is widely respected and revered by large portions of the population, and his emphatic messages are taken to heart. Soeharto stresses family planning as an integral part of the Indonesian "Code of Ethics" which states that belief in God, Nationalism, Humanity, Democracy, and Social Justice are the five pillars on which people should base their lives. The government's commitment is also reflected in its flexible programming and widespread acceptance and use of international population assistance.

Commitment by government leaders and availability of international assistance alone cannot effect the desired change, however. In Indonesia, cultural and religious beliefs have had a positive effect on contraceptive use at the community level. Traditional Islamic religious law or "Adat" is a strong behavioral influence on Muslim people. When the government instituted its national family planning program there were fears that contraception would conflict with the law of Adat for Javanese Muslims. But the Koran states that "all of God's children must be cared for," thus providing an underlying admonition to have only wanted births. Islamic leaders and "Klian" members (village elders) have publicly endorsed contraception as a means of preventing unwanted births which thereby enables families to better provide for children already living. Traditional Islamic values

constrain the use of certain methods because of their modes of administration. According to the Koran, any public display of the genital area renders one "malu" or "shamefully embarrassed" which poses problems with IUD insertion. The fear of malu is especially strong among rural Muslims on the outer islands where peer influence is most important. Since most doctors in Indonesia are male, a woman using an IUD would almost certainly be considered malu. Interestingly, this fear is unknown in Bali, where Hindu tradition imposes no such threat. The pill has consequently been the favored modern method in Java while the IUD has gained widest acceptance on Bali.

Bali is a unique example of an area where the family planning program has been woven into the island's cultural fabric through the use of strongly structured existing institutions to promote contraceptive behavior. For centuries on Bali there have been organizational divisions within villages, called "ban jars." The banjars, which have been trusted foundations of local government for hundreds of years, are also effective mechanisms for social change. Since 1974, as part of the village family planning program, these units have been responsible for encouraging and monitoring family planning services and use. Each village has from 5 to 10 ban jars; each ban jar contains up to several hundred nuclear

families. A good deal of agricultural work is performed collectively by banjar members for the benefit of the entire community, which defuses much of the argument that a family needs many children in order to increase its labor force.

No one factor can be cited as the key to the successes experienced in Indonesia. Socioeconomic development and higher age at marriage undoubtedly played important roles. The islands of Java and Bali may also have been ripe to embrace the notion of limiting their numbers by the visible evidence of population pressures present in a crowded city like Djakarta or within the confines of a small island like Bali. Generally speaking, family planning measures were made available, found acceptable and desirable, and their use was not disruptive of people's day-to-day lives.

Based on its swift national success, the government of Indonesia has shortened the time span during

which it hopes to reach its 1970 goal of a 50 percent reduction in fertility: the deadline date is now 1990 instead of 2000. Since 1979 the government has also professed a "beyond family planning" philosophy, which includes incorporating family planning efforts with nutrition and other development services through integrated programs at both administrative and field levels. Vigorous efforts to recruit new contraceptive users and maintain current usage levels are continuing.

Although the elements of Indonesia's family planning success cannot be neatly diagramed for replication in other settings, the high priority given by the government to providing Indonesians with both the motivation and the means to limit their fertility has clearly been a powerful influence.

Appendix B references

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