Indonesia and Family Planning: An overview

Background

Indonesia comprises a cluster of about 17,000 islands that fall between the continents of Asia and Australia. Of these, five large islands (Sumatra, Java, Kalimantan, Sulawesi and Papua), along with two island groups (Maluku and Nusa Tenggara) host the majority of the population, while most of the other islands are small and uninhabited. This means that the country sees extremely uneven population densities not only between islands, but also within an island. From an administrative viewpoint, the country is divided into 33 provinces, each of which is further subdivided into districts and municipalities.

According to the 2010 census, the population of Indonesia is 237.6 million (Statistics Indonesia), of which 50.17% are male and 49.83% are female (Population percentage by Province & Gender, 2009, 2010, 2011). The annual population growth rate is declining. It was 1.98% in the decade 1980–1990, and reduced to 1.49% over the next decade. The projected average annual growth rate in the decade starting in 2000 was 1.28% (Statistics Indonesia). As can be seen from Figure 1, a large proportion of the Indonesian population is constituted of children and people in the reproductive age group.

Situation Analysis

The national DHS are one of the most important sources of information on family planning and related matters. In 2007, the Government of Indonesia with support from donors such as United States Agency for International Development (USAID) and UNFPA conducted the sixth DHS, which captured data from a sample of ever-married women aged 15–49 years as well as currently married men in the age group 15–54 years.
Table 1: Key indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Total population (in millions), 2010 census</td>
<td>237.6</td>
</tr>
<tr>
<td>Population growth rate, 2005–2010</td>
<td>1.08%</td>
</tr>
<tr>
<td>Population density (people per square km), 2010</td>
<td>126</td>
</tr>
<tr>
<td>Urban population, 2010</td>
<td>44%</td>
</tr>
<tr>
<td>Population &lt;15 years of age, 2010</td>
<td>27%</td>
</tr>
<tr>
<td>Total fertility rate, 2012</td>
<td>2.6</td>
</tr>
<tr>
<td>Contraceptive prevalence rate, 2012</td>
<td>61.9%</td>
</tr>
<tr>
<td>– Female sterilization</td>
<td>3.2</td>
</tr>
<tr>
<td>– Male sterilization</td>
<td>0.2</td>
</tr>
<tr>
<td>– Pill</td>
<td>13.6</td>
</tr>
<tr>
<td>– IUD</td>
<td>3.9</td>
</tr>
<tr>
<td>– Injectable</td>
<td>31.9</td>
</tr>
<tr>
<td>– Implant</td>
<td>3.3</td>
</tr>
<tr>
<td>– Male condom</td>
<td>1.8</td>
</tr>
<tr>
<td>– Periodic abstinence</td>
<td>1.3</td>
</tr>
<tr>
<td>– Withdrawal</td>
<td>2.3</td>
</tr>
<tr>
<td>– Folk method</td>
<td>0.4</td>
</tr>
<tr>
<td>Unmet need, 2012</td>
<td>11%</td>
</tr>
<tr>
<td>Median age at first marriage (in years), 2012</td>
<td>20.1</td>
</tr>
<tr>
<td>Median age at first birth (in years), 2012</td>
<td>22.0</td>
</tr>
<tr>
<td>Crude birth rate (per 1000 population), 2005–2010</td>
<td>19.1</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100 000 live births), 2010</td>
<td>220</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000 live births), 2012</td>
<td>32</td>
</tr>
<tr>
<td>HIV adult prevalence (age 15–49 years), 2013</td>
<td>0.43%</td>
</tr>
</tbody>
</table>

Source: Achieving the Health-related, Millennium Development Goals in the South-East Asia Region: Measuring Indicators 2014

**Total fertility rate (TFR)**

As can be seen in Figure 2, the TFR has been gradually declining in Indonesia over the years. DHS 2007 showed that the TFR was 2.6, which was no change from the previous DHS in 2003–2004. However, an urban–rural differentiation shows that while the TFR in urban areas has reduced from 2.4 to 2.3, it has increased from 2.7 to 2.8 in rural areas. The significant inter-provincial differences in TFR reflected in DHS 2003–2004 were also reflected in DHS 2007, with TFR being 1.8 in the Special Region of Yogyakarta and as high as 4.8 in East Nusa Tenggara.
A comparison of age-specific fertility rates between the last two surveys shows that (a) women are choosing to delay childbirth to their late twenties, and (b) women in urban areas start having children later than their rural counterparts.

The 2007 survey shows an unusual inverted U-shaped relationship between education and fertility, wherein women with no education and those with the highest level of education have the lowest fertility rates. There was no clear-cut association seen between fertility rates and wealth quintiles.

Global evidence says that the ideal birth interval for reducing maternal and infant mortality ranges from 3 to 5 years. In Indonesia, DHS 2007 found that for second and higher order births that took place in the 5 years preceding the survey, the median birth interval was 54.6 months, and 70% of the births took place after a gap of 3 years or more.

Figure 2: Trends in TFR, 1991–2012

According to DHS 2007, about 61% of currently married women were using a contraceptive method. Of these, 57% were using a modern method of contraception. As can be seen in Figure 3, these rates are similar to those found in the 2003 survey, and about 4% higher than the 1997 survey results, thus reflecting a plateauing in the uptake of contraceptives. The urban–rural difference in CPR was not high, at 63% and 61%, respectively.

Figure 3: Trends in CPR, 2005–2011

Contraceptive prevalence rate (CPR)

Contraceptive method mix

As can be seen from Figure 4, Indonesian women largely rely on reversible methods of contraception. Injectable contraceptives are the most preferred method, with about one third of the women opting for the same. Figure 5 shows that the use of injectables had increased by 4% in 2007, compared to the previous survey in 2003. On the other hand, IUD use has been constantly declining over the years. Unlike many countries in the South-East Asia Region, permanent methods are not very popular in Indonesia and only 3% of women are opting for female sterilization, and another 0.2% are opting for male sterilization as the contraceptive method of choice.

The contraceptive method mix varies among urban and rural women in Indonesia, with urban women opting for IUD, condoms and female sterilization, while rural women prefer injectables and implants. Also, younger women (aged 20–34 years) are more likely to use injectables, pills and implants, whereas older women (35–44 years) prefer longer acting contraceptives such as IUDs or permanent methods such as female and male sterilization.

Use of reversible contraceptives, especially hormonal contraceptives, requires regular intake of pills or timely repetition of shots to ensure protection against pregnancy. DHS 2007 found that 80% of women using the pill were regular with their daily pill intake and over 90% of injectable users were current with their doses at the time of the survey.

Figure 4: Contraceptive method mix used by currently married women, 2007

Source: Indonesia DHS, 2012
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Unmet need for family planning

Both DHS 2003 and 2007 showed that 54% of couples wanted to limit their family size at the time of the survey. The wanted fertility rate was about 2.2 children on average compared to the actual TFR of 2.6.

The total unmet need for family planning in Indonesia has been stagnant at 9% since 1997. Of this unmet need, 4% is for spacing and 5% is for limiting. Also, of all the pregnancies in the 5 years preceding the survey, about 10% were mistimed (a further subindicator reflecting unmet need for spacing), and 10% were not wanted at all (indicating unmet need for limiting). If all the unmet need of the population is covered, the CPR in Indonesia would be 71%.

Adolescent fertility

Figure 6 shows that adolescent fertility in Indonesia is reducing over the years, and is lower than the regional average. In 2007, 9% of married teenage girls (15–19 years) had begun childbearing, with 7% already having delivered a live child and 2% pregnant with their first child. This represents a 1% reduction in teenage childbearing rates compared to 2003. The proportion of teenage girls entering the childbearing phase increases rapidly with age. The survey of DHS, 2007 found that while only 1% of girls aged 15 years had begun childbearing, about one in five girls aged 19 years had done so.

DHS 2007 found that the median age at marriage (measured for women aged 25–49 years) was 19.8 years, which had increased from 19.2 years as per DHS 2003–2004, indicating an increasing preference of girls and women to delay their first marriage. As most childbearing in Indonesia occurs within the context of marriage, this change in age at marriage is also reflected in the median age at first birth, which increased from 21.0 years to 21.5 between the last two surveys. This shift was also seen in the age-wise disaggregated data of the DHS, 2007 survey, which showed that while the median age at first birth was 20.4 years for women aged 45–49 years, it was 22.5 years for women aged 25–29 years.
Women in urban areas begin childbearing about 2 years later than their rural counterparts. While the median age at first birth was 22.9 years for the women living in urban areas, it was only 20.6 years for those living in rural Indonesia.

The gradual and steady increase in age at first marriage since the 1970s can be attributed to improvement in the educational attainment of girls. In 1971, 62% of boys and 58% of girls aged 7–12 years were enrolled in schools. These proportions had increased to 93% and 98%, respectively, by 2007. This is also reflected in the survey results, wherein a positive relationship was observed between women’s educational status and a delay in childbearing. On an average, women who had no education gave birth to their first child at the age of 19.6 years, whereas those with at least some secondary education had their first childbirth at 21.2 years.

**Access to family planning information and services**

Family planning-related messages are disseminated in Indonesia through both interpersonal communication led by family planning-related grass-root level functionaries as well as through the use of mass media such as radio, television and print. Men and women from urban areas, those with a higher educational status and those belonging to a higher wealth quintile have greater exposure to mass media messages on family planning.

Knowledge about contraceptive methods is very high among Indonesian women and men, with over 98% of married women and 94% of married men able to identify at least one modern contraceptive method. The most common methods quoted were injectables and pills, which tallies closely with the actual method mix in use. However, very few people were aware of emergency contraception in 2007, as it had been newly introduced into the programme at that time.

Most Indonesian women (69%) rely on private medical sources such as private midwives or pharmacy and drug stores for procuring contraceptive supplies. Only 22% rely on government sources, and this proportion decreased by 6% between the last two surveys. Almost all contraceptive users (91%) pay for the services they receive. This payment is highest among users of injectables and pills (96% and 97%, respectively), and lowest for IUDs (69%).
Current Family Planning Efforts

Family planning activities were initiated in 1957 by the Indonesian Planned Parenthood Association, which provided family planning counselling and services along with maternal and child health care. The Government committed to promoting family planning, in order to control population size to result in economic development, and formed the National Family Planning Institute in 1968, which was later re-named the National Family Planning Coordination Board (BKKBN in Bahasa Indonesia). BKKBN is an autonomous body that reports directly to the President of Indonesia, thus according the programme the highest national importance.

The family planning programme focuses not just on controlling births, but on improving family welfare through delaying marriage, spacing births and fostering family resilience. With the decentralization of Government programmes to the district level in 2004, BKKBN reformulated its family planning strategy and promoted community participation and involvement (“All Families Participate in Family Planning”) as the cornerstone of the programme. The five strategies of the family planning programme are given below.

1. Mobilizing and empowering the community.
2. Readjustment of family planning management.
3. Strengthening human resources for the programme.
4. Enhancing resilience and welfare of families.
5. Increasing financial resources for family planning at all levels.

Challenges and Opportunities

1. **Reliance on supply-centric methods:** Most contraceptive users are opting for reversible methods of contraception. While this means that contraception is used to ensure appropriate spacing between births rather than only as a tool to limit the number of births, it also means that the Government needs to focus on provision of a regular and assured supply of contraceptives. The programme also needs to ensure uptake of other methods such as IUDs, condoms, etc. The general population also needs to be informed about emergency contraception through an extensive communication campaign.

2. **Unmet need:** Despite the rising CPR, unmet need has been stagnant at 9% since 1997. This means that services have not been able to keep pace with the rising demand for family planning services. The Government would benefit from conducting an assessment of the epidemiology of this unmet need, and planning programmes to address the same.

3. **Population growth momentum:** The large young population base means that even if Indonesia achieves replacement fertility levels, the population will continue to grow. Indonesia needs to ensure that the trend seen in increasing CPR and decreasing TFR is maintained in the coming years.
4. **Decentralized programme:** The recent initiative to decentralize the family planning programme gives an opportunity for planning, implementing and monitoring the programme at the local level, thus ensuring that the services are in sync with local needs. However, in order for this approach to be successful, district- and municipal-level officials need to be trained in planning and management of the family planning programme.

**References**


