



Indonesia and Family Planning: An Overview

Background

Indonesia is in the process of decentralization and reform. Political and fiscal power is being dispersed to sub-national units of government, districts and cities. Within this new context of civic participation, people are asserting their rights more. Unfortunately, the economic crisis in the 1990s forced many into near-poverty and restricted access to social services, especially for women and children. An unemployment level in double-digits has left many below the poverty line, and more than 1.3 million Indonesians remain displaced by violence. **Long-standing progress made in improving health has been severely undermined.**

More than 60% of Indonesia's population lives on the islands of Java, Madura and Bali, which together account for less than one-tenth of Indonesia's total land area. Furthermore, **Indonesia is undergoing rapid urbanization.** In 1950 only 12% of the population lived in urban areas; now over 40% do so.

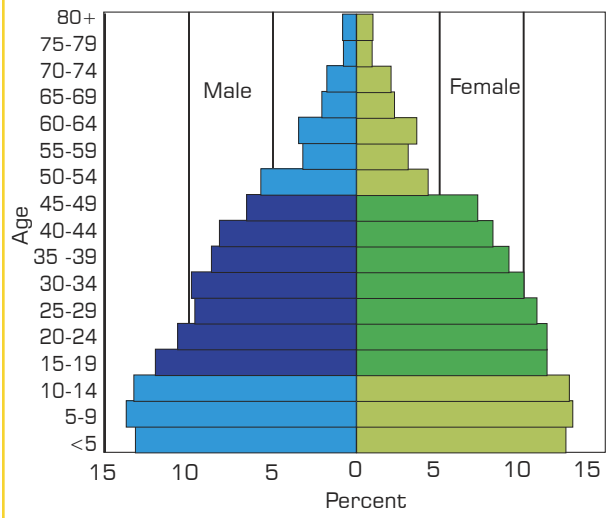
Indonesia is the fourth most populous country in the world, with almost 220 million people. As shown in Figure 1, 31.6% of Indonesia's population is under 15 years of age and 54.1% is of reproductive age. Indonesia's population is growing at an annual rate of 1.49%.

Situation Analysis

Family planning is coordinated by the National Family Planning Coordinating Board (NFPCB), a government institution. However, family planning services are delivered through the health system, utilizing the health infrastructure under the Ministry of Health (MOH). Since the 1970s, the Indonesian family planning programme has contributed to considerable gains in family planning.

- **Contraceptive prevalence rate (CPR) has more than tripled in**

Figure 1: **Population Pyramid Indonesia, 2002-03**



Source: DHS Indonesia, 2002/3

just 27 years; CPR went up from 19% in 1976 to 60.3% in 2003.

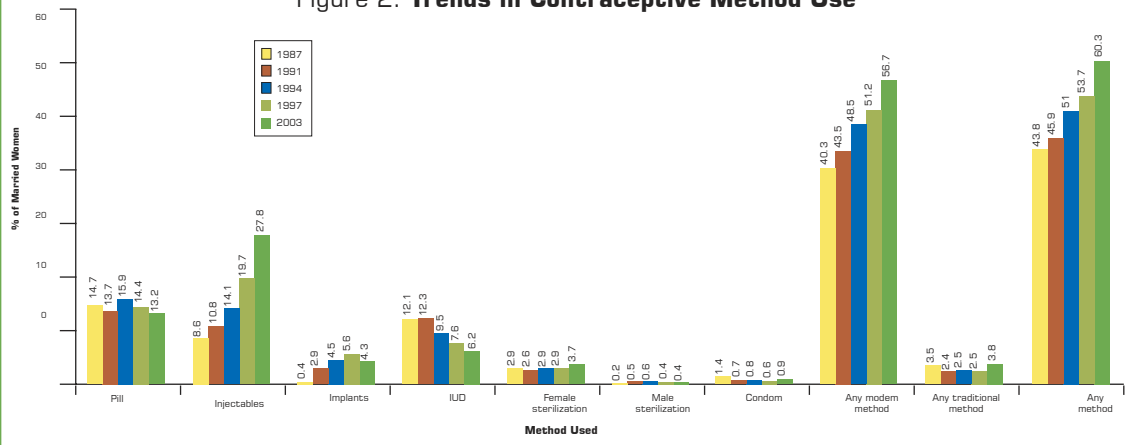
- **Total fertility rate (TFR) has decreased by more than 50% in just 35 years**; TFR dropped from 5.6 in 1968 to 2.4 births per woman by 2003.
- **Unmet need for family planning has decreased**, from 13% in 1991 to 8.6% in 2003.

Family planning in Indonesia is also characterized by the following:

As the fourth most populous country in the world, Indonesia's progress in protecting human health and stabilizing population growth has considerable implications.

- **For most women in Indonesia first sexual intercourse occurs at the time of marriage.**
- While in 1997 half of women aged 25-49 married at 18.6 years, by 2002/3 the age at first marriage had risen to 19.2 years.
- **The average woman in Indonesia has become a mother or is pregnant by the age 21.**
- Women in urban areas tend to have fewer children (2.4) compared to women in rural areas (2.7).

Figure 2: Trends in Contraceptive Method Use



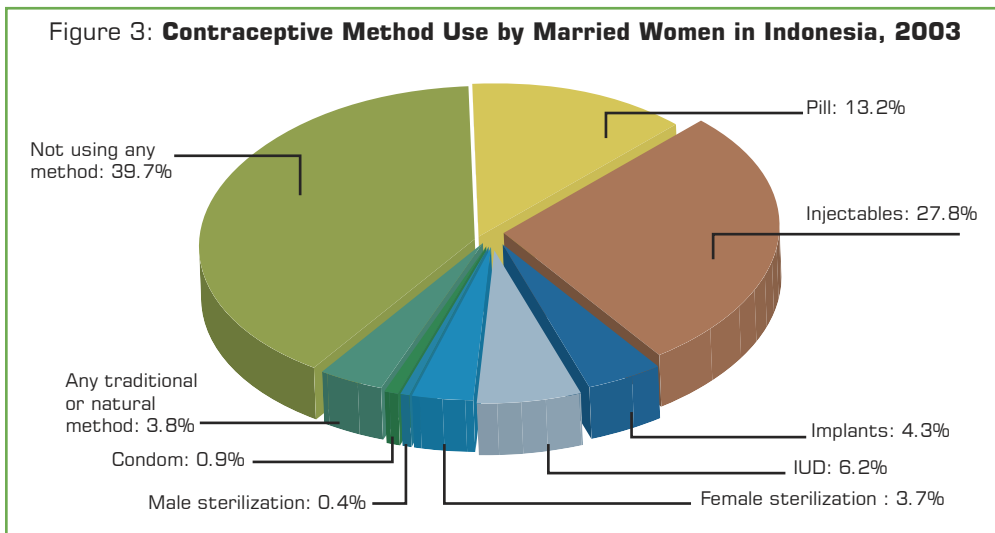
Source: DHS Indonesia, 1987, 1991, 1994, 1997, 2003

- More than one-fifth of reproductive age women have had 4 children or more.
- The average family size in Indonesia is roughly 3 children.
- Abortion is illegal in Indonesia and it is often performed under unsafe conditions. It is estimated that 15-30% of the maternal mortality is the result of unsafe abortion.
- Half of births occur 54 months after the previous birth, up from a birth interval of 45 months in 1997.

As Figure 2 shows, dramatic changes have taken place in the level and pattern of contraceptive use in Indonesia over the past two decades. However, since the economic crisis the number of active family planning users has not increased significantly.

As shown in Figure 3, 60.3% of currently married women were using contraception in 2003. Injectables, which account for almost half of all family planning methods used, followed by oral contraceptives are the most widely used

Figure 3: Contraceptive Method Use by Married Women in Indonesia, 2003



Source: DHS Indonesia, 2002/3



methods in Indonesia. The current contraceptive method mix also includes the IUD, whose popularity is decreasing, and implants. The use of permanent methods such as sterilization (male and female) remains low, as does condom use. The most common reasons for choosing a specific method include side effects of other methods (27%), convenience (22%), and the desire for a more effective method (18%).

If all unwanted births could be prevented Indonesia's TFR would be 2.2.

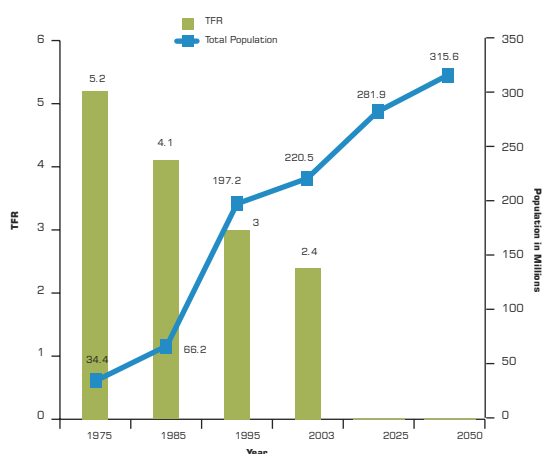
Based on data from surveys and in-depth studies, **women who would prefer to avoid pregnancy do not use contraception** because of:

- Constraints in access to and quality of family planning services;
- Shortages or an unreliable supply of contraception;
- Method failure;
- Health concerns about contraceptives and side effects;
- Lack of information;
- Opposition from husband, family, and community; and
- Little perceived risk of pregnancy.

Key Indicators:

Total Population, 2003 (in millions)	219.883
Population Growth Rate, 2003	1.49%
Population Density, 2003 (people per square km)	109
Urban Population, 2003	42%
Population <15 years of age, 2003	31.6%
Total Fertility Rate (TFR), 2000-2005	2.4
Contraceptive Prevalence Rate (CPR), 2000	60.3%
- Pills	13.2
- Injectables	27.8
- Implants	4.3
- IUD	6.2
- Female Sterilization	3.7
- Male Sterilization	0.4
- Condom	0.9
- Traditional or Natural Methods	3.8
Unmet Need, 2003	8.6%
- For spacing births	4
- For limiting births	4.6
Average age at first marriage, 2003	19
Average age at first birth, 2003	21
Crude Birth Rate (CBR) (per 1,000 population), 2000	23
Maternal Mortality Ratio (MMR), 2003	230
Infant Mortality Rate (IMR), 2003	47
HIV adult prevalence, 2001	0.1%

Figure 4: **Population Projection: Indonesia**



Source: World Population Policies, 2003; DHS Indonesia, 2003

Almost nine percent of currently married women have an unmet need for family planning; 4% wish to limit their births and 4.6% wish to space their births. The total demand for family planning in Indonesia is 70%, of which 88% is currently satisfied. If total need for family planning was satisfied the contraceptive prevalence rate would be around 68% instead of the current 60%

Previously, all family planning services were fully subsidized by the government for all Indonesians. In the late 1990s there was a gradual shift towards the private sector. Government reduced free public services and promoted the use of private family planning services. As a result, **while there was an increase in overall contraceptive use, access through government sources declined and users increasingly relied on private**



sources for contraception, including private midwives (*bidan*) and private practice providers offering services at the community level.

- Use of government sources decreased from 43% in 1997 to 28% in 2002/3;
- Use of private medical sources increased from 42% in 1997 to 63% in 2002/3;
- Use of other sources, such as village birth delivery posts (*polindes*), integrated health posts (*posyandu*), village contraceptive distribution centres (VCDCs), traditional birth attendants, or friends, dropped from 15% in 1997 to 8% in 2002/3.

Indonesia's health system faces **capacity problems in reaching remote areas or isolated islands**. The provision of comprehensive services is hampered by a lack of transport and communication infrastructure. In addition, the national programme does not have the capacity to address the diverse family planning needs of the different ethnic and religious groups, or to do so in various languages. Reaching the poor and marginalized groups is a problem.

Current Family Planning Efforts

The Indonesian National Family Planning Programme is implemented by the government with involvement and participation by the community and private sectors. The government aims to decrease TFR and make family planning an integral part of government policy.

The NFPCB recently decentralized the family planning programme, four years after other sectors, including health, but still centrally secures the budget for family planning. Under the new decentralization laws, 249 regencies and 65 municipalities will absorb responsibility for planning, financing and managing health and family planning programmes.

Sources

1. Epidemiological Fact Sheet on HIV/AIDS and Sexually Transmitted Infections: Indonesia, 2002. UNAIDS, UNICEF & WHO.
2. Indonesia Country Health Profile, WHO/SEARO, 2003. <http://intranet/cntryhealth/indonesia/index.htm>
3. Indonesia Country Profile, 2003. International Planned Parenthood Federation. http://ippfnet.ippf.org/pub/IPPF_Regions/IPPF_CountryProfile.asp?ISOCODE=ID
4. Indonesia Demographic and Health Survey, 1987, 1991, 1994, 1997/8, 2002/3. National Family Planning Coordinating Board, Ministry of Health, Jakarta, Indonesia, and ORC Macro, Calverton, Maryland USA.
5. Indonesia, Population and Health. USAID/Indonesia, 2003. http://www.usaid.gov/locations/asia_near_east/countries/indonesia/indonesia.html
6. Indonesia Reproductive Health Profile, 2003. Ministry of Health, Republic of Indonesia. Supported by WHO. Jakarta, 2003. Unpublished
7. World Contraceptive Use, 2003, United Nations, Population Division, Department of Economic and Social Affairs.
8. World Population Data Sheet, 2003. Population Reference Bureau. www.prb.org
9. World Population Policies, 2003. United Nations, Population Division, Department of Economic and Social Affairs.

UNFPA, USAID and the World Bank support the government in developing the family planning programme.

Challenges and Opportunities

Key family planning issues that need to be addressed include unmet need, lack of birth spacing, and a stagnated CPR and TFR.

- 1. Capacity to provide appropriate and high quality services.** A policy of zero personnel growth to optimize efficiency has been adopted in the public sector. This could have negative effects on health service delivery in the public sector, by limiting its capacity to open new facilities and additional and higher quality services where they already exist. On the other hand, the increasing role of the private sector in health poses questions related to access and equity, although private facilities are required to provide subsidized services to the poor.
- 2. Decentralization and programming at different levels.** In light of recent decentralization it is important that responsibilities at central, provincial, and district levels are clear in practice, and that financial and human resources are sufficient and adequate at the local level. Commitment of local authorities to support and invest in family planning is crucial. It is important to improve local logistics management and delivery systems for contraceptives, ensuring continuity of supplies.
- 3. Diversification in contraceptive methods used.** While use of family planning has been increasing, there is still a heavy reliance on supply methods, particularly injectables and the pill. Longer term methods, such as the IUD and implants, could be emphasized.



For Further Information please contact:

The Department of Family and Community Health, World Health Organization, Regional Office for South-East Asia, World Health House, Indraprastha Estate, Mahatma Gandhi Marg, New Delhi - 110002 India, Email: fch@whosea.org, www.whosea.org, <http://w3.whosea.org/fch>