



Discussion Paper on Family Planning, Human Rights and Development in Indonesia

Complement to the State of the World Population Report 2012
November 14, 2012 | Jakarta Indonesia



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Introduction ¹

Indonesia's Family Planning Program in
Transition ¹

A Human Rights-Based Approach to Family
Planning in Indonesia ²

Challenges in extending access to everyone
in Indonesia ⁴

Social and Economic Benefits of a Human
Rights-Based Approach to Family Planning
in Indonesia ⁵

Costs and Savings of Upholding the Right to
Family Planning in Indonesia ⁶

Conclusion ⁷

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Introduction

Indonesia's family planning program has been recognized as one of the key international successes in national-level interventions on reproductive health. During the past 40 years, Indonesia has achieved a significant drop in the total fertility rate from 5.6 in the late 1960s to a current rate of 2.3.¹ The use of contraceptives among adults of reproductive age rose steadily from 18.3% in 1976 to 61.4% in 2007.² This can be directly credited to the family planning program founded in 1970 under the auspices of the National Family Planning Coordination Board (BKKBN – now the National Population and Family Planning Board) with the goals of addressing rapid population growth leading to economic progress and improving the health and quality of life for citizens.

Indonesia's Family Planning Program in Transition

The successes of the Indonesian family planning program can be attributed to several key factors. First, since the 1970s, there was a very strong political commitment from the government at all levels. Using strong behavior-change communications campaigns and the provision of clinic and integrated community-based services, BKKBN facilitated the decrease in the birth rate, a decrease in maternal mortality, and contributed to the health and increased economic participation of women. Strong campaigns promoted a small family ideal with aggressive messages such as "Two is Enough," and contributed to a change in social ideal for family size.

Secondly, in addition to national level campaigns and programs, services were integrated at the village-level and through multiple sectors. In the 1970s and onwards, about 35,000 salaried family planning field workers worked at the village level to promote contraceptive use, and motivate and recruit women into the family planning program.³ There were also about 100,000 volunteers who managed village-level family planning posts for re-supply of contraceptives. Many sectors were mobilized to promote family planning, including the army and police and NGOs.

Third, in the past, there were strong support and financial commitments from international donors and the Government of Indonesia (GoI) to the family planning program, and there was sufficient financing for the program.

³ *ibid*

¹ Ascobat Gani (2012). Social and economic benefits of family planning in Indonesia. Paper provided to UNFPA by author.

² *ibid*





However, given the successes of the program and Indonesia's gradual transition into middle-income country status, international donor commitments to family planning have declined sharply. This led to some significant transitions in the family planning program. By the beginning of the decade in 2000, almost all family planning programs were funded by the GoI, leading to a significant drop in funding for the program at that time. Systematic advocacy to high level decision makers has led to steady increases in the national family planning budget in recent years. Adapting to the loss of donor support, the government has expanded the role of the private sector, which now constitutes 69% of family planning services⁴. There have been notable successes in public-private partnership programs such as the *Lingkaran Biru* program for rural family planning access and midwife training.

A Human Rights-Based Approach to Family Planning in Indonesia

A human rights approach to family planning suggests that every individual of reproductive age has the right to access quality family planning information and services. This approach develops the capacities of individuals to claim their rights, and develops the capacities of governments and other duty-bearers to fulfill their obligations. The right to family planning is more than just the use of contraceptive methods. It is about how a person – especially a woman – can exercise her rights over her own body and make decisions such as when to start having sexual intercourse, when and with whom to get married, when is the right time to have a baby, how many

children to have, and how many years between children. Approaching the issue of family planning from a rights-based perspective puts the woman at the centre of the decision-making about her health.⁵

At the time of the International Conference on Population and Development (ICPD) in 1994, the dominant approach to family planning was demographically driven, where governments tended to enforce family planning programs as part of national population goals. The ICPD Programme of Action suggested an approach that is based on human rights and the needs, aspirations, and circumstances of each person.⁶ The right to family planning became part of a spectrum of reproductive rights, where every individual has the right choose whether to use family planning and what types of contraceptive services they would like to access.

The right to family planning is closely linked with the realization of other human rights, such as the right to health, the right to education and the achievement of a life with dignity. Delaying and spacing births through the use of effective contraception is essential for women's reproductive health and for the health of their children. The State of the World Population Report argues that "the inability to determine when to have children and how large a family to have results from and further reinforces social injustice and lack of freedom."⁷

A rights-based approach to family planning also has implications for the State, which is considered one of the main duty-bearers. According to ICPD, "states should take all appropriate measures to ensure, on

4 Dr. Agung Laksono (2012). Family Planning in Indonesia: Lessons Learned from Its Success. Background paper submitted to the London Summit.

5 Ninuk Widyantoro (2012). Family Planning and Human Rights. Paper provided to UNFPA by the author.

6 UNFPA (2012). By Choice, Not By Chance: Family Planning, Human Rights and Development. State of the World Population Report 2012.

7 *ibid*

the basis of equality of men and women, universal access to healthcare services, including those related to reproductive healthcare, which includes family planning and sexual health.”⁸ The State is also obligated to respect, protect and fulfill the right to contraceptive information and services.⁹

These rights are enshrined in the Constitution of Indonesia and other national laws such as the Law on Human Rights (Law No. 7/1984) and the new Health Law (No. 36/2009). The preamble of the Health Law states that every individual is the same before the law. It has a new chapter on reproductive health which supports the human rights principles to realize reproductive health rights, including better family planning. Under the family planning articles, it stated that everyone has the right to choose their own contraceptive method without coercion and that each choice will be provided according to the health status of the person. Another point under the family planning article is that a husband should support his wife and should participate in the family planning program including participating in the use of male contraceptives.¹⁰

Reproductive rights, in general, are legitimized through long-recognized international human rights instruments; Indonesia is a signatory to most of these international conventions, and has therefore, made international commitments to realizing these rights for its citizens. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979, ratified by Indonesia in 1984) states:

Article 12(1) States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Most recently, Indonesia completed its Universal Periodic Review (UPR) at the UN Human Rights Council. As signatories to international human rights conventions, most states undergo the UPR, a state-led process that reviews the human rights situation in the

country every 5 years. Indonesia was reviewed in the 13th session of the Human Rights Council in May 2012. The Gol was presented with 180 recommendations, of which 150 were accepted, including the following recommendations pertaining to the right to family planning:

A - 108.66. Eliminate completely all legal and political provisions which discriminate on the basis of civil status of women and violate sexual and reproductive rights;

A - 108.123. Provide universal access to family planning and reproductive health for young women and quality education on these issues;

A - 108.124. Ensure, through the Ministry of National Education, the inclusion of sexual and reproductive education in the national secondary curriculum as part of the preparation for adult life, which will contribute to prevent, inter alia, early marriage, unwanted pregnancy and the spread of HIV/AIDS among adolescents

While Indonesia has agreed to these provisions at the international level, the Indonesian Population Law No. 52/2009 mandates that national level family planning services are only provided to married couples, therefore discriminating on the basis of civil status. Government facilities do not provide contraceptives or family planning information to unmarried couples, leading these individuals to seek private sector family planning services or receive no service at all. This is contradictory to the Constitution, the Law on Human Rights, CEDAW, the Health Law, and most recently, Indonesia's commitments under the UPR process.¹¹

Adolescent sexual education is a second area of commitments made by the Gol at the Human Rights Council. The 2012 session of the Commission on Population and Development, chaired by Ambassador Hasan Kleib of Indonesia, also focused on adolescents and youth, and contained decisions on several issues related to youth sexual and reproductive rights that are directly applicable to Indonesia.¹² Because of the lack of legal basis for addressing issues of adolescent

⁸ ICPD (1994). Programme of Action. www.un.org/ecosocdev/geninfo/poplatin/cpd.htm

⁹ UNFPA (2012). *By Choice, Not By Chance: Family Planning, Human Rights and Development*. State of the World Population Report 2012.

¹⁰ Ninuk Widyantoro (2012). *Family Planning and Human Rights*. Paper provided to UNFPA by the author.

¹¹ *ibid*

¹² Commission on Population and Development. Resolution 2012/1: Adolescents and Youth. <http://www.un.org/esa/population/cpd/cpd2012/cpd45.htm>

sexual education in Indonesia, there is an inability to empower adolescents with comprehensive reproductive health and education, including information about contraceptive methods. Young people need to have the power to take responsibility for their own decisions about their health and their family planning. The level of knowledge among young people about contraception is quite low, since the adolescent reproductive health program for unmarried people ages 10-24 focuses only on moral issues and abstinence.¹³

The realization of universal human rights is a slow process, and in recognition of these realities, states can demonstrate that they are taking steps with a view to steadily achieving the full realization of these rights, to the extent of their maximum available resources. Achieving the right to family planning for all citizens of reproductive age will be a challenging process for Indonesia.

Challenges in extending access to everyone in Indonesia

Within the past 10 years, there have been a number of challenges to the successes of the national family planning program. First, BKKBN underwent decentralization under the Regional Autonomy Law in 2001, leading to significant variations in the delivery of the family planning program across Indonesia. The central authority of BKKBN continues to set policies, but the application of policies can be adjusted by district and local level authorities. Some district Family Planning Offices were closed and/or combined with other institutions. The quantity and quality of contraceptive services differed depending on local level commitments to family planning; in addition to central level procurement of contraceptive commodities, each regency/municipality also had parallel procurement systems. Measures have been taken to address these issues, such as the Presidential Regulation No. 7 of 2005 which calls for family planning revitalization.¹⁴

Second, historically family planning in Indonesia has been government mandated as part of national goals on population and economic growth and promoting health outcomes for families. The policy limiting access and information on family planning to married couples significantly reduces accessibility and affordability for other groups. This eligibility criteria for family



planning services also leads to several issues related to the measurement of the effectiveness of the family planning program. Unmet need for family planning has been defined as “the percentage of currently married women who either do not want any more children or want to wait before having their next birth, but are not using any method of family planning.”¹⁵ Thus, current data on the demand for family planning does not capture all people of reproductive age.

Third, access and availability of contraceptives remains an on-going challenge. Men’s participation in family planning is still low, remaining at about 1.5%, with only a 1.3% condom usage.¹⁶ The use of long term methods is declining, mainly as a result of the high up-front cost. Only 10.7% of women who want no more children are using long term methods.¹⁷ Under the Medical Practice Act No. 29/2004, only medical doctors can provide a resupply of contraceptives and contraceptives can only be stored in clinics that are under the supervision of doctors. This significantly limited the effectiveness of family planning field workers and midwives at the village level. As the prevalence of premarital sex increases¹⁸, access to contraceptives is a growing health concern for young people. Emergency contraception is part of a full range of contraceptive services, but is not widely available despite its impact on preventing unwanted pregnancies and abortion.

15 UNFPA Indonesia (2012). Universal Access to Reproductive Health Services: An Unfinished Business.

16 BPS – Statistics Indonesia, Indonesian Demographic and Health Survey, 2007.

17 *ibid*

18 UNFPA Indonesia. Supporting Document for Thematic Meeting on Reproductive Health ICPD Beyond 2014 Review, Surabaya, Sept 2012 based on data from Indonesian Demographic Health Survey, 2007

13 Ninuk Widyantoro (2012). Family Planning and Human Rights. Paper provided to UNFPA by the author.

14 *ibid*

Social and Economic Benefits of a Human Rights-Based Approach to Family Planning in Indonesia

Many experts agree that there are significant social and economic benefits to a rights-based approach to family planning. First, there are great benefits to each family, as women increasingly make reproductive health decisions based on the overall prosperity and aspirations of their children and their families. Family planning and birth spacing helps to increase the years of schooling for children, as families can afford to send fewer children to school for more years.

Second, fertility declines are associated with increases in women's paid labour force participation; in 2011, labour force participation among women was 52.4%.¹⁹ As women have fewer reproductive duties, they are increasingly able to be full workforce participants, which contributes to overall economic development of the country.

Third, at a national level, a manageable population growth rate translates into higher gross national product (GNP) per capita, and this translates into higher incomes, high savings, and higher investments. The combination of effective population growth management and rapid economic growth is the key in triggering wide-scale poverty eradication.²⁰

Fourth, and most importantly, family planning leads to healthier children. Women who have children in quick succession tend to be unhealthier. The health of a child is very much determined by health and nutritional status of the mother during pregnancy and during early childhood (1-5 years old). Diseases and undernutrition during pregnancy and in infants under 5 years old have a big impact on brain development in children. There is a significant difference in weight and brain cell density between healthy children and children having a history of infection and undernutrition. Undernutrition among children under 5 years old is currently a serious health problem in Indonesia. National Basic Health Survey in 2007 revealed that 18.4% of infants born have low birth weight, 36.8% of children under 5 years old experience stunting, and 13.6% experience wasting. Stunting can be prevented or reduced if infants are exclusively breast fed; however the 2007 survey reveals that only 32.4% of infants received exclusive breast feeding.²¹



¹⁹ Dr. Agung Laksono (2012). Family Planning in Indonesia: Lessons Learned from Its Success. Background paper submitted to the London Summit.

²⁰ *ibid*

²¹ Ascobat Gani (2012). Social and economic benefits of family planning in Indonesia. Paper provided to UNFPA by author.

Costs and Savings of Upholding the Right to Family Planning in Indonesia

Rights-based policies can only benefit individuals when they are supported by budgets – from government, donors and the private sector.²² Independent experts agree that in Indonesia, there is a significant cost to realizing the right to family planning for all individuals of reproductive age and thereby addressing the challenges and existing gaps in the national family planning program.

As international donors have withdrawn from providing family planning services in Indonesia, almost all family planning programs are being financed either solely by the GoI or in collaboration with the private sector. The national budget for family planning has steadily increased – from 600 billion Rp (2005) to 1.1 trillion Rp (2010) to its current 2.5 trillion Rp in 2012. This figure does not include the budget allocations provided by district and municipal governments. It also does not include the out-of-pocket expenses borne by the individuals accessing private sector services. Around 69% of family planning services are provided by the private sector, 22% by the government and 7.6% by other providers.²³

In the calculations of the cost of family planning, it is important to note that effective family planning programs lead to cost-savings in other areas. For instance, a UNFPA Indonesia study in 2005 shows that the cost of family planning over 5 years would lead to savings in the cost of antenatal care, delivery services and obstetric complications of about 28%.²⁴ There are also significant cost savings in the health system, education system and to households. The UN Population Division argues that globally, “For every dollar spent in family planning, between 2 and 6 dollars can be saved in interventions aimed at achieving other development goals.”²⁵

22 Steenberg, V. (2011) A Guide to Costing Human Rights. Equal in Rights.

23 Dr. Agung Laksono (2012). Family Planning in Indonesia: Lessons Learned from Its Success. Background paper submitted to the London Summit.

24 Sri Moertiningsih Adioetomo (2007). Study and Analysis: Reproductive Health Costing in Indonesia 2005-2010. UNFPA Indonesia.

25 UN Population Division. 2009. What would it take to accelerate fertility decline in the least developed countries? UN Population Division Policy Brief, No. 2009/1 March 2009 http://www.un.org/esa/population/publications/UNPD_policybriefs/UNPD_policy_brief1.pdf

Several cost-benefit analyses (CBA) have been performed in a number of regions in Indonesia by Professor Ascobat Gani at the University of Indonesia over the past 10 years. The results of the analyses are summarized in the following table.

Cost Benefit Analysis of Family Planning Programs

No	Location	Cost Benefit Ratio	Year
1	Jakarta	1 : 14.5	1997 – 2000
2	North Sumatra Province	1 : 2.3	2001 – 2003
3	Nangro Aceh Province	1 : 3.44	2001 – 2005
4	West Nusa Tenggara	1 : 2.95	2007

The cost benefit ratio indicates financial return from an investment of a certain amount. In Jakarta for example, investment of US\$1 in family planning will yield a return of US\$14.50 in four years in savings in government and household expenditures. The cost benefit ratio in Jakarta is quite high presumably due to high cost of education and reproductive health services that would be saved if the household reduced its fertility by practicing family planning. The other cost benefit ratios in the table are relatively consistent. The CBA analysis confirmed the assumption that family planning benefits both the household and government in the form of private and public savings. In other words, family planning is an economic investment with real financial return.²⁶

Realizing the right to family planning for all individuals of reproductive age is quite complex, especially in terms of national policies and budgets. However, there are several factors that can help realize these commitments. First, international human rights practice allows for a progressive realization of the policy and budgetary requirements to enable particular rights. Changes need to be gradual, well-planned, and use the most effective methods. These commitments can be gradually realized over the period of several years, with appropriate benchmarks for progress.

26 Ascobat Gani (2012). Social and economic benefits of family planning in Indonesia. Paper provided to UNFPA by author.



Second, while Indonesia's national family planning program is currently financed almost entirely at the national level, a rights-based argument for family planning has potential to attract additional partners, donors and public-private partnerships to expand and improve the quality of the national family planning program. Indonesia has a prominent role in shaping the post-2015 Millennium Development Goal (MDG) agenda through President Susilo Bambang Yudhoyono's co-chairing of the United Nation's High Level Panel (HLP) of Eminent Persons on the Post -2015 Agenda. Indonesia is also actively participating in the ICPD Post-2014 Review Process. These are just a few of the avenues that might lead to partnerships for co-financing an expansion of the family planning program.

Third, realizing the right to family planning in Indonesia may mean the examination of national laws that contradict international human rights commitments. A rights-based approach incorporates principles of equality and non-discrimination into the fiscal and budgetary policies, so that policies promote access for everyone. Questions of accessibility and affordability need to be at the forefront of policy making and budgetary commitments, especially in addressing the family planning rights of poor and marginalized groups.

Conclusion

As a broad international development agenda takes shape over the next few years, especially the post-MDG and post-2015 ICPD agendas, there will be a likely shift towards defining development goals in terms of the rights of individuals and communities. Family planning is increasingly recognized as a basic right of all individuals of reproductive age. Indonesia has long recognized the benefits of family planning and has implemented a largely successful family planning program over the past 40 years. A rights-based lens addresses persistent barriers to access for certain groups who have difficulties accessing family planning programs. For women, a rights-based approach to family planning puts them at the centre of decision-making about their health, and allows all Indonesians to realize a full spectrum of reproductive rights.

Monitoring ICPD goals: Selected Indicators for Indonesia²⁷

	Indicator	Indonesia	Asia-Pacific	World
Maternal and Newborn Health	Maternal mortality ratio (deaths per 100,000 live births), 2010	220	160	210
	Births attended by skilled health personnel 2000/2010	77%	69%	70%
	Adolescent birth rate per 1000 women, aged 15-19, 1991/2010	52	33	49
	Under age five mortality rate, per 1000 live births, 2010-2015	31	51.4	60
Sexual and Reproductive Health	Contraceptive prevalence rate, women aged 15-49, any method, 2007	61%	67%	63%
	Contraceptive prevalence rate, women aged 15-49, modern methods, 2007	57%	62%	57%
	Unmet need for family planning, 2007	9.1%	11%	12%
Education	Primary school enrolment for school-aged children 1999/2011, Male	97%	95%	92%
	Primary school enrolment for school-aged children 1999/2011, Female	93%	94%	90%
	Secondary school enrolment of school-aged children, 1999/2010, Male	68%	63%	64%
	Secondary school enrolment of school-aged children, 1999/2010, Female	67%	60%	61%

²⁷ UNFPA (2012). By Choice, Not By Chance: Family Planning, Human Rights and Development. State of the World Population Report 2012.