Family Planning in the 1990's : A New Era....*

Haryono Suyono**

Honorable Chancellor,
Distinguished Professors,
Distinguished Faculty Members,
Distinguished Guests,
Ladies and Gentlemen.

It gives me a great pleasure indeed to be honored by the Monash University with a Degree of **Doctor in Medicine *Honoris Causa***. I am certain that thousands of village and community leaders in Indonesia, religious leaders, women and youth leaders, government officials and voluntary leaders, are as emotionally touched as myself with this honorary degree that the Monash University convers on me. Therefore, I would like to dedicate this honorary degree to all family planning and family development workers in Indonesia. I would also dedicate this honorary degree to all family planning acceptors in Indonesia for their participation in the program.

In this auspicious occasion, I would like to thank His Excellency President Soeharto who has constantly lend his strong personal and political support, guidance and blessings to the developmental work all have dedicated ourselves to for the last 25 years.

I would like also to thank Prof. Short and Dr. Biran Affandi who have nominated myself as the recipient of such distinguished degree from this prestigious university. Finally I would like also to thank the Honorable Chancellor of the University and all his distinguished faculty of Professors for their trust in me to carry this coveted degree.

Permit me at this occasion to present for your academic consideration a humble contribution on the conduct of the Indonesian population and family planning program.

The New Era

This is indeed a most appropriate time to submit to this distinguished academic forum the current future-oriented strategic development of family planning and family development in Indonesia. This, I feel, is most relevant considering the fact that our world is currently facing a new era for family planning and health services.

Fertility rates in Indonesia has dropped sharply within the past twenty five years, and similarly has mortality rates - especially those of infant and child - dropped dramatically. To achieve further gains in both fertility and mortality reduction will be so much more difficult, and will require new thinking and increasingly flexible approaches.

Although much of what I will present is based on our experiences in the national family planning program, much of what we have learnt applies to all our counterparts and partners in the health sector. We recognize the very significant linkage between fertility and mortality, and the important contribution gains in child mortality reduction have on couples' willingness to practice family planning. The National Family Planning Coordinating Board's (BKKBN) achievements have been, in many ways, based on a partnership with the health workers and health infrastructure. Because of the rapid changes occuring in Indonesia, our health leaders also have to continuosly reshape their strategies to meet the new circumstances. Therefore I can say that we will see changes in the health sector going in parallel to that in family planning.

The Indonesian Family Planning program is, I believe, one of the most advanced in the region and probably in the world. We are now at a stage which requires a shift in the implementation approach and in the restructuring of the thoughts about promoting and providing family planning services. As the Indonesian people

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** *State Minister for Population / Chairman National Family Planning Coordinating Board, Republic of Indonesia*

have matured in their way of living and way of planning for their future, BKKBN has also had to rethink and to mature. It is now evident that Indonesian families are preparing to manage and implement their own family planning needs by themselves and, as the country itself goes through rapid socio-economic development, the responsibility for the management of family planning will shift from 'management by BKKBN' to 'management by the people and by the families'.

It has become apparent to me that many donor communities, while giving us moral, technical and financial support, believe that BKKBN's shift to include and develop the private sector in late 1980's stems for budgetary constraints in the face of a growing population base. Actually that was a minor or even a nonexistent concern. The fact was that our information from the field, from studies, surveys and experience, have shown that after 20 years of family planning, many acceptors have internalized the need for planning a family. There were indications all over the country that people no longer see family planning as only a program promoted by the government, but rather as a real need, a need that they are willing to pay for. As the socio-economic levels rise, so does the need to get deeper and more comprehensive information, to enjoy personalized services, to be "fashionable", to show-off status, and part of this status is to pay private doctor or midwife for family planning; not just shifting some responsibility and finances to the private sector, but rather learning to utilize all the expertise and techniques of the modern marketing world and psychological and sociological research.

Potential acceptor segmentation and targeting of messages through mass media are approaches that go far beyond the basics of commodities and general IEC messages. These are what a new era demands and what a succesful family planning program must be ready to evolve to meet these demands.

Background

The Indonesian Family Planning Program has become and evolved to its current status only after considerable efforts and multiple stages of development. In 1970, when BKKBN was established and began operation, we felt contend and very succesful when we achieved 50,000 acceptors, since family planning was a new controversial idea. However, we had the support and the mandate of the President himself, and from this early modest beginning, we have evolved into the current situation where we have between 23 to 24 million acceptors throughout Indonesia, with approximately 15,000 to 20,000 new acceptors added every day.

According to the 1987 Demographic and Health Survey conducted by the Central Bureau of Statistics and Westinghouse in 20 provinces in Indonesia, 94.5% of married women know about family planning; approximately 48.5% of all eligible couples use family planning; and 65% of married women have ever used contraception. In the 1994 Demographic and Health Survey conducted in 27 provinces in Indonesia, 95.6% of married women know about family planning, approximately 55% of all eligible couples use family planning, and 75% of married women have ever used contraception. The total fertility rate has dropped to approximately 2.7, down from a level of 5.6 in the 1960'S. The growth rate of the population is currently estimated at 1.62%, down from 2.34% between 1971 - 1980.

To achieve these results, BKKBN has had to build a system of service and supply that stretches across all 13,000 islands, to serve a population currently estimated at 196 million, employing 50,000 field workers and staff. However, logistics of supplies and personnel have only been a part of the equation. For the greater part is that we have had to capitalize and utilize the Indonesian culture and community norms to change the perception of the prevailing Indonesian family. We have had to make family planning a part of every community and of every family's life. The idea of the small happy and prosperous family as the norm, where a son or a daughter is equally valued, has slowly replaced the desire for a large family which was the norm when the program was introduced.

Our program has developed through a "**Three Dimensional Strategy**". During the first phase, emphasis was devoted to the expansion of institutional development and program coverage both with strong IEC efforts, and in the provision of services and supply of contraceptives. Beginning with a clinic - based program, we quickly realized that the focus of the program must be the community organizations, such as the *Kelompok Ibu-Ibu* (Mother's Club) and *PKK* (Women's Welfare Association) as well as religious and non-formal community leaders as family planning managers, and the maintenance of continued supply of contraceptives.

The second phase is program maintenance, within which efforts were concentrated on making family planning as part of community development activities. Every institution working for rural development were

asked to convey family planning and health messages in their activities. The contraceptive mix was improved to give people more choice in selecting the most appropriate method for them. Community organizations were then considers as managers of an extensive network of community participation.

The third stage is when family planning became a truly community and family activities. Family planning clubs were truly given the responsibility for motivation; integrating family planning with health and nutrition activities as well as income-generating; the credit system and other family development activities. Many communities managed their own family planning actitivies, arranging for supplies and services. At this point family planning became an accepted part of the overall economic and social fabric of the community and family life.

KB Mandiri (Self - Sufficiency Family Planning)

The system of community participation worked encouragingly well particularly in the rural areas, but in 1984-85 there were some concern that the contraceptive prevalence in urban areas fell laging behind that of the rural areas. Information from attitudinal and behavioral surveys and other researches suggested that urban people were not responding to community activities, peer consensus and general family planning messages which worked so well in rural settings. Urban people were simply different; they are more heterogenous in culture, more likely to have disposable income, more exposed to mass media advertising, more fashion and trend conscious. In addition, there seemed to be a higher utilization of private health services, with some people even willing to pay for family planning services and supplies that they could actually obtain free from government clinics.

In respons to this information, a special program with an urban emphasis was developed. Private doctors and midwives were offered training courses by BKKBN and by their own local professional societies in the management of family planning services. IUD kits were distributed to the participants of these short courses. If these doctors and midwives were to serve growing numbers of acceptors in their private clinics, clearly they needed acces to affordable supplies, and so the *"Jalur Swasta"* or "private line of services" came into being. This program provided private doctors, midwives and some pharmacies with free contraceptive products, so that acceptors would only have to pay for services..

Despite the growing numbers of private providers trained in family planning methods, research found that the general public had come to rely on BKKBN and the public clinics for the provision of family planning. Therefore, we instituted the **"Blue Circle IEC Campaign"** in 4 selected cities. In this project, BKKBN used the services of private sector family planning providers. Advertising messages in radio, print media, TV and billboards urge people to "come to the sign of the Blue Circle" for information and quality family planning services. This program has rapidly expanded beyond the original 4 test cities to 31 major cities. Many more cities have adopted the idea spontaneuosly.

To provide these acceptors with high quality, low cost contraceptives has really been a challenge, considering that in the past contraceptives have always been made available free from the government or at relatively high cost from the commercials sectors, which formed only 2% of the contraceptive market. However, acceptors willing to pay for their own family planning must have access to a wide range of affordable contraceptives, and so the idea of Blue Circle products was born. An initial six methods were selected and their manufacturers agreed to repackage and distribute the products *under the Blue Circle label, to reduce the commercial price by 40-60%*, and *to established a return-to-project fund.* In return, funding for advertising and market research of the first three product was provided by a local private firm. Market research was used to design the advertising messages emphasizing reliable products available through trusted doctors and midwives at affordable prices. The Blue Circle products were launched by the President in November 1988, and are now available all over Indonesia, in urban and rural areas. Later in early 1990's we added to the program a more elaborate program strategies and products carrying the Gold Circle label.

In all of these activities of the last few years, a central theme has emerged and has become very evident - the Indonesian people have internalized the concept of family planning and recognize it as an important part of their family life. And as Indonesian have become more self sufficient, the concept of *KB Mandiri* or "self-sufficiency family planning" has come to the surface. The Indonesian acceptors are willing to take the responsibility for their own family planning needs, and if they are economically able they are even willing to pay for their family planning services and supplies.

This was a major shift in the attitude and the behaviour of people and these are reflected now in all our

programs. At the urban areas, acceptors are flocking to the private sector manage local family planning services and to contribute to the cost. This has, as I mentioned, required a fundamental change in the structure and operations of the Indonesian Family Planning Program itself, as we enter a new era with sophisticated acceptors seeking quality services in an updated world. And this is the reason for BKKBN to be flexible and to adapt and to change with the times. Thus, we too become more sophisticated in our approach to family planning.

Three Types of Programs in the 1990's

We are now at the height of these changes and have gone through many stages of development. Some of our experiences and successes may have been unique to the Indonesian setting, but in general, all family planning programs will have some of these same elements. As we are in the 1990's, there seems to be three catagories of family planning programs. Perhaps some of our experiences in Indonesia are relevant to each.

The first type is a program that has been *newly introduced* and thus has an initial level of acceptance. The thrust of the program usually rely on *the maternal and child health approach.* Sophisticated medical terminology were introduced to families at the villages. Family planning and health information and services were brought directly to the door-steps of the couples. Our experience has proven that one of the major reasons for success of the Indonesian program was the very strong *political commitment and support* - right from the beginning - of the highest official in the country - President Soeharto himself. This allowed us to be innovative and bold, and hence we advanced rapidly.

The second type of program is one which is in the transition stage to a full *family planning, health and development approach.* Family planning and health become parts of total development activities. Although incorporating a commodity and logistics system in most cases, the truly successful programs are aware that more than a supply oriented approach is necessary. Our primary focus is no longer on traditional family planning, with or without the 'beyond family planning' additives. Our concern is in improving the total developmental inputs to the Indonesian family as an institution. Family planning is part and parcel of total development for the family. All development agencies were asked to convey family planning and health messages and to be actively involved in clinical services.

Although measures such as total fertility rates, contraceptives prevalence rates and population growth statistics are exciting to the hearts of sociologists and demographers, they have little relevance to the hearts and minds of the average person thinking of his or her family. Thus, we must design programs so that people can see the difference what family planning makes in the quality of their everyday lives, and how the acceptors can provide a better life for all members of the family and his or her children.

Some of our concern for the family does, of course, continue with the aspects covered by the earlier program - we still provide opportunities for people to limit their family size *if they so desire,* we still actively encourage safe motherhood, and we continue to provide some of the same opportunities for people - mostly women - to improve family income, to improve their ability to raise their children, to improve their access to higher education, etc.

I am convinced that in reference to the Plan of Action emanating from the International Conference on Population and Development in Cairo 1994, that the second type is more to what is categorized as the realm of Reproductive Health programs.

The third type of program, is the truly advanced program; the one that *may* lead donors such as AIDAB/AUSTRAID and others to think that their support is no longer needed. This is actually a much more difficult and complex stage. We no longer perceive family simply as the institution that receives all of these benefits from the society. The family, in this new construct, is also the engine, the advocate, the one who make their own decision for their own development and their own future. The program has already had high acceptance rates and the necessary supplies and distribution system, the family can support themselves up to certain levels of self sufficiency. They now realize that the world has changed and that people are *demanding improved, personalized services and quality family planning,* and they are getting all of these. This is the stage that demands the *utmost moral support and understanding,* particularly from the donor agencies, and the utmost sophistication and flexibility in terms of time and care to position family planning as one of the basic needs of every modern individual.

The unfortunate fact is that the private sector is not always perceptive to see existing market opportunities since family planning is seen as a government social service. Sometimes even the sophisticated advertising

agencies produce dull messages when it comes to family planning. This new demand creation for family planning services and products is also closely tied to the improvement of health services in both the public and private sector, since very few family planning products are self- administered. Actually, some creative private sector organizations could seize this opportunity and should be able to tackle this problem and develop contraceptives that can be as accessible and easily used as a tube of toothpaste, shoes, lipstick and the likes !

I would like to add in this context that in this particular type - the stage where Indonesia is today - the scope of work has exceeded the Reproductive Health concerns, and has graduate into what we refer to as Reproductive Welfare concerns. To present you with some examples, in this regard Indonesia is fully committed to lowering the *Maternal Mortality Rates* by capitalizing on a holistic approach. It is not merely the medical aspects that we are directing our efforts to, rather the whole family and the community at large. The prevention of unnecessary maternal death can be done by motivating mothers and fathers to use contraceptives with care. A pregnant mother, on the other hand, is the concern of not only the medical personnel at health centers or hospitals, but most of all she is the concern of the whole family and particularly of the father of the family. It becomes the family's duty to care for her health and her well being. Here is where one goes far beyond the health and medical profession.

Another example is the prevention of HIV/AIDS in the Indonesian context. We are indeed going all out at it, although in percentages the number of identified cases are still minute compared to other countries. We are not zeroing-in on the disease itself and follow each case with diligence. Rather, we are concentrating our efforts on *healthy families,* to enlighten them on the dangers of this dreaded disease, on how to prevent it with *the strong resilience of family life.* We are even devoting one telephone line on a national scale for *anonymous inquiries* about this disease, and thus, again, personalizing information services to all.

Bye and large this is the era of the sociologist and of modern marketing techniques. As global mass media and fashionable trends rapidly sweep the world, we cannot be left behind still discussing logistics. Successful *demand creation* means that we have to understands our potential acceptors and the changing ways to approach them. We have to learn to design programs and products to meet consumer demands. We have to use modern marketing techniques such as specific target segmentation of messages, evaluation through omnibus surveys and focus group interviews, positioning product presentation and appropriate pricing strategies.

All this does not mean that we give up our ultimate goals, but rather that we change with the times and recognize the changing nature of our people who are, after all, the ones who will make family planning a part of their daily lives.

Some Final Suggestions

I am sincerely grateful to the Monash University for honoring me with *Honoris Causa* Doctoral Degree in Medicine, particularly at a time when many begin to ask about our family planning success story. I somehow feel that this is a confirmation of support to our program which I hope I have presented before you in its proper perspective. We feel that our program has achieved one of the few type 3 programs in the world, and is stil facing a lot of challenges and work. Therefore, we indeed appreciate your moral and academic support. Most programs are still at type 1 or type 2, but I am confident that they can advance more rapidly to the next types by learning from the experiences we have had in our program.

Speaking as an academic learner and as partner in development, I would like to invite you as partner in population and family centered development to join hands in this noble mission for the betterment of mankind and for a more secure life for our future generations. Let us strengthen the collaboration of our research programs to enrich the operational programs in the field. Let us work together to develop innovative approach, for it is out of these that often times unexpected outcomes, new ideas and new programs are born.

Let us strengthen our collaboration although we sometimes have differ in our priorities, yet we all have the same ultimate goals - to make our countries and our world a better place with improved quality of life through better health and family planning.

Thank you.