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THE INHIBITING FACTORS OF FERTILITY RATE DECREASE AND THE DIRECTION OF FAMILY PLANNING PROGRAM REVITALIZATION

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Intisari

Tulisan ini menganalisis stagnasi penurunan angka kelahiran di Indonesia. Keseimbangan penduduk salah satunya dapat dicapai dengan mengontrol angka kelahiran. Namun survei demografi dan kesehatan Indonesia tahun 2012 mengungkapkan tentang jumlah kelahiran yang tidak jauh berbeda dengan survei tahun 2002 dan 2007. Di samping itu, terdapat faktor-faktor seperti pergeseran paradigma politik di negara berkembang, perubahan tata kelola pemerintah daerah dan perubahan institusional yang mempengaruhi stagnansi dalam menurunkan angka kelahiran. Rekomendasi tulisan ini adalah perlu menemukan cara dalam mengakomodasi keseimbangan antara sistem demokrasi dan efektivitas capaian. Selain itu penurunan angka kelahiran juga memerlukan keseriusan dan keikutsertaan pemerintah daerah dalam berpartisipasi. Untuk tujuan ini, model pendekatan kultural dan sosiologis dapat digunakan sebagai alternatif dalam mempengaruhi perilaku masyarakat.

Kata Kunci: stagnasi TFR, kontrasepsi, keluarga berencana, desentralisasi

Abstract

This paper analyzes stagnation of fertility rate decrease in Indonesia. Population balance can be achieved by controlling fertility. Indonesian survey of demography and health in 2012, however, shows no significant difference of fertility rates from similar surveys in 2002 and 2007. In addition to that, there are factors such as the shifting political paradigm in the developing world, change of local governance, and institutional change that influence the stagnation of fertility rate decrease. This writing recommends ways to accommodate balance between democratic system and effective achievement. Besides, the decrease of fertility rate also requires serious commitment and determination of local government to participate. For this goal, sociological and cultural model can be used as an alternative to transform the behavior of society.

Kata Kunci: TFR stagnation, contraceptives, family planning, decentralization

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Introduction

One of the aims of the 2010-2014 National Medium-Term Development Plan (RPJMN) is to control the Population Growth Rate (LPP) to achieve a target with the poverty rate declining to 5 percent at the end of 2025. Population development and family planning are targeted to achieve a balanced population growth in 2015. It is designated with the net reproduction rate (NRR) equal to 1, or the total fertility rate (TFR) equal to 2.1.

It appears that Indonesia is facing difficulties in reaching the target. The temporary result of the Indonesia Demographic and Health Survey (SDKI) 2012 indicates that the fertility number has remained at 2.6, never decreasing from the results of the previous two SDKI surveys (2002/2003 and 2007). The analysis conducted by Terence Hull using the data of the 2010 census results and the last three SDKIs even indicates a fertility increase in the last 10 years (Hull, 2013: 15).

Observing the result of the SDKI introduction report, the RPJMN 2010-2014 target is a lofty, if not impossible goal. However, this achievement cannot be ignored since Indonesia also has an interest in achieving the target Millennium Development Goals (MDGs) as follows: The maternal mortality rate must decrease to 102/100,000 live births; child mortality rate must decrease to 23/1,000 live births; population growth rate must decrease to 1.1 percent; TFR must decrease to 2.1 percent; and unmet needs must be suppressed to 5 percent.

In order to achieve these goals, or, at least, in order to decrease population growth, ministries and institutions at the central level of government, and provinces, regencies, and local governments need to strengthen their commitment, sharpen their strategy, and strengthen their actions. What kind of strategy should they apply? This study

intends to formulate recommendations for the policymakers of population and family planning so that, in the future, the family planning program will be stronger and will be able to achieve the determined goals or targets. In order to arrange accurate policy recommendations, a prior analysis on the failure of the efforts to maintain the sustainability of fertility decrease needs to be conducted. There are several questions that need to be answered in this study. What are the factors that did not make the fertility rate decrease in the last ten years? Is there a situation in a number of variables that can explain the absence of fertility decrease? Is this trend due to the change of the management structure and population policy since the political reformation occurred?

In order to answer these questions, an analysis of the results of a number of national surveys, such as the 2005 Intercensal Population Survey (Supas), 2010 Population Census, 2007 and 2012 Indonesia Demographic and Health Survey (SDKI), and 2002/2003 and 2007 Small and Cottage Industry Survey (SKKR) is conducted. This study also utilizes research results and government documents on relevant issues, such as contraceptive use, sexual behavior in children and adolescents, and early marriage.

Factors Affecting Fertility

There are some variables among those that are assumed to contribute to the limited fertility decrease in Indonesia. Table 1 explains a number of achievements of the 2010-2014 RPJMN targets. Only six of the eight 2010-2014 RPJMN targets are in the form of numbers (quantitative) as seen in the table. If the situation development until 2010/2012 is observed, those six targets will not be reached or will be difficult to reach.

The 1.1 population growth target is difficult to achieve, since the last situation based on the

Table 1
RPJMN Achievement Targets in 2014 and Situation of 2005-2012 Program Targets in A Number

Targets	2005/7 Situation	2010/12 Situation	2014 Targets
The decrease of regional population growth rate (% per year)	1.3*	1.49*	1.1
The decrease of TFR per every woman of reproductive age	2.6**	2.6**	2.1
The increase of modern methods of CPR (5)	57**	58**	65
The decrease of unmet needs of family planning for couples of childbearing age (%)	9.1**	8.5**	5.0
The decrease of ASFR 15-19 years old per 1,000 women	35**	48**	30
The increase of the median age at first marriage for women (years old)	19.8*	19.8**	21
The increase of the compatibility of population control policy			
The increase of the availability and the quality of demographic data and information derived from demographic census, surveys, and vital registrations			

Data sources:

* 2005 SUPAS or 2010 Census

** 2007 or 2012 SDKI

2010 census indicates that the population growth was still 1.49. That number is even higher than the Supas number, 1.3. The 2.1 Total Fertility Rate (TFR) decrease target is also still too far to reach since the last SDKI result indicates that the TFR number did not move from some previous SDKI results, which remained at 2.6. The three targets below it are the determinants of population growth rate and fertility rate. Those three targets are also difficult to reach. The declared target of the modern method contraceptive prevalence rate (CPR) is 65. The unmet need of contraception was targeted to be able to be suppressed to 5 percent for the couples of childbearing age, while the temporary result reached until 2012 was still 8.5 percent. The adolescent fertility rate (15-19) was targeted to be suppressed to 30. However, instead of decreasing, the number actually increased from 35 in 2005 to 48 in 2012. The median age at first marriage is still lower than the declared target, which is 21 years old. From the last two SDKIs, it is indicated that the median age at first marriage remained at 19.8.

In order to achieve a better description, some variables which are assumed to contribute to the fertility increase will be analyzed further. As stated previously, the rate for contraception use is still lower than the target, so it is necessary to conduct further discussion about the trend of the use of contraceptives and oral contraceptives. Theoretically, it can be said that the fertility rate will be low if the number of children in the community is low (all the women or the couples desire to have a limited number of children) and all the women or the couples who do not desire to have children anymore use contraceptives (perfect contraceptive society). Therefore, if there is a higher use of contraceptives, the fertility rate will lower. In order to approach the situation of a perfect contraceptive society, the concern needs to be directed to the marginal groups by analyzing the difficulty marginal groups face in accessing contraceptive services. The analysis on this matter is important since they often cannot reach contraceptive services.

Another important aspect that needs to be emphasized in the analysis is the sexual behavior of unmarried adults. The analysis on this population group is important since, so far, the group that the family planning program targets are couples of childbearing age who are legally married. Meanwhile, there are many sexually active women who have not been married or are not married, so they have a high chance of pregnancy. The high proportion of the adolescents who are sexually active and the young age when people first marry causes high age-specific fertility rate (ASFR) in female adolescents (15-19 years old). Therefore, it is very important to conduct an analysis on the population group.

Trend of Use of Contraceptives and Oral Contraceptives

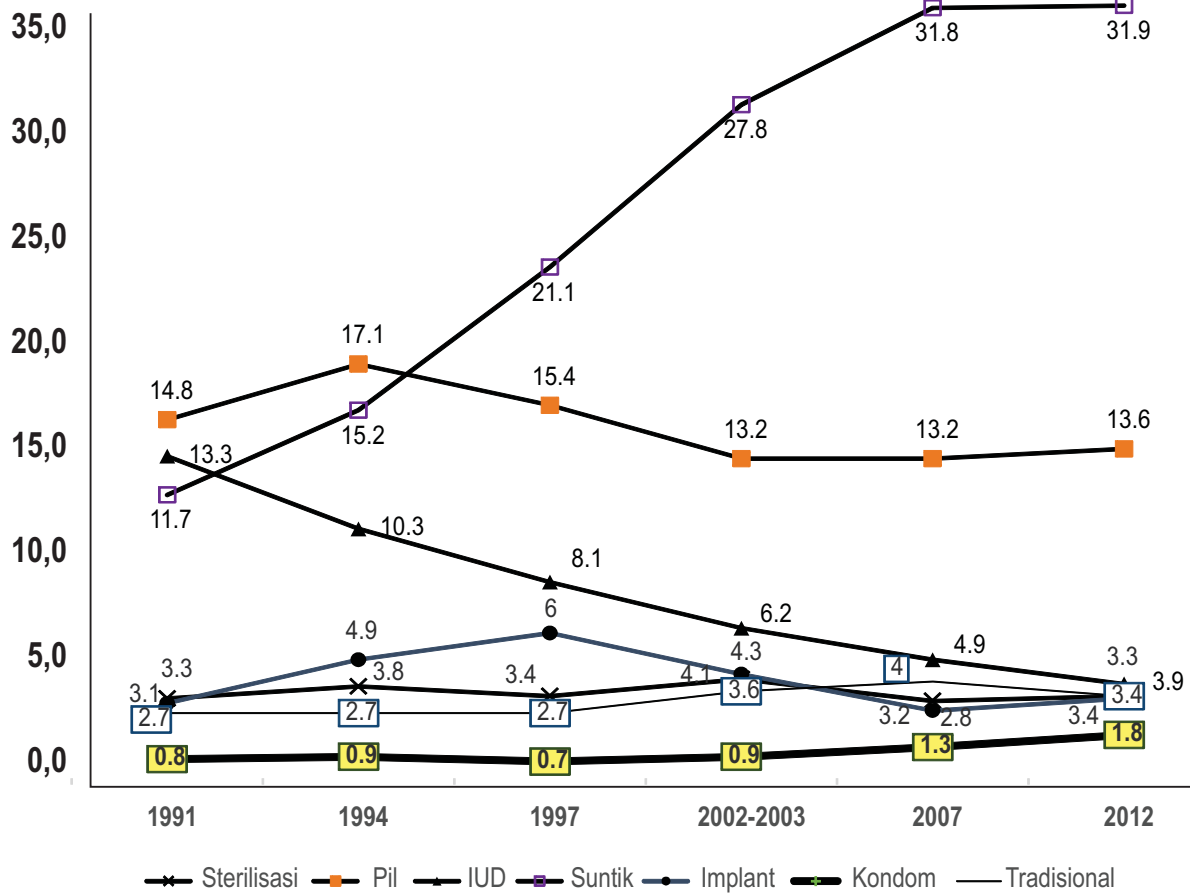
Based on the data of 2012 SDKI, the use of all methods of contraceptives and oral contraceptives among the couples of childbearing age reached 61.7 percent. This number indicates a very small increase from the use of contraceptives in 2007, which was 61.4 percent. In addition, the newest SDKI data does not indicate a significant development in the use of the long-term family planning method (see Figure 1). The data are a reflection of the low success rate of the Institution of National Demographics and Family Planning (BKKBN) in encouraging the use of the long-term family planning methods (intrauterine device or IUD, vasectomy, and tubectomy) among the couples of childbearing age (Jakarta Post, December 12, 2012). Most of the women at reproductive age use pills and injections as their family planning method, although for long-term planning, these methods tend to be more expensive compared to the long-term family planning methods. Also, using pills and injections carries a higher risk of unplanned pregnancy. Although injections have a longer effect compared to pills, injections are considered a hormonal resupply method and,

as a result, there are many injection users who quit using this method so they face the risk of unplanned pregnancy. The rate of quitting and the unplanned pregnancy risks among injection users is relatively higher compared to the users of IUDs and implants (Statistics Indonesia & Macro International, 2008; Steele & Curtis, 2003; Withers, et.al., 2012). Another risk faced by injection users is that they are susceptible to disturbances in the supply chain for injections (Ross, 2003). Discontinuing the use of family planning methods is a concern in Indonesia. Based on the data of the 2007 SDKI, the most common reasons stated by women who quit using family planning methods were health considerations, side effects, and the desire for pregnancy (BPS & Macro International, 2008). The data of the 2012 SDKI indicates that the reasons for quitting the use of family planning tools were similar to the reasons stated by women in the 2007 SDKI (BPS, BKKBN, Kemenkes, and ICF International, 2013).

The decisions regarding contraceptives – for instance, deciding whether someone wants to use them, or deciding what kind of contraceptive will be used – are related to various factors. Many policymakers assume that the use of contraceptives positively correlates with access and costs. Although access and costs often obstruct the use of contraceptives, other things that are just as important to be concerned about include behavioral factors, such as the desire to have more children, disagreeing with the family planning program, and the worries about the effects of the contraceptive methods on the user's health (Schoemaker, 2012). Cultural factors also play an important role among the users, the potential users of contraceptive methods, and the contraceptive service providers (Amnesty International, 2010; Herartri, 2004).

The family planning program does not operate in a norm-less context. Culturally, the main purpose of marriage is family formation

Figure 1
The Percentage of the Use of Modern Contraceptives & Oral Contraceptives



Source: Processed from 2012 SDKI

or procreation. This view is often held by the midwives who provide family planning services. As a result, they refuse to provide modern family planning services to young women who have not had children. At the cognitive level, they understand that the use of contraceptives and oral contraceptives will not cause infertility. However, their cultural background makes them worried about the infertility of the family planning users since they know that women will be automatically considered infertile for couples of childbearing age, even though it might be the man who is infertile. As a result, women who do not have children tend to be pitied or even given certain stigmas. If the women who use contraceptives finally cannot have children, the midwives are

afraid of being blamed because they provided modern family planning services. The solution used by the midwives is by giving advice to use traditional methods, such as withdrawal or coitus interruptus, even though this traditional method is susceptible to unplanned pregnancy (Amnesty International, 2010).

The assumption of the purpose of family planning is a very important factor to understand why the fertility rate in Indonesia stagnates. A case study by Herartri (2004) in two villages in West Java indicates that the majority of the informants stated that their participation in the family planning program was encouraged by the desire to have distance between their

children's ages. This reason was also stated by women who did not want to have children anymore. They assumed that family planning is a good program since it enables them to control the birth of their children so the age difference between children is not too close. Most likely, this matter is a reflection of the message from religious figures who emphasize that the purpose of family planning is to give space between children's ages, not as a fertility limitation. Fertility limitation is considered to oppose God's will. This perception is a key of family planning acceptance among the community with strong religious beliefs. Even though the research by Herartri (2004) cannot be generalized for Indonesia, it is important since it can open the door for understanding various perceptions on the purpose of family planning at a grassroots level.

Another cultural factor is the strong patriarchal culture which sometimes limits the choices of family planning methods. Normally, women must consult their husbands before using family planning methods (Amnesty International, 2010; Herartri, 2004). Generally, the husband will agree with the wife's desire to use a family planning method, even though there are some husbands who are worried about the side effects of certain family planning methods. However, since family planning is considered "women's business," women are eventually considered to be "more appropriate" to decide whether to use family planning methods rather than their husbands (Herartri, 2004). Perhaps, this assumption contributes to the small number of men using family planning methods.

The research by Herartri (2004) in West Java indicates that the low use of IUD and sterilization methods is strongly related to the lack of socialization of the family planning programs. The lack of socialization creates rumors that makes women increasingly unsure about using the methods.

BKKBN considers the lack of the use of the long-term family planning method as an impact of the reduced number of family planning field officers (PLKB). Until 2000, the number of PLKB was around 36,000. This number decreased to 21,000 at the beginning stage of decentralization. The lowered priority for the family planning program after decentralization encouraged a number of PLKB to change careers. Since then, one PLKB, who is on duty in the field for the education of family planning, has to cover four villages. Ideally, one PLKB should be on duty only in two villages. The number of villages covered by PLKB varies between different areas in Indonesia. In Papua, for instance, one PLKB has to cover 42 villages (Jakarta Post, December 12, 2012).

Marginal Communities or Communities Outside The Target Communities' Access to Contraceptives and Oral Contraceptives

In recent decades, the status and role of women in Indonesia has changed dramatically, particularly in relation to the participation of women in work. However, if it is more deeply observed, the status and role of women is still strongly related to marriage and parenting (Bennet, 2004; Utomo, 2005). Getting married and having children are considered as two inseparable and important things for women. There is a very strong social hope that all women get married and have children. In contrast, all women who have children should get married. The importance of marriage for adults and young females is one of the factors encouraging early marriage in Indonesia. Although there is a decrease in the number of early marriages, this social phenomenon is still commonly seen in rural areas and around poor areas (WHO, without date). In 2009, the number of couples marrying under 18 years old reached 690,000. This number is equal to one third of the total marriages in Indonesia (Jakarta Globe, May 17, 2010).

Today, sex is considered a taboo subject and is seldom talked about openly. The attitude towards women's sexuality and women's roles in the context of social relationships is relatively conservative in general. Virginity is something considered very precious (Bennet, 2004) and adults and young women who have pre-marital sexual intercourse will be heavily punished in social ways, such as being shunned and considered to be "cheap women", "naughty women", and "bad women".

The social-cultural construction on the relationship between sexuality and marriage has a big impact on policy formation. The Law on Population Growth and Family Development (Law No. 52 of 2009) and the Law on Health (Law No. 36 of 2009) state that access to sexual and reproductive health services are only given to legally married couples. Particularly, Article 72 and 78 of the Law on Health mention that access to sexual and reproductive health services will be given only to legal couples and couples of childbearing age. The implication of this statement is that in practice, only married couples can get access to family planning services. According to the Law on Population Growth and Family Development, the rights on reproduction and service provision regarding family planning are aimed at couples bound with legal marriage. In Article 21, Section 1, the Law on Population Growth and Family Development states that family planning policies are meant to support husbands and wives in making good decisions in regards to their rights on reproduction. Article 24, Section 1 and Article 25, Section 2 emphasize that contraceptive services are aimed at legally married couples who are husband and wife.

The laws and regulations mentioned above have brought negative impacts to access to contraceptive services for men and women out of the target group. Adolescents, youth, and single men and women have very limited access to contraceptive services (Pangkahila,

2001; Utomo & McDonald, 2009). The topic about sexuality becomes marginalized in the agenda of education and health. Sexual education in schools, if it exists, is not adjusted to the needs and sophisticated challenges faced by youth. Meanwhile, parents have relatively limited experience and knowledge related to sexuality. In addition, parents generally feel uncomfortable to talk about sexuality with their children. Meanwhile, children and adolescents have a limited capacity to face emotional and personal dimensions in intimate relationships with the opposite gender, such as dating (Utomo and McDonald, 2009). The combination of those various factors mentioned above cause children and youth to have limited knowledge of sexual and reproductive health which could enable them to avoid the serious problems such as unwanted pregnancies, abortions, and sexually transmitted diseases, including HIV and AIDS (Hidayat, 2005).

Unmarried youth who are sexually actively seldom use contraceptives and oral contraceptives because they have a very limited knowledge of sexual and reproductive health (Situmorang, 2003). The absence of access to contraceptives also causes a high abortion rate among youth, which is 33 abortions per 100 live births per year (Utomo and MacDonald, 2008). The result of the survey on health and reproduction among youth in Indonesia (Indonesia Young Adult Reproductive Survey/ SKRRI) in 2007 indicates that 60 percent of unwanted pregnancies ended with abortions, while the remaining 40 percent carried out their pregnancies to birth (Central Statistics Agency (BPS), 2008). Abortion is often conducted in a medically unsafe environment and, as a result, this kind of abortion is a contributor to high maternal mortality rate (Amnesty International, 2010). Out of marriage pregnancy is also a factor encouraging early marriage because if two young adults are facing out of marriage pregnancy, getting married is a solution that

the public can accept (Moeliono, without date; Utomo, et.al, 2012).

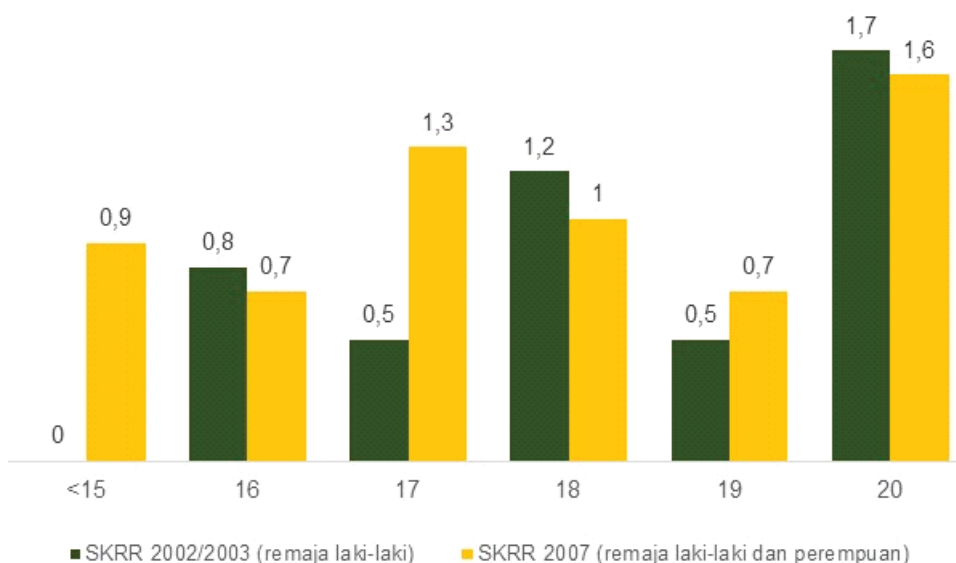
Sexual Behavior among Unmarried People

Nowadays, children go through puberty at an earlier age. The ages of first sexual intercourse is also getting younger (see Figure 2). This contrasts with the age when people get married in Indonesia, which has become relatively older. As a result, youth in Indonesia face a higher risk of pregnancy outside of marriage (Hidayat, 2005). Unemployment among youth in Indonesia is also a factor encouraging youth to get married at an older age. Socially, youth are expected to have a permanent job before they decide to get married. In 2011, the World Bank reminded that the unemployment rate among 19-24 year-old youth reached 30 percent (Jakarta Globe, March 27, 2011). Unemployment also has an impact on the possibility of pre-marital sexual intercourse and pregnancy. Sexual intercourse outside of marriage happens because there is only limited information and limited adequate services of sexual and reproductive health.

The government has some programs for youth covering information about reproductive health. However, the existing programs reflect a gap between what information the youth should know and the real information that is provided in these programs. This gap reflects culturally-based thoughts and legal limitations in providing access and information regarding family planning to those who are unmarried. There is a strong disinclination among various stakeholders to provide information regarding contraceptives and oral contraceptives such as condoms to unmarried adolescents because there are worries that this action would be seen as a promotion of casual sex (Amnesty International, 2010, Utomo et. al., 2012).

Nowadays, youth in Indonesia are continuously bombarded with information that is full of sexuality by mass media, the internet, the entertainment world, and even by their friends of the same age. Media also encourages youth to find out about sex for recreational purposes. On the other hand, as mentioned above, their access to information about sexual health and reproductive health is very limited (Amnesty

Figure 2
Percentage of 15-24 Year-Old Youth According to Ages at First Sexual Intercourse



Source: processed from 2002/2003 and 2007 SKRR.

International, 2012; Utomo and McDonald, 2009, Utomo et. al., 2012). The research by Holzner and Oetomo (2004) indicates that the dominant discourse regarding sexuality in East Java is colored by the tendency to forbid and describe adolescent sexuality as something unhealthy. This discourse is strengthened by the intimidation about the dangers of sex because sex can lead to unwanted consequences, such as pregnancy outside of marriage. However, limited access to information about sexuality does not stop youth from finding information regarding sexuality on their own (Holzner and Oetomo, 2004). Some of them successfully obtain precise information and widen their knowledge about sexual and reproductive health (Holzner and Oetomo, 2004).

The youth who are socially marginalized because of their social status tend to obtain imprecise or incorrect knowledge. The case study by Moeliono (without date) among the youth in the slums of Duri Utara, Jakarta indicates that the social group of those at the same age whom they meet in places to hang out opens the chance for youth who are poor, unemployed, or work part time to share knowledge about unhealthy sexuality. They encourage each other to show their masculinity through risky behaviors, such as using drugs and having sexual intercourse with more than one partner, including with commercial sex workers, without using condoms. As a result, infection and out of marriage pregnancy is common among them. Instead of making them shy or sad, sexually transmitted infections or out of marriage pregnancies can even become their source of pride. Pregnancies outside of marriage are sometimes used as a strategy to force parents to allow their son to marry his girlfriend, even though they might disagree with their son's choice of girlfriend. If the son does not want to marry the girl who gets pregnant out of marriage, then abortion is a solution that is widely accepted among them (Moeliono,

without year). The study by Moeliono (without year) is very important for the study on sexual behavior among youth because this study covers rarely-researched groups, such as marginalized youth groups. Their status is out of school, while most education about sexual and reproductive health is conducted in schools.

In the more updated data from 2010, the 2010 Greater Jakarta Transition to Adulthood Survey among respondents of 20-34 years old indicates that 14 percent of men and 7 percent of women who date have sexual intercourses with their partner. Furthermore, this survey discovered that 15 percent of married men who dated their fiance for more than twelve months had sex before their marriage. Meanwhile, 8 percent of married men who dated their fiance for less than six months had sex with their fiance before their marriage.

The above research indicates that the absence of access for youth about information and services regarding sexual health and reproductive health did not reach its primary goal of preventing them from being sexually active. In contrast, they still wanted to know about sexuality, still wanted to experiment, and they did these activities without enough knowledge about sexual and reproductive health. As a result, many of them engaged in high-risk sexual activities, which caused sexually transmitted infections, unwanted pregnancies, abortions, and early marriages.

The Impact of Political, Governmental, and Institutional Factors

Global Environmental Changes

The beginning of population and family planning policies resulted from the global challenges that occurred in the 1960s that included the issue of the global population explosion. At that time, population and family planning became part of the international

agenda. International donor institutions provided aid for developing countries in an effort to control population growth. Indonesia and a number of developing countries in the world gave a political commitment to control their population growth through family planning programs. The country formed an institution called the National Family Planning Coordinating Board (BKKBN), which is responsible for organizing demographic and family planning programs. Through this program, the government encourages changes for community behavior, such as the acceptance of small family norms, the willingness to get married at older ages, and controlling fertility by using contraceptives. The purpose of all these efforts is to decrease the fertility rate.

In the first three decades (1970-2000) of the implementation of demographic and family planning programs, there was proof of a significant fertility decrease from 5.6 in 1970 to 2.4 in 2000. However, after that, the fertility trend moved in the opposite direction. In the last three SDKIs, fertility rate remained at 2.7. Interestingly, the trend change occurred after Indonesia experienced a great political transformation from an authoritative political system to a democratic political system and from a centralized governance system to a new, decentralized governance system.

In this era of democracy and decentralization, the institution in charge of the implementation of family planning programs has had structural changes that make it weaker in dealing with family planning issues. BKKBN, which previously had offices at the provincial and district levels, had to willingly let them go. Local/District BKKBN was removed and the implementation of family planning became the responsibility of the Local/District Government Task Force (SKPD). Even in many cases, family planning concerns were only settled in a sub-institutional status, which certainly had a lower capacity than previously as a main mandate

of SKPD. The budget to support this program from the division for those concerns was more limited. Besides, family planning field officers (PLKB) in the reformation era were included as local apparatuses and their numbers continued to decrease due to several factors. First, a part of PLKB was assigned to a new job or position outside of family planning affairs. Second, the number of PLKB decreased because of job relocation or retirement and were not being replaced by new PLKB soon after. Because of that, overall, there was a crisis for the continuation of PLKB's existence. This situation certainly had a great impact on the ability of the family planning service unit to reach the target groups in various places.

Besides that, human rights, reproductive health, and gender, which have been global agenda issues since the 1990s, also contributed in narrowing the space for the application of coercive ways in the implementation of family planning. Meanwhile, in the middle of the democratic political climate, and also when human rights and gender become important criteria in the implementation of development programs, the coercive ways that were conducted in the New Order era are no longer possible to conduct. At the same time, family planning faces new challenges, including the rise of larger family values which is shown by the celebrity community, and the anti-family planning attitude which is clearly stated by radical groups.

Decentralization in Family Planning Management

In the last ten years, significant changes in the family planning management system took place. The first is regarding the legal status of family planning affairs in governance. For instance, if we observe Law No. 32 of 2004 on Local Governance, it does not mention that family planning is a compulsory affair delegated to the province and regency/city. Article 13-14

only refers to demographic and civil registry services as a compulsory affair.

The implication is that not all territories have the same commitment to family planning programs. The responses of the regency/local government to family program institutions also vary. There are various governmental institution nomenclatures at the local level which handle family planning. They are in the form of an agency, board, or office, or associated with other field institutions. The basis of the formation also varies. Some of them are based on local regulation, local decree, etc. Budget efficiency or human resources also often become a reason to decide the form of the institution.

From all the regencies/municipalities in Indonesia, there are 208 institutions at the regency/city level handling family planning which are in the form of an agency. 150 are in the form of a board, and 65 are in the form of an office. 371 institutions are based on local regulation, 52 are based on local decree, and 10 are based on other regulations (Table 3).

Three years after July 9, 2007, Government Regulation No. 38 of 2007 regarding the Distribution of Governmental Affairs between the Government, Provincial Regional Government, and Regency/Municipality Regional Government was created as an implementation of Law No. 32 of 2004. In that Governmental Regulation, it is clearly stated that family planning and a prosperous family are one of the 26 compulsory affairs delegated to provinces and regencies/municipalities as a form of basic services (Article 7). Besides, the government also created Government Regulation No. 41 of 2007 regarding the Organizational Structure of Regional Governments. Article 22, Section 5, Point i states that one of the supports to the affairs placed in the form of a board, office, inspectorate, and hospital, is the field of women's empowerment and family planning. It means, organizationally, this regulation gives mandates that the field of

women's empowerment and family planning are placed in one institution. However, the government institution is not fully operated by the local government. In the implementation, there are many institutions in regencies/municipalities working in the field of family planning which are united with women's empowerment. However, some of them are independent and some are also united with the other fields that are not related to women's empowerment.

In its development, family planning issues become a concern of the government. This can be seen from Law No. 36 of 2009 regarding Health which states that family planning is an aspect which needs to be concerned about in the implementation of health efforts (Article 48). In Article 73, it is also stated that the government must guarantee the availability of the means of reproductive health services that are safe, excellent, and affordable, including family planning services. Particularly, in the Law on Health that regulates family planning, Article 78 states that health and family planning services are meant to control pregnancies for couples of childbearing age in order to form a healthy and intelligent next generation (Section 1). Therefore, the government is responsible for and guarantees the availability of staff, service facilities, tools, and medicine in providing family planning services that are safe, excellent, and affordable for the community (Section 2). The implementation of family planning services is regulated with special laws (Section 3).

In the same year, the government issued a law on demography and family planning which is Law No. 52 of 2009 regarding Population Growth and Family Development as a replacement for Law No. 10 of 1992 regarding Population Growth and Prosperous Family Development which was no longer suitable to the recent demographic developmental conditions, either at the national or international level. In the new law, family planning is understood in the perspective of rights. It is mentioned that family planning

The Inhibiting Factors of the Fertility Rate Decrease

Table 3
The Institution of Family Planning Division of the Local Government Task Force (SKPDKB)
in Each Province in July, 2007

Province	Basis of Formation			Form of Institution		
	Local Regulation	Local Decree	Etc.	Agency	Board	Office
Nanggroe Aceh D.	19	2	0	13	2	6
North Sumatera	23	2	0	15	7	3
West Sumatera	19	0	0	10	2	7
Riau	6	4	1	6	4	0
Jambi	10	0	0	5	5	0
South Sumatera	14	0	0	3	9	2
Bengkulu	9	0	0	5	3	1
Lampung	9	1	0	2	6	2
Bangka Belitung	6	1	0	2	0	5
Riau Islands	4	1	0	4	1	0
Special Capital Territory of Jakarta	-	-	-	-	-	-
West Java	24	1	0	13	9	3
Central Java	32	3	0	22	8	5
Special District of Yogyakarta	5	0	0	3	2	0
East Java	35	2	1	19	14	4
Banten	6	0	0	4	2	0
Bali	7	2	0	3	3	3
West Nusa Tenggara	3	6	0	2	3	4
East Nusa Tenggara	13	3	0	9	6	1
West Kalimantan	8	3	1	8	2	1
Central Kalimantan	13	1	0	8	6	0
South Kalimantan	12	1	0	2	9	2
East Kalimantan	10	3	0	8	2	3
North Sulawesi	8	1	0	1	7	1
Central Sulawesi	8	2	0	4	5	1
South Sulawesi	23	0	0	12	11	0
South East Sulawesi	8	2	0	5	5	0
Gorontalo	5	0	0	2	3	0
West Sulawesi	5	0	0	4	0	1
Maluku	7	1	0	2	6	0
North Maluku	8	0	0	1	4	3
Papua	11	3	6	10	3	1
West Papua	1	7	1	1	1	6
Total	371	52	10	208	150	65

Source: Bureau of Law, Organization, and Management of Central National Demographic and Family Planning Board (BKKBN), July, 2007

is an effort to control child births, spacing of births, and the ideal age for giving birth, and controlling pregnancies through protection and help according to reproductive rights in order to realize a quality family.

In order to implement the family planning program, this law controls the government's authority and responsibility, either at the central or local level (provinces and regencies/municipalities). The central government has responsibilities in creating national policies while provincial governments are responsible for creating local policies (Article 12-13) which are inherent in national policies. Meanwhile, the government of regencies/municipalities is responsible for creating the implementation of population growth and family development in regencies/municipalities or acting as the implementer of the policy made by BKKBN (Article 14). The authority at the regency/municipality level can be seen as a chance for family planning policy in local areas to work in the same way with national policy (and/or provincial policy).⁶

Through Article 53, the National Family Planning Coordinating Board (BKKBN) was formed as a non-ministerial government institution at the central level. Furthermore, at the local level, the Local Family Planning Coordinating Board (BKKBD) was formed, either at the province or regency/municipality level. In implementing its duty and functions, BKKBD has a functional relationship with BKKBN (Article 54), which means that between BKKBN and BKKBD, either province or regency, there is no vertical relationship. However, the functions of the coordination among them are not clear.

From the aspect of funding, the funding of the family planning program is nationally

charged to the National Budget (APBN), and in local areas it is charged to the Regional Budget (APBD) (Article 15-16). This means that local areas do not receive any budget support from the central government in implementing the programs regarding population growth and family development. Therefore, the success of family planning becomes very dependent to the commitment of the regional head and legislative members, which is visible from the budget support for demographic and family planning programs. Remembering that the local area commitment to the national program of family planning widely varies, likewise the APBD fund allocated for implementing the national program also varies.

In relation to the new duty and functions of BKKBN, the government has enacted Presidential Decree No. 62 of 2010 regarding the National Family Planning Coordinating Board. In that decree, it is regulated that BKKBN is a non-ministerial government institution which is responsible to the president through the minister who is responsible in the field of health. BKKBN has a duty to conduct governmental tasks in the field of population growth and family planning provisions. In implementing its duties and functions, BKKBN is coordinated by the minister who is responsible in the field of health (Article 5). Chapter 2 regulates the organizational structure of the new BKKBN. In order to implement the Presidential Decree, the Decree of BKKBN's Head No. 72/PER/B5/2011 regarding the Organization and Management of Provincial Representatives of the National Family Planning Coordinating Board was enacted.

The Presidential Decree regulating the same matters is Presidential Decree No. 3 of 2013 regarding the Seventh Amendment of

⁶ However, this is not separated from the affairs of the formation of local government which is regulated in Law No. 32 of 2004 regarding Local Government.

Presidential Decree No. 103 of 2001 regarding the Position, Duty, Function, Authority, Organizational Structure, and Management of Non-Ministerial Government Institutions. That Presidential Decree regulates the change of BKKBN nomenclature, from the National Family Planning Coordinating Board into the Demographic and Family Planning Board. As a consequence, its duty, function, and structure of the new BKKBN organization also changed.

According to Presidential Decree No. 62 of 2010 (Article 55), Representatives of the National Family Planning Coordinating Board (BKKBN) become Provincial Representatives of the National Family Planning Coordinating Board (BKKBN) until the formation of all Local Family Planning Coordinating Boards (BKKBD) of the Province and Local Family Planning Coordinating Board (BKKBD) of the Regency/Municipality as meant in Law No. 52 of 2009. BKKBN through Provincial Representatives of BKKBN implement counseling and facilitate the formation of BKKBD of the Province and BKKBD of the Regency/Municipality according to the provision of law and regulation. The Provincial Representatives of BKKBN have a duty to implement some tasks of Provincial BKKBN.

However, it has been three years since the enactment of Law No. 52 of 2009 and there have not been many regencies/municipalities that have formed BKKBD. It indicates that the commitment of many regions to the issues on demographic and family planning is still low. BKKBN targeted that until 2014, there would be at least 66 representative offices of BKKBD which independently operate and are not united with other institutions.⁷ Through the formation of a special board that handles the issues on demographic and family planning, it is expected that every region can solve them comprehensively. Therefore, it is necessary to devise a significant innovation so the issues on

demographic and family planning become one of the priorities of regional development.

Family Planning Services after Law No. 52 of 2009

It is necessary to emphasize that family planning services after Law No. 52 of 2009 have had a number of new innovations. On June 18, 2012, the BKKBN Head enacted The Decree of BKKBN Head No. 232/PER/E4/2012 regarding Guidelines for the Participation of Family Planning in Maternity Insurance. The counseling for the participation of family planning in Maternity Insurance has a purpose to improve the access, quality, and to guarantee the participation of family planning after delivery or after miscarriage in all health service facilities which provide Maternity Insurance services. The counseling target population for the participation of family planning in Maternity Insurance are pregnant mothers, delivering mothers, post-delivery mothers, and post-miscarriage mothers. This also includes the service providers and managers of the family planning program.

In order to accelerate the revitalization of demographic and family planning programs, BKKBN cooperated with the Indonesian National Armed Forces (TNI) by signing the Joint Regulation between the Head of the National Family Planning Coordinating Board and the Commander of the Indonesian National Armed Forces, Number 72/Per/G2/2013 and Kerma/5/V/2013, regarding the Directions for the Acceleration of the Revitalization for the Implementation of the Demographic and Family Planning Programs of the 2013 Cooperation between BKKBN and TNI on May 7, 2013. The purpose of this cooperation is to be able to reach family planning movements and services in all territories and community levels in order to accelerate the National Joint Security

⁷ The statement of the head of BKKBN in *Pos Kota*, August 20, 2013.

Committee (KKB) toward achieving the 2015 Millennium Development Goals (MDGs). This cooperation was protested by some NGOs. They were worried that the cooperation would bring about the return of a model of forceful family planning services which happened in the New Order era. However, these worries were repelled by the head of BKKBN by stating that this cooperation had a purpose of improving the participation of family planning from the family of TNI/Indonesian National Police (Polri), not to scare the community.

Conclusions and Policy Recommendations

This final report presents the analysis and results on family planning policies in Indonesia and addresses the temporary results of the 2012 SDKI. This analysis was conducted to respond to the Introduction Report of the 2012 SDKI which states that the fertility rate has not decreased from the previous two SDKIs, which were 2.6, although the 2010-2015 RPJM has declared 2.1 as the fertility decrease target of 2015. The remaining two years are too short. Without the basic changes on the orientation of family planning policies, the RPJM target will be very difficult to reach. Therefore, it is necessary to conduct a serious study to find what solutions the government should implement so that fertility decrease can be actualized.

In the broad outline, this analysis elaborates two possible answers to the fertility issues mentioned above: First, by analyzing the changes on a number of mediating variables; and second, by analyzing the institutional reformation of family planning conducted in the era of democracy and decentralization. In the matters of mediating variables, this analysis discovers that the changes that happened did not support the efforts to decrease fertility. The goals in some analyzed variables, such as family planning usage, the proportion of the use of long-term contraceptives and oral contraceptives or secure contraceptives, the

15-19 year old ASFR, ages at first sexual intercourse, and ages at first marriage, have not reached the declared targets.

In the last fifteen years, there was a movement from global and demographic issues to issues on gender, human rights, reproductive, and sexual health. As a consequence, the direction of international aid for developing countries moved from efforts to respond to demographic issues to the new issues listed above. It created an unfavorable environmental situation for the implementation of an effective national family planning program.

At the national level, there have been significant changes from authoritative governance to democratic governance, and from centralization to decentralization. As a consequence of these political changes, there were structural changes in the handling of family planning in Indonesia. BKKBN which, in the era of the New Order, was the main institution in national family planning management, became the key institution behind the success of the family planning program at that time. It disappeared when the nomenclature of this institution changed, which was when the first 'K' of BKKBN was no longer '*Koordinasi* (coordination)' but rather '*Kependudukan* (demographic)'.

In other words, the task coverage of this institution was widened to all demographic aspects (population quantity and quality). However, the central role of this institution was narrowed, which was when the function of 'coordinating' was removed and the implementing institutions at the regency and municipality levels were dismissed. In other words, BKKBN, an institution which was very central in the New Order era for implementing population growth control, had been dwarfed and lost its authority to conduct the coordinating functions and the program implementation. The extension of BKKBN roles to sectors

outside of family planning (migration, mortality, education, and health) does not have any meaning because, in fact, BKKBN does not have control in program implementation for the sectors of non-family planning. It also failed to implement the horizontal coordinating function, which is with related institutions at the central level, due to the absence of a mandate to coordinate with those institutions. Meanwhile, the ability to implement the vertical controlling function, which is aimed at the implementation of local family planning programs, has also become weaker since there is no implementing institution at the local level.

Nowadays, the local institutions handling family planning tend to be weak because of the limited local budget support. The mandated law that states that BKKBD should be established in every region has not been followed by most of the local governments. The number of PLKB, which in the era of the New Order was the strength of BKKBN in reaching rural areas, tends to decrease and the available budget to support their duties tends to be limited. Besides that, in the last fifteen years, the attention of politicians, media, and the public no longer goes focuses on the issues of demography and family planning. Those issues and the actors playing them are also not celebrities that fulfill news in mass media.

Universities no longer focus on conducting studies or publications on demography. Many demographic experts in universities, in the era of the New Order, who were very active in researching and writing their views to respond to various developing issues of demography and family planning, were no longer interested in staying in the field of demography. In contrast, some new pro-natal demographic experts appeared by stating that population growth has positive contributions to economic growth.

The recent issues of family planning do not “call” the civil public to participate in handling

them. In the New Order era, there were some NGOs which paid special attention to the issues of demography and family planning. Some of them included the Indonesian Family Planning Association (PKBI) and the ZPG (Zero Population Growth) student organization. These organizations are considered to be dissolved because the focus of their projects has moved from family planning issues to issues of gender, reproductive health, and sexuality.

In order to strengthen the solutions for the issues of demography and family planning, it is necessary to conduct new strategic steps:

1. It is necessary to conduct serious efforts to strengthen demographic institutions, particularly in conducting the functional implementations at the basic level.
 - a. It is necessary to conduct serious efforts with a clear deadline and establish BKKBD in the province and regency/municipality levels.
 - b. It is necessary to make efforts so that the new institution will be have reliable human resources, including reliable family planning field officers and reliable financial supports for local family planning programs.
 - c. The leader of the new institution must be able to mobilize the resources in the institution and act in a ‘brokering’ role by establishing institutional collaborations with non-government parties in order to make the implementation of local family planning program smoother.
 - d. Providing optimum facilities for the institution so that it is able to conduct important actions as follows:
 - i. Socializing family planning by establishing positive assumptions toward small family norms and modern contraceptive use in the community. This

socialization is necessary to be introduced to children through school educative media, to adolescents through various available media, to new couples when they are getting married, and to young families that still expect to have children.

ii. Conducting sociological approaches toward religious groups which still oppose the idea of small family values, which refuse the idea of waiting to get married at a later age (preventing early marriages), or which resist the idea of family planning and contraceptive use.

iii. In order to make sure these sociological approaches succeed, family planning officers need clear knowledge, directions, and guidelines so that they will be able to explain how important family planning is, utilize arguments that can be accepted by religious groups, explain the basis of religious considerations of the need for family planning, and accurately respond the thoughts or arguments of the parties opposing family planning programs.

iv. Improving the quality of contraceptive services:

- Replacing choices of contraceptives from hormonal to non-hormonal and from short-term contraceptives and oral contraceptives to long-term contraceptives and oral contraceptives.
- Providing reliable services about contraceptive side effects and possible contraceptive failures.
- Optimizing the role of Community Health Center (Puskesmas) in providing contraceptive services. In order to handle the private practices of health care and family planning services by state doctors and paramedics out of their working hours, the service hours of Puskesmas need to

be extended to 24 hours a day. Therefore, the compensation system of Puskesmas officers needs to be improved.

- Reactivating the family planning mobile car service team as an effort to extend contraceptive service coverage to villages, particularly to rural areas which are far away from health and family planning service centers. The function of the mobile service team is extended not only for family planning services, but also for community health services (outpatient care, immunization to infants, weighing infants, and birth certificate services). Therefore, cooperation with related institutions is necessary for the mobile service team.

- Providing education on sexuality, reproductive health, and family planning to adolescents and creating a condition so that sexually active, unmarried women can get access to contraceptives and oral contraceptives and family planning.

e. Developing a strong monitoring and evaluating system to monitor and evaluate the quality of the local family planning process and implementation and creating a reward and punishment system for local conducting units in order to implement the functions of the local family planning program.

2. Improving the political commitment of political institutions or politicians in order to revitalize the demographic/family planning program. The politicians, whose position is in the central and local executive board and central and local parliament, need to improve their commitment to the efforts of population growth control.

a. Demography and family planning need to be focused as a main agenda in the education of political party cadres and as a public agenda for every political party to

- fight for.
- b. Political education for citizens needs to emphasize to the voter the importance of voting for politicians or governmental leaders who are committed to demography and family planning.
3. Developing a synergic relationship to governmental elements out of government which are:
- a. NGOs at the central and local level:
- i. NGOs need to have nomenclatures of family planning. For instance, PKBI needs to be approached so that they will return to their main mission, which is family planning, and can be a partner of BKKBN and BKKBD (or other local institutions that can carry out family planning mandates) in socializing and implementing local family planning programs.
- ii. BKKBN needs to initiate or develop further cooperation with religious organizations, such as Muhammadiyah and Nahdlatul Ulama, in the field of family planning.
- iii. BKKBN needs to encourage the establishment of new societal organizations that are interested in supporting relevant efforts for the mission of family planning.
- iv. BKKBN or local family planning institutions need to build cooperation with media, conducting training for young journalists in order to encourage the interest of media in reporting events related to issues of demography and family planning, and to give positive impacts for society in regards to family planning.
- b. Community organizations:
- i. Making use of a number of existing community organizations to socialize the idea of family planning and extending community access (particularly for women) to contraceptive use.
- ii. Encouraging the establishment of new organizations, such as family planning user associations in villages, and making them as a medium to strengthen the motivation for citizens to practice family planning.
- c. Business sectors:
- i. Raising cooperation with the business world so that they will facilitate their employees to practice family planning.
- ii. Encouraging companies that have company social responsibilities, or corporate social responsibility (CSR), to direct some of their programs to support national family planning programs.

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