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THE ROLE OF I.U.D. IN THE INDONESIAN NATIONAL FAMILY PLANNING PROGRAM

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I N D E X .

THE ROLE OF I.U.D. IN THE INDONESIAN NATIONAL FAMILY PLANNING PROGRAM

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I. Population and its impact on Development in Indonesia;

Indonesia is an archipelago of three thousand islands, lying between the Indian Ocean in West and South, the South China Sea in the North and the Pacific Ocean in the East. It is a member of the Association of South East Asian Nations (ASEAN) with its neighbours : Thailand, Malaysia, Singapore and the Philippines.

In the five major islands, the man and land ratio is inequitably distributed. Java for example, covers only 7 percent of the land area but has 63 percent of the total population – with an average population density of 659 persons per square km. ; Kalimantan, on the other hand accounts for 28 percent of the land area, with only 4 percent of the population having an average density of 11 persons per square km.

Indonesia is predominantly Moslem (almost 90 percent). with the remainder Christians, Hindus etc. Although Indonesia has the largest Muslim population in the World, it is not a Muslim State.

Population problems pose constraints over the overall development of Indonesia – especially as a result of unequal distribution of the population, and the relatively high rate of population growth (about 2 percent per year).

The solution of these problems involves family planning and transmigration from Java and Bali to other less densely populated islands.

(II). The National Family Planning Program :

Development of the Program.

The earliest efforts in Family Planning in Indonesia began about 1957 by the Indonesian Planned Parenthood Association (IPPA).

Ten years later, IPPA organized the First National Congress of Family Planning in Jakarta.

In 1968 an Ad Hoc Committee was formed, which led to the establishment of a National Family Planning Institute, a semi governmental institute in which IPPA played a substantial role.

In 1968 an expert commission sponsored by U.N., World Bank and WHO visited Indonesia and made recommendations on various aspects of Family Planning Program, which became incorporated in the First Five Year Program of Family Planning.

In 1970, Presidential Instruction No. 8, followed by Presidential Instruction No. 33, 1972 established the National Family Planning Coordinating Board (NFPCB or BKKBN in Indonesian) as a fully governmental agency reporting directly to the President.

Since then, the program's mandate has grown to meet the increasing National needs in Java and Bali. In 1974, the Program extended its services to 10 provinces outside Java and Bali. The remaining 11 provinces will be incorporated in this year, with the start of the Third Five Year Family Planning Program (April 1979 to March 1984).

In 1978, (Presidential Instruction No. 38/1978) NFPCB was reorganized, and its responsibilities expanded to cover the broad population and beyond Family Planning Issues.

II.2 Goals and Phases of the Program. :

The ultimate goal of Indonesia's Family Planning Program is the widespread adoption of a small family norm.

In quantitative terms, the program is striving to reduce fertility as measured by CBR by 50 percent by the year 2000 from the 1970/71 level of about 44 per thousand.

To achieve this goal, while keeping in line with other development efforts, the National Family Planning Program is divided into three broad phases :

1. **Short Term Phase (5 – 10 years)** : to intensify informational and educational activities to implant Family Planning concept and services at the grassroots level.

   At the same time, the program, together with other government agencies and private groups, lays the foundation to integrate the idea of the small family norm in their own development program.

2. **Medium Term Phase (10 – 25 years)** : to completely integrate most of population program with existing government programs each ministry will devote part of its resources and manpower to combat the population problem in its own activities. The role of BKKBN here will be to coordinate various programs to ensure implementation of the overall population policy.

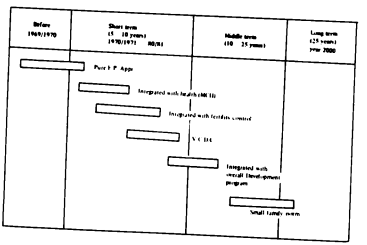
3. **Long Term Phase**, which has already begun but will need many years, is to create the Social economic and psychological conditions, where the small family norm becomes an integral part of Indonesian way of life.

II.3. Implementation of the Program : (table 1)

At the start, the Family Planning Pr gram as executed by IPPA was aimed Family Welfare with its three compc nents (Family Life Education – Infert lity – and spacing) i.e. Pure Family Planning Program, and was implemente in the MCH clinic, besides Information Education and Motivation.

For practical reasons, this Pure FP approach continued in the short tern program. After the establishment of BK KBN in 1970, and the integration o F.P. clinics with MCH clinics, there was also a gradual movement from the clinical based distribution of oral contraceptives to community based distribution by the establishment of Village Contraceptive Distribution Centres (VCDC) in 1974.

Tabel 1. Stages and Approaches.



Source *Haryono Suyono MA PhD (1)*

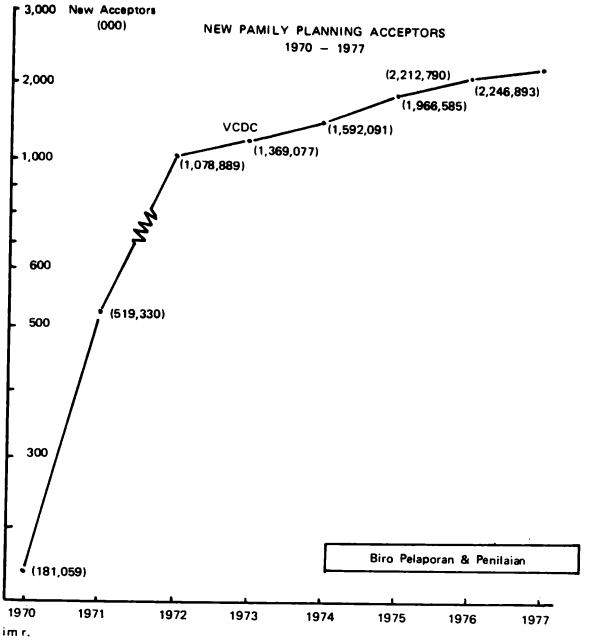
II.4. Results of the Program.

Figure 1 shows the development of the number of new acceptors, which in 1970 was 181.059 and quickly increased with the establishment of BKKBN, rising to 519,330 in 1971 and to 1.078. 889 in 1972.

With the establishment of VCDC, further increase in the number of acceptors

was achieved from 1.369.077 in 1973 to 2.246.893 in 1977.

Figure 1.



(III) Contraceptive Services.

III.1. Development of Contraceptives available

In the beginning of Family Planning efforts of IPPA, only foam tablets and diaphragm (Dutch Cap) were available, this latter in only limited numbers.

A year later, under a grant from the Pathfinder Fund, the Margeliez IUD was used, and shortly afterwards the Lippes Loop and the M device were introduced; as well as the Dalcon Shield. The M device was soon abandoned and the Dalcon shield was no longer available. Since that time till now only the Lippes Loop is used in the Program.

In 1958 the oral Pill became available for the first time on a limited scale in selected areas of the country. By the year 1971/72 there was already a major

shift from IUD to pill with the establishment of VCDC in 1974, the use of pills increased even more and by 1976/77, pill users have become the large majority.

Since 1976, Cu 7 and Cu T become available in the market, but these are very expensive and are only used by those who can afford them.

Along with IUD and pills, condoms have always been available and since 1974, their distribution was also made by Jamu (traditional herbs) dealers. (fig. 2, fig. 3)

fig. 2

fig. 2 Traditional herb factory

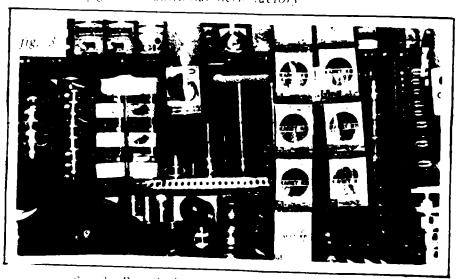


fig. 3

fig. 3 Retail shop
Karet K.B. = condom.

III.2. Result of Contraceptive Useage.

At the beginning of the Program, the majority of new acceptors were on IUD (55 %) while the pill constituted 37 % and condoms and others 8 %.

Table 2 shows the development of contraceptive acceptance from the start of BKKBN 1971/72 till 1976/77.

By the year 1971/72 there was already a start of shift to the pill with 54,2% of new acceptors, while the IUD acceptors became 41 % and condoms 3,1 %.

Table 2

New acceptances by contraceptive mix fiscal year years 1971 – 1972 through 1976 – 1977.

Fiscal Year	Total New Acceptors	Contraceptive mix			
		O.C.	IUD	Condom	Othe
Jawa – Bali					
71 – 72	519,330	54.2	41.0	3.1	1.7
72 – 73	1.078,889	56.3	35.2	7.2	1.3
73 – 74	1.369,077	62.6	21.4	15.4	0.6
74 – 75	1.475,016	68.5	11.3	19.3	0.9
75 – 76	1.785,908	67.5	12.5	18.8	1.2
76 – 77	1.979,445	66.8	18.4	12.8	2.0
Outher Island					
74 – 75	117,875	66.0	16.8	14.3	2.9
75 – 76	180,877	68.6	16.2	11.2	4.1
76 – 77	233,345	68.6	15.5	10.5	5.4

Source : Soetedjo M. ; Parsons J.S.

It can be seen that by 1974/75, the situation has been reversed. Pill new acceptors have become by and large the majority. In Java and Bali, the pill new acceptors became 68.5 % while IUD became 11.3%, condoms and others 20.2%. By 1976/77 the percentage are 66.8 % for the pill, 18.4 % for the IUD, 12.8 % for the condoms and 2 % for others including sterilization.

If the acceptance of contraceptives is considered by province, however, marked differences will be observed, as illustrated by Table 3.

Tabel 3 New acceptances by contraceptive mix by province (modified)
Java – Bali : 1976 – 1977

Province	Total New Acceptors	O.C.	Contraceptive mix		
			IUD	Condom	Other
Jakarta	128,876	61.6	15.4	18.0	5.0
West Java	597,443	89.6	3.3	5.5	1.6
Central Java	534,712	64.4	11.0	23.0	1.6
Yogyakarta	52,042	37.3	13.1	43.8	5.7
East Java	620,925	53.4	37.7	7.2	1.7
Bali	45,447	24.6	53.4	18.0	4.0
Java – Bali	1.979,445	66.8	18.4	12.8	2.0

Source : Soetedjo M.; Parsons J.S.

From this table, it can be seen that the acceptance of IUD in Jakarta, Central Java and Yogyakarta is about the same. In Bali, where people are mainly Hindu, IUD is the preferred method.

In East Java, the high incidence of IUD acceptance is probably due to the special attention given to the IUD by key program and government administrators.

In West Java, which is more conservative Muslim, the IUD use is low, and that province is predominantly a pill program.

On the whole, and because of the factors previously mentioned, there has been lately a shift to pills. Of the total of 8.7 millions new acceptors, 5.8 millions selected the pill and only 1.6 millions selected IUD (table 2).

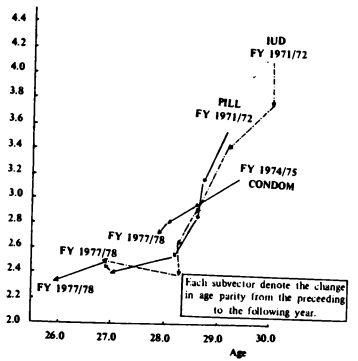
At the start of the program the new acceptors was about 29 – 30 years of age, with 3.7 – 4.2 living children. By 1977, the age of acceptance has declined to 26 – 27.5 years and parity declined to 2.4 – 2.8 children (fig.5).

It is thus seen, that the attractiveness of IUD for the group of women with higher parity and older age is due to the relative finality of the method in preventing unwanted or further pregnancies

IUD has generally been favoured by those women desiring to stop childbearing rather than to space pregnancies.

Figure 5.

AGE PARITY TRENDS, NEW ACCEPTORS BY CONTRACEPTIVE IN JAVA AND BALI



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(IV). The Role of I.U.D.: Present and Future.

IV.1. Development of the role IUD in the Program :

At the start of the Program, IUD new acceptors constituted the majority (55 %) whereas the new acceptors of pills were 27 % and condoms 18 %.

With the supplies of pills and their availability and distribution especially at the village level through VCDC, pills gained considerably until they became the method of choice : covering in 1977/78 72% of new acceptors, while IUD covered 19% and condoms and others 9%.

Although the proportion of IUD remained around 20% of new acceptors in recent years, the absolute number of new IUD acceptors increased dramatically from 58.000 in 1969 to about 500.000 in 1978.

Throughout, IUD users have tended to be slightly older with higher parity, as can be seen from the graph (fig. 5).

In terms of continuation rates, a Java and Bali survey in 1976/77 (Table 4) revealed that after 12 months of exposures some 64% of pill acceptors continued using the method, whereas 90% of IUD acceptors did. After 36 months, all but 32% of pill acceptors had terminated its use, whereas for IUD's only 25% did.

Table 4.
First method continuation and pregnancy rates by method Java-Bali.

Month once Acceptance	Pill			IUD			Condom		
	Accr	Se	Acpr	Accr	Se	Acpr	Accr	Se	Acpr
1	93.4	.6	1.	97.6	.6	3	91.5	1.7	2.4
6	75.4	1.2	9.5	93.4	1.1	1.4	65.4	3.8	12.7
12	64.2	1.7	17.8	89.8	1.3	4.8	55.8	4.1	18.3
24	47.1	2.1	34.5	79.7	1.9	10.5	52.1	4.4	28.9
36	32.3	2.7	50.6	74.1	2.4	13.4	...	...	...

Source : Soetedjo M., Parsons J.S. (2).

Note
Accpr = adjusted cumulative continuation rate.
Acpr = adjusted cumulative pregnancy rate.
Se = standard error.
... = denotes values based on sample size less than 15.

Although pill continuation rates in Indonesia are generally on a par with rates in other national programs in the region, IUD continuation rates are considerably better than most other programs elsewhere in the world.

The potential of IUD for affecting fertility in Indonesia is obviously much greater than any other method, if we consider the fact that abortion is illegal and sterilization is not popular.

IV.2. Measures to improve the Role of IUD in the Program.

The present role of IUD in the Indonesian Family Planning is in variance with its potential role.

Despite the superior effectiveness of IUD overall other contraceptive methods presently offered by the Program, its popularity is limited to less than one fifth the number of new acceptors each year; and these IUD acceptors tend to be slightly older and of higher parity than acceptors of other methods.

In order to strengthen the contribution of IUD assisting the Indonesian National Family Planning Program achieve its objective of a 50 percent decline in fertility between the years 1970 and 2000, several decisions have been made which will be implemented over the coming years:

1. A device more superior to the present Lippes Loop should be introduced into the Program.

Although the continuation rate of the existing Lippes Loops are quite high, there is some evidence that these rates are declining, partly in response to poorly locally manufactured devices. In addition, the device is only marginally attractive to the potential new acceptors, because of the various side effects and complications associated with Lippes Loop.

Various IUDs have been experimented within the Indonesian context. Continued international donor assistance will permit the program to offer a wider selection of more readily acceptable IUD devices than before.

2. A directive has gone out from the Chairman of NFPCB to all implementing units at all levels of government that acceptance of IUD is to be consciously and more explicitly encouraged than in the past.

3. Special information and motivation campaigns are to be undertaken in the belief that better and more relevant information concerning the IUD will greatly enhance its overall popularity.

4. Special problems about IUD which arise in an essentially Islamic society are to be addressed directly, including the notion that the IUD is an abortifacient, or the need for female medical and paramedical practitioners to insert the device.

5. New efforts are to be directed at making the IUD more readily available to the users.

Heretofore, the number of service points where IUD services or any contraceptive services were made available were limited primarily to government health clinics and certain private facilities. Since 1971, the National Family Planning Program has been enganged in expanding not only the range of Family Planning services offered but also the location of such services.

On most Java and Bali today, and in increasing areas of outer islands, contraceptive services are becoming more widely available in villages and hamlets, through the efforts of locally organized and operated acceptor groups, local networks of fieldworkers and outreach service activites of mobile medical teams. (fig. 6).

fig. 6 acceptor group organization.

Although these approaches remain essentially untried in the Indonesian context, especially for IUD, it is expected that the gap between the potential role of IUD and its present role can be greatly reduced.

V). Discussion.

The legal basis of the National Family Planning Program was needed to ensure that no coercion employed and has been established by the Presidential Instruction No. 8 (1970), No. 33 (1972) and No. 38 (1978).

Although IUD is the most effective contraceptive, it is less popular than the Pill. Its acceptance is largely affected by complications such as dislocations and perforations, and would be much improved if such complications could be eliminated. Also side effects such as low – back pain, dysmenorrhoea, spotting, and vaginal discharge could be kept to minimum.

So far, only Lippes Loop (or the spiral, as it is called in Indonesia) is used in the National Family Planning Program.

The need for trained medical personnel, preferably females, for insertion, as recommended by leaders should be met.

Previously held views that IUD is absortive is disappearing.

Whether contradictory views among religious leaders had influenced the use of IUD is difficult to assess. No concrete differences could be observed in the case of IUD (Table 5).

Table 5 Percentage New Acceptors by Religion and Contraceptive Type Java and Bali 10% sample 4th Quarter GOI FY 71/73

Type	Islam	Catholic	Christians	Hindu	Other
O.C.	58	39	53	25	54
IUD	39	49	40	69	43
Condom	2	8	6	6	1
Foam Tablet	1	4	2	1	1
	100	101	101	101	99

Source Soetedjo M., J.J. Clinton (4).

All acceptors	O.C.	56
	IUD	40
	Condom	3

Total may not add to 100% due to rounding

With more efforts and special program attention it is possible to increase the use of IUD, as was successfully demonstrated in East Java. (Table 3).

The quantity of IUD used is substantial.

During the First Five Year Plan (1969 – 74) 1.326.318 pieces were used. During the Second Five Year Plan (1974–1979) till November 1978, 1.874.633 pieces were used.

The role of IUD in Indonesia is at variance with its superior effectiveness. The shift from IUD (at the start of Family Planning) to pills has an adverse effect on achieving the target of 50% decline in the fertility of 1970/71 by the year 2000.

In order to strengthen the role of IUD in the Program, a number of decisions have been made, and will be implemented over the coming years.

Further, continous supply of IUD should be ensured. During the Third Five Year Plan, it is estimated that 9.418.230 IUD will be needed. (table 6).

Table 6

	IUD needed (pieces)
1979 – 1980	1.320.300
1980 – 1981	1.517.910
1981 – 1982	1.898.820
1982 – 1983	2.159.700
1983 – 1984	2.521.500
	9.418.230

Source : Biro Logistik – BKKBN.

These IUD needs are much higher (5 or 6 times more) than IUD used in the First or the Second Five Year Family Planning Program (Table 7).

Table 7

Contraceptive use

Five Year Plan		Orall Pill (cycles)	IUD (Pieces)	Condom (dozen)
First	1969/70 – 1973/74	13.947.314	1.326.318	330.318
Second	1974/75 – 1978/79	120.066.906	1.874.633	4.960.300 *
Third	1979/80 – 1983/84	253.530.000	9.418.230	13.592.345 **

* Figure untill November 1978
** Estimated
Source : Biro Logistik – BKKBN.

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