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**THE EVOLUTION OF PRIVATE SECTOR INVOLVEMENT
IN THE INDONESIAN FAMILY PLANNING PROGRAM:
TRANSFER OF RESPONSIBILITY
FROM THE GOVERNMENT TO THE PEOPLE**

By
Santoso S.Hamijoyo
Donald Chauls



**STATE MINISTRY FOR POPULATION /
NATIONAL FAMILY PLANNING COORDINATING BOARD**
Jakarta, December 1995

Family Planning activities in Indonesia were pioneered by the Indonesian Planned Parenthood Association or the Perkumpulan Keluarga Berencana Indonesia (PKBI) in 1957. When the family planning programme was absorbed as an integral part of the National development, a semi government body known as the National Board of Family Planning or the Lembaga Keluarga Berencana Nasional (LKBN) was established in 1968. As part of the speeding up to the implementation of the family planning programme the LKBN was changed into the National Family Planning Coordinating Board (NFPCB) or Badan Koordinasi Keluarga Berencana Nasional (BKKBN) in 1970. The BKKBN as a non department government institution is responsible directly to the President and is charged with the formulation of family planning and population policies which its implementation is supported by the implementing units. Support by government and private community institutions increased substantially during the year and ultimately the programme develops into a social Family Planning movement. Currently, as the Family Planning Movement enters the Fifth Five Year Development Plan, greater emphasis is placed on "Self reliant family planning".

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PREFACE

In 1987, BKKBN established the International Training Program (ITP) to host the ever-increasing number of foreign visitors we were receiving. Three different types of 'observation-study tours' are offered - scheduled multi-lateral (open to people from a mix of countries), scheduled bi-lateral (long-term multi- group arrangement with a single country), and non-scheduled (for groups whose timing or topical interest does not allow them to participate in scheduled programs). Under all types of programs, since the beginning of 1990, we have received an average of slightly over twenty participants every month.

During the first two years of the ITP's operation, ten brochures were prepared, on various topics, to assist participants to understand different aspects of the family planning program. In some instances, the information in those brochures is now outdated. Thus, ITP has decided to prepare a completely new set of reference materials to help outsiders to better understand the why's and how's of family planning in Indonesia. These brochures are intended to be both descriptive and analytical.

This brochure is intended as an overview of the past and current relationship between the government and the private sector in the family planning program. The private sector is defined broadly to cover any individuals or institutions who do not receive salaries from the family planning or health programs. The brochure was prepared for two different ITP audiences - those participating in Observation-Study Tours that focus on Social Marketing or some other topic directly related to the private sector (and for whom other documents describing and analyzing private sector activities in more detail are also available), and those participating in other OSTs focused on public sector activities, for whom a single overview of the relationship between the public and private sector might be useful.

We sincerely hope that readers will assist us to question the validity of this description and analysis. By doing so, they and we will accomplish two

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important goals - helping us to improve our program and obtaining ideas to improve their own. This is the essence of South-to-South collaboration. We would like to express our appreciation in advance to the readers of this brochure from whom we fully expect to learn ideas to make our program better.

We are grateful that the Chairman of BKKBN, DR. Haryono Suyono, provided us with the opportunity and guidance to prepare these papers. In addition, we would like to thank the BKKBN staff and consultants who contributed to its preparation. But we, the authors, take full responsibility for its content.

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GLOSSARY

- BKKBN** - Badan Koordinasi Keluarga Berencana Nasional, or National Family Planning Coordinating Board (NFPCB), a non-ministerial institution reporting directly to the President, in charge of the coordination and management of the family planning program.
- Dua Lima** -Literally, 'two five'; the brand name of a condom used in the first public-private social marketing effort in the mid-80s.
- IEC** -Information, Education, and Communications (for the family planning program).
- KB Mandiri** -Self-Reliant FP. A national campaign to encourage people to assume greater responsibility for family planning.
- PKBI** -Indonesian Planned Parenthood Association.
- PKMI** -Indonesian Association for Secure Contraception.
- PKK** -Women's Family Welfare Movement. A national organization, with branches down to the village level, to promote the role of women in family and community development. PKK plays a major role in the family planning activities, especially at village and sub-village levels.
- PLKB** -Family Planning Field Worker. The lowest-level employee of BKKBN. There are approximately 20,000 PLKBs in Indonesia.
- Posyandu** -Post for Integrated Services (the services being baby weighing, immunization, family planning, nutrition improvement, and diarrhea control). A monthly community-run event in every sub-village.
- PPKBD** -Village Family Planning Management Assistant. The chief

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A. Family Planning in Indonesia: An Historical Overview

Modern family planning in Indonesia began in the early 1950s, initiated by private medical practitioners and other concerned individuals. In 1957, some of these people combined their efforts to form the Indonesian Planned Parenthood Association (PKBI). The government's position at the time was officially opposed to family planning, although this was partially balanced by the fact that some of the leading persons in PKBI were in highly influential government positions.

With the New Order under President Suharto in the late 1960s, the government's position changed. In 1967, the President signed the World Population Declaration, presaging a move to address population issues more substantially. The first implementation efforts were made in the city of Jakarta through a special project begun in 1968. The following year, the National Family Planning Institute, a semi-government institution, was established to plan a nation-wide family planning program.

In the process of planning such a large-scale program, consideration was given to the expected roles of the public sector and of the private sector. It was concluded that the initial program had to be implemented primarily by the government, simply because of the large size of the country and the scope of the initial work that needed to be performed. If the program were to be established on a meaningful scale, it had to be done by an institution large enough to be effective: non-government organizations simply did not have the resources or the clout to be able to do so.

Yet the private sector was not completely ignored. The pioneering role of PKBI and other NGOs was recognized, and it was expected that they would continue to be supportive of a government-led effort.

The national government family planning program began in 1970 with the establishment of the National Family Planning Coordinating Board (BKKBN). From the very beginning, the word 'coordinating' in the title of the organization was taken seriously; in operational terms, it meant that BKKBN would not try to do everything itself, but rather would try to get other agencies to take on much of the responsibility and do much of the work, with BKKBN in the role

of linking their efforts. But this was to be an 'active' coordinating role, with BKKBN doing considerable prodding to ensure that services were really provided; in addition, all of the program support functions - planning, training, information, research, etc. - were also considered to be legitimate aspects of 'coordinating'. The 'other agencies' that were to be responsible for implementing much of the program meant private organizations as well as other units of the government.

B. Stages in the Development of the Program

One of the basic conclusions drawn from an extended process of planning that preceded the initial strategy development for the program was that the Indonesian people, in general, were not yet ready to take initiative in the area of family planning. In 1970, most knew little or nothing about it. Therefore it would not be reasonable to expect them, at first, to do much more than listen and then make individual or couple decisions. Thus, the initial program strategy had to be one where the government led the program for the people.

This decision then became the basis for the development of broad program planning strategy: if initially the program were to be by the government for the people, what should follow?

The early leaders of the program recognized that eventually the family planning effort had to become integrated into everyday life if it were to be sustainable. They also knew Indonesian culture well, and recognized that community action, encouraged and led by respected formal and informal community leaders, would be the most effective way to bring about sustained social change. Thus, they decided that eventually the family planning effort had to be one that was planned and run by the people; this became the key descriptor for the program's final stage. But in the interim, before that stage could be achieved, a transition stage would be needed, with government working with the people.

Thus, the idea of a program that would evolve through three different stages was very basic:

- o Stage 1 - for the people
- o Stage 2 - with the people
- o Stage 3 - by the people.

The next step was to flesh out this broad strategy, to identify what 'for', 'with', and 'by' the people meant in operational terms, plus the primary characteristics of each stage, and how one made a transition from one stage to the next.

The essential characterization of the stages for, with, and by the people are each summarized in a single term: expansion, maintenance, and institutionalization. Each term is, of course, an over-simplification, but nevertheless does capture the core intent of the stage - first, to expand the basic infrastructure of the program throughout the country, then, to maintain this initial structure while developing mechanisms to strengthen the program's achievement, and finally, to imbed this structure so deeply within the many groups of which the society is composed that family planning becomes truly institutionalized¹.

The transition from one stage to another does not occur at the same time in all places. First of all, the entire effort to develop a family planning program nation-wide was not begun everywhere at the same time, but rather staggered over a fifteen-year period. In addition to this, it was recognized that local cultural conditions, and even the relative effectiveness of different individuals in BKKBN or the Department of Health or the government administration could have a major impact on the rate of progress. Therefore, the timing of the transition was established on the basis of achievement criteria, rather than duration in the program or any other factor.

Eventually, for practical purposes, a quantitative measure of the appropriate time for each of the transitions to occur proved to be necessary. Transition from stage 1 to stage 2 was established at a contraceptive prevalence of approximately 35%, and from stage 2 to stage 3 at a CPR of approximately 55%. The main characteristics of each stage and rough criteria for each transition are described below.

¹Later, a fourth stage - integration of family planning with broader family and population development - was added. But this stage goes beyond what had been envisioned in the early 70s.

1. Stage 1: Program Expansion - FP By the Government FOR the People

The essence of the program's first stage was to establish a BKKBN presence as rapidly and as widely as possible, and to recruit as many new 'acceptors' as possible. For practical reasons, it was not possible to begin everywhere at once. It was decided to start first in Java and Bali, the areas which were, simultaneously, most densely populated and best developed in terms of administrative and communications infrastructure, and thus most capable of supporting any innovation. The program in the remainder of the country began, in two phases, at the start of the following five-year development plan periods. Thus, stage 1 began in Java-Bali in 1970, in Outer Islands I in 1974, and in Outer Islands II in 1979.

The initial activities of this first stage were to obtain personnel and set up BKKBN offices at provincial and district levels, then for the personnel of these offices to try to get other agencies to promote family planning. However, their initial success was minimal, and it was quickly recognized that BKKBN could not succeed unless it had its own personnel at lower levels. The first staff at sub-district level were established in the early 1970s.²

Initially, the sub-district staff - Family Planning Field Workers (PLKBs) and their supervisors - were assigned to work within the Department of Health's clinics. They were not medically trained; their job was to motivate for family planning anyone who came to the clinic for any purpose, then direct them to the clinic's medical personnel for appropriate services. The second aspect of their job was to maintain records of family planning services and supplies.

²The first sub-district level field workers were actually started by the Indonesian Planned Parenthood Association before BKKBN existed. These individuals were transferred to BKKBN, but only as temporary staff. Many of them could not fulfill standard civil service requirements to become government employees, primarily because they were older than the normal starting government employees. Although BKKBN tried to keep them - as it was recognized that their role was crucial to the success of the family planning program - bureaucracy prevailed. Many of these 'pioneers' had to be dropped and replaced by younger workers. By 1976, all sub-district and village-level positions were filled by official government employees.

Parallel to the establishment of a BKKBN presence at all levels, down to the sub-district level, BKKBN also worked with the Department of Health to provide technical training in contraceptives to the medical personnel and to provide an adequate supply of contraceptives.

This approach worked almost too well. Within a very short time, there was no longer a need to motivate the small proportion of the population that came to the clinics; most of them readily became family planning 'acceptors' (ie, contraceptive users). As a result, a phased transition to a program based more at community level was instituted. First the PLKBs extended their motivation from the clinics to the houses in the area immediately around the clinic. Then, when this succeeded, teams of sub-district personnel - including the PLKB, but also including other government and non-government personnel - visited outlying villages to motivate people and provide services. In the next phase, the PLKB was no longer clinic-based, but rather assigned to cover two or three villages, with her base being at the sub-district headquarters.

In 1976, the first steps were taken to develop what was to become an extensive community-based structure. Village-level volunteers were recruited, under the auspices of a nation-wide women's organization, the PKK, which has branches at all levels down to and including the village. The volunteers' title was 'Village Family Planning Management Assistant', although initially this title was broader than their job, as their responsibility in the 1970s and early 1980s was simply to serve as a village contraceptive distribution center for pill and condom resupply.

Other national and local non-government organizations - ranging from organizations of the wives of civil servants and the military to scouts and other youth groups - began what has become a continuing and expanding involvement in motivation and education concerning family life and family planning.

During this stage, a few private sector medical practitioners - primarily in urban areas - continued to provide services and contraceptives as part of their regular medical practice. There were no government restrictions on this practice; nor was there any government assistance.

By this time, the Indonesian Planned Parenthood Association (PKBI) had branches in most provinces. It continued its involvement in family planning through the provision of services by its members and through its small network of clinics. It also contributed by providing IUD services at a time when these were not included in the government's range of methods offered³. PKBI also conducted training on contraception for private doctors and midwives.

2. Stage 2: Program Maintenance - FP By the Government WITH the People

The transition from stage 1 to stage 2 could not occur until there were enough people to serve as a 'critical mass' - people who were themselves family planning participants and were interested in assisting the program to expand. This border was established as a Contraceptive Prevalence Rate of about 35%. At this level of participation, it was felt that there would be a sufficient quantity of people - primarily of women - to provide psychological support for each other in performing a task as culturally sensitive as motivating a neighbor to have a smaller family.

³In the early years of the program, the government quickly retreated from its initial promotion of IUDs because there was considerable opposition to this contraceptive method from religious leaders. Instead, they listened to the religious leaders, and discovered the reasons for their opposition. There were two reasons: some believed that an IUD was a form of abortion and many objected to a male service-provider inserting the IUD. The first required education. The second required compromise by BKKBN, agreeing in some cases to limit IUD insertion to female service-providers, in other cases to ensure that another woman or the client's husband be in the room. As a result of BKKBN's willingness to listen and to modify its policies to suit the concerns of religious leaders, formal deliberations were held among leading ulamas, and a 'fatwa', or Muslim religious decree was issued, on the basis of which the religious establishment agreed to support IUDs, and even formally requested that BKKBN add them to the program. Thus, although there was an initial delay of a couple of years, this has been more than counteracted by the active support of religious leaders for the program in general and for IUDs in particular.

In the second stage, it was necessary to maintain the achievements of the first stage, not simply in the sense of retaining a static level of contraceptive use, but rather in the sense of building institutions with the capability of ensuring that this CPR level (or higher) could continue. This was the transition stage between one primarily by the government and one primarily by the people. Thus, its focus on institution-building was to prepare for the eventual situation when these institutions could be self-sustaining.

During stage 2, the community approach expanded extensively. The Village FP Management Assistant (PPKBD), who had initially served only as a village contraceptive distribution center, took on far more substantial responsibilities for IEC, for logistics, for monitoring, for planning. Under her auspices, each sub-village established a '*Posyandu*', an integrated health and family planning services post in which community volunteers plan, implement, and evaluate a monthly service for all children under five and pregnant women⁴. Personnel from the Department of Health's sub-district health center and from BKKBN participate in these events, but the *Posyandus* continue to be real community institutions. With the guidance of the PLKB, the PPKBDs' roles have changed to become managers of *Posyandu* and other volunteers - thus fulfilling the meaning of their title. In most provinces, there is now an intermediate tier under each PPKBD, with a Sub-PPKBD for each sub-village, and *Posyandu* volunteers and other volunteers under her. There are many different types of volunteers under this structure, some of whom only work an hour or two per month for the program, others making far more substantial contributions. Nearly all responsibility for motivation of potential clients has been transferred to these village volunteers.

With the exception of pill and condom resupply, however, this village structure does not provide contraceptive services; in stage 2, this is still done nearly completely by the government health center personnel - partly when they come to the *Posyandus* and partly when the people go to the health centers.

During stage 2, sub-village-level groups of female family planning participants

⁴The *Posyandu*'s services and procedures evolved over several years, rather than beginning as a completed institution.

- Acceptors Groups - were expanded considerably². Acceptor Groups act as 'shock absorbers', deflecting problems before they develop. For example, if one member is experiencing slight bleeding after receiving an IUD, and complains to others in the group, another woman who has already encountered the same problem might describe her own similar experience, thus reducing her level of concern. One important result of this support arrangement is the very low level of reported contraceptive complications. These Acceptor Groups also serve as a form of social influence and control from below. Their village's fieldworker and volunteers know that Acceptor Group members exchange information about them, and thus must treat all members politely and fairly.

The primary 'private' involvement in the family planning program at this stage were the local volunteers, via non-government or semi-government institutions, such as PKK and Acceptor Groups.

During most of stage 2, the provision of contraceptive services by private sector medical practitioners was still on a small scale - in part because they still faced the difficulty of competing against free government services. Still, by 1987, even without any government encouragement, the contribution of the private sector to contraceptive use had reached 12%.

Beginning in 1985, the situation began to change, as BKKBN recognized the need to prepare for the transition to stage 3. Both the supply and demand side would have to be addressed - to have appropriate services and supplies available from the private sector and to have people willing to bypass the free government services.

²The first Acceptor Groups were established in 1975 during the first stage, but their key role has been to 'maintain' their members. During Acceptor Group meetings, members discuss the contraceptives they are using, exchange information on problems and consider possible changes. They may also discuss the motivation of other non-acceptor neighbors. Actually, most of a meeting's time is usually devoted to other issues, ranging from exchanging new recipes to reading religious passages. The monthly group meeting is an occasion for socializing, as well as for more serious purposes. This aspect is encouraged by BKKBN, which recognizes that such a formally-sanctioned but voluntary structure could not long survive unless the acceptors enjoy attending the meetings.

It was BKKBN's responsibility to plan the transition to the next stage. It never contemplated that the public sector would simply start charging fees, as BKKBN recognized that this would likely result in a significant drop in contraceptive use. Instead, the basic policy it adopted was to encourage people to make a conscious decision to pay for family planning, even though free services were still available. The encouragement was to be based on a mix of altruistic reasons and an advertising approach appealing to self-interest and status.

To prepare for stage 3, the first activity attempted was the marketing and sale of a partially-subsidized condom, *Dua Lima*. This was limited in scope to three urban areas, but it served both to expand private purchase and to provide BKKBN and several of its implementing units with experience in this very different approach to promoting contraceptive use. The basic model of this project was a government subsidy to reduce the cost of the product, government payment for a privately-run marketing campaign, and private sales of the condom. This same model was also followed in stage 3 with a broader range of contraceptives.

During this stage, PKBI expanded its clinical coverage, and several other family planning-focused non-government organizations and private health clinics/hospitals also joined in providing clinical services. Some of these - especially the Indonesian Association for Secure Contraception (PKMI) - complemented the government's efforts by providing two methods not promoted by the government - male and female sterilization⁶. In coordination with BKKBN, these NGOs also focused on research and action aimed at improving program and service quality. Finally, some of these organizations have also provided training in service provision, not only for their own but also for government personnel.

3. Stage 3: Program Institutionalization - FP BY the People

⁶The reason for sterilization not being included in the government program is similar to the initial exclusion of IUDs described above. BKKBN continues to conduct a dialogue with religious leaders opposed to these methods, and is clearly coming closer to a time when sterilization will be culturally and religiously acceptable to the Indonesian people.

The third stage in the evolution of the Indonesian family planning program is one in which the government no longer needs to take the initiative, but can now leave initiative to others. 'Others' means both individuals/couples (who decide upon and pay for their contraceptives and services), and community groups (who develop and implement motivational and service provision activities). In such a scenario, BKKBN becomes a 'behind-the-scenes' institution, providing a little help here and there, but not designing and directing the program. Family planning, instead of being a government program, becomes a community movement. The concept and the practice of family planning in this stage becomes completely institutionalized into society's norms as well as society's organized units.

Family planning clients are no longer perceived as 'acceptors', but rather as 'participants' in a family planning 'movement'.

For operational purposes, the rough guide used to determine when a place is ready for the transition from stage 2 to stage 3 was set at 55% CPR. At this level, approximately two-thirds of potential participants have at some time used some form of modern contraception, and over half continue to do so - a large enough proportion to form the basis for institutionalization.

The major difference between stage 3 and previous stages, from the perspective of the private sector, is that the government was no longer neutral towards their activities. Now it became the government policy - supported by substantial strategies, actions, and resources - to encourage as many people as possible to take responsibility for family planning, including paying the private sector fully or partially for their services and contraceptives.

The same community institutions begun in stage 1 and expanded in stage 2 continue in stage 3 to form the core of much of the activity'. Especially in

This community participation is described and analyzed in a set of three documents prepared by BKKBN's International Training Program:

- o The Events in Which Community Members Participate in the Indonesian Family Planning Program
- o Volunteers in the Indonesian Family Planning Program
- o Why Community Participation Succeeds in the Indonesian Family Planning Program

rural areas, the Acceptor Groups and the PKK with their volunteers are the institutions that are the nucleus for motivating people to become 'responsible' for their family planning. Community financing arrangements have evolved under their auspices to enable payment to be handled more efficiently and to provide opportunities for poorer people to contribute financially, even if their payments only partially cover the actual costs.

BKKBN addresses both the demand and supply side. It encourages the demand for family planning via the private sector through an extensive social marketing effort. Following the success of the *Dua Lima* project in the mid-80s, an expanded set of products and services were marketed under the Blue Circle logo and, more recently, a more-or-less complete set of products and services under the Gold Circle logo. Both are now large, nation-wide campaigns.

The core social marketing message is to encourage '*KB Mandiri*', or 'Self-reliant FP'. Both individuals/couples and community groups are targets of this campaign. BKKBN also supports it indirectly via a campaign among its own program staff and volunteers. Even the information system plays an indirect motivational role, as staff and volunteers are now required to collect and report information on the 'proportion of *mandiri* participants'.

On the supply side, BKKBN is now playing a major role in strengthening the ability of private medical practitioners to contribute to the family planning movement. Major government assistance to private doctors, midwives, and pharmacists is channelled through their professional organizations, especially in the form of training programs. Subsidies for the contraceptives (Blue Circle) enable the prices they charge to be lower than would be the case if the full commercial price were paid.

A different type of private involvement begun during this stage is the encouragement of business enterprises, such as factories and plantations, to establish their own family planning clinics and outreach services. Often, these services are not only offered to their employees and their families, but also to other people living and working in the vicinity of the institution.

- o Private sector service providers - doctors, midwives, and pharmacists;
- o Professional organizations of the service providers;
- o Local, national, and international non-government organizations similar to such organizations in other countries;
- o 'Semi'-government organizations such as the PKK, the Family Welfare Movement;
- o Village and sub-village groups set up directly under the auspices of the family planning program, such as Acceptors Groups and the PPKBD/Sub-PPKBDs and their organized volunteers;
- o Business institutions that provide family planning services or support the IEC effort for family planning; and
- o Religious leaders and their organizations that support family planning.
- o Journalists and other professionals and their organizations.

All of the above are 'private' in the sense that they do not receive salaries from the government. All have played important roles in the evolution of the family planning program.

Private community groups - most notably the Acceptors Groups, PPKBDs and Sub-PPKBDs, and PKK - have been at the core of the extensive community participation in the Indonesian family planning program. This involvement began late in stage 1, expanded considerably during stage 2, and continues, with ever-changing functions, at present. Although present in both urban and rural areas, these private community institutions tend to be most effective in rural parts of Indonesia. Quantitatively, this is the largest private sector involvement in the Indonesian family planning program.

Private medical practitioners were, for the most part, at the periphery of the family planning program during stage 1 and most of stage 2. The government neither encouraged nor discouraged them. Of course, since the Health

BKKBN. Often 'coordination' takes more substantial forms than simply sharing information; BKKBN may provide additional support, such as equipment, supplies, or funds.

One measure of the extent of private sector involvement in the family planning program is the proportion of people who now receive their contraceptive services outside the government sector. This statistic - currently 29.8%⁹ - is a mix of very different items, such as people paying private practitioners at full cost, people paying private practitioners at partially-subsidized cost, community financing schemes paying for contraceptives and/or services, factory or plantation clinics, and NGO clinics. Nevertheless, its rapid growth over the past few years presages a future when the bulk of the Indonesian people will really have 'taken responsibility' for their own family planning requirements.

C. Summary

In essence, the role of BKKBN in the Indonesian family planning program has been to stimulate and coordinate the activities of private and government implementing units, to perform the various program support functions, and to implement activities only in situations where no other appropriate potential implementing unit was available.

As the program has evolved from one stage to the next, BKKBN has focussed on preparing for the next stage, and hastening the transition. During all of the first and most of the second stage, this government agency was primarily concerned with the government family planning activities. Private action was not discouraged, but largely ignored. But beginning with the third stage, BKKBN has been playing a major role in supporting a transition towards much greater private involvement in family planning.

The 'private sector' has a number of very different meanings in the context of the Indonesian family planning program. There are:

⁹"Feedback report: Field Control for February 1994", Bureau of Reporting and Statistics, 29 March 1994.

- o Private sector service providers - doctors, midwives, and pharmacists;
- o Professional organizations of the service providers;
- o Local, national, and international non-government organizations similar to such organizations in other countries;
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- o Journalists and other professionals and their organizations.

All of the above are 'private' in the sense that they do not receive salaries from the government. All have played important roles in the evolution of the family planning program.

Private community groups - most notably the Acceptors Groups, PPKBDs and Sub-PPKBDs, and PKK - have been at the core of the extensive community participation in the Indonesian family planning program. This involvement began late in stage 1, expanded considerably during stage 2, and continues, with ever-changing functions, at present. Although present in both urban and rural areas, these private community institutions tend to be most effective in rural parts of Indonesia. Quantitatively, this is the largest private sector involvement in the Indonesian family planning program.

Private medical practitioners were, for the most part, at the periphery of the family planning program during stage 1 and most of stage 2. The government neither encouraged nor discouraged them. Of course, since the Health

Department's Health Centers offered free services and contraceptives to anyone, the private sector could only attract clients for whom cost was not an important factor. Private family planning-focussed organizations did play key roles in complementing the contraceptive methods offered in the government program, and in developing innovative approaches.

Late in stage 2, the situation began to change. As the next stage was expected to emphasize individual/couple responsibility for family planning - including paying for supplies and services - BKKBN needed to prepare both the public and private practitioners for the transition to this stage. The initial effort in this respect - the *Dua Lima* condom project - proved successful in preparing the family planning program for the much larger expansion of private sector service provision and social marketing as a tool to stimulate demand.

In stage 3, responsibility for fp shifts to the people - both as individuals/couples and as organized groups. Private sector service provision, for those who can afford it, is becoming the norm rather than the exception. To reach this stage, extensive government support is provided to prepare the potential clients and to prepare the potential service providers. This includes initial subsidies for contraceptives, training of service providers, and an extensive social marketing campaign aimed at both the clients and the providers.

In addition, BKKBN has promoted a variety of meanings for the concept of 'self-reliant family planning'. For those who can afford it, the meaning is conceptually simple - going to a private practitioner and paying market prices. For those less able to afford to pay full cost, a variety of approaches have been developed to enable them to pay part of the costs of their contraceptives and family planning services.

Thus, there continues to be a process through which the government sector and the private sector cooperate with each other. In the early years of the program, government was the 'parent', with different elements of the private sector as its children. Now these children are growing up, becoming independent. The government is a supportive parent, not objecting but helping them to achieve this independence.

Acceptor Groups and the PKK with their volunteers are the institutions that are the nucleus for motivating people to become 'responsible' for their family planning. community financing arrangements have evolved under their auspices to enable payment to be handled more efficiently and to provide opportunities for poorer people to contribute financially, even if their payments only partially cover the actual costs.

BKKBN addresses both the demand and supply side. It encourages the demand of the family planning via the private sector through an extensive social marketing effort. Following the success of the *Dua Lima* project in the mid-80s, an expanded set of products and services were marketed under the blue circle logo and, more recently, a more-or-less complete set of products and services under the gold circle logo. Both are now large, nation-wide campaigns.

The core social marketing message is to encourage '*KB Mandiri*', or 'Self-reliant FP'. Both individuals /couples and community groups are targets of this campaign. Couples are encouraged to be completely self-reliant if possible. But, for those who really cannot afford to pay fully for their services, opportunities are also created for partial self-reliance, whereby they pay part of the costs involved.

BKKBN also supports privatization indirectly via a campaign among its own program staff and volunteers. Even the information system plays an indirect motivational role, as staff and volunteers are now required to collect and report information on the 'propotion of *mandiri* participants'.

On the supply side, BKKBN is now playing a major role in strengthening the ability of private medical practitioners to contribute to the family planning movement. Major government assistance to private doctors, midwives, and pharmacists is channeled through their professional organizations, especially in the form of training programs. Subsidies for the contraceptives (Blue Circle) enable the prices they charge to be lower than would be the case if the full commercial price were paid.

A different type of private involvement begun during this stage is the encouragement of business enterprise, such as factories and plantations, to establish their own family planning clinics and outreach services. Often, these services are not only offered to their employees and their families, but also to other people living and working in the vicinity of institution.

Still another type of private business enterprise involvement has been to encourage sponsorship of some of the advertising for family planning. For example an automobile agency or bank may provide financial assistance for a billboard promoting the concept of the small, happy, prosperous family or promoting family planning self-reliance.

A very different type of private sector involvement in family planning has been by journalists, sociologists, and other non-medical professionals and their professional organizations. The media example is instructive: private media, of course, report on family planning activities as a normal aspect of reporting on the country's developments. But, to improve the quality as well as the quantity of this reporting, BKKBN has provided educational opportunities for journalists and help them, in conjunction with the national journalists' association, to establish a separate family planning journalists' unit. A result is that many journalists are very knowledgeable and interested in family planning and population matters, and the quality of their reporting is very good. Similar although less extensive relationships have also evolved with several other non-medical professional groups.

Many NGOs - including Muslim and Christian NGOs - continue, during this stage, to supplement the contraceptive services offered by the government and other private practitioners. Sterilization and menstrual regulation services are now provided by PKMI and PKBI. Some NGOs also assist through research and training activities¹⁰; for example, one NGO, *Yayasan Kusuma Buana*, as

10 Pudjo Rahardjo Creating a Conducive Atmosphere for the Collaboration Between the NGOs and the Government in Family Planning Program Expansion: Case Study of Indonesia, paper presented to ICOMP International Seminar on Management Challenges for the 1990s, Nanjing, China, May 1992) identified four major roles played by NGOs in the FP program: 1) satisfying unmet needs, 2) program institutionalization, 3) new initiatives, and 4) implementing where the government can not.

outreach program from its clinics, is trying to determine how best to serve urban slum populations; the lessons it learns are available to BKKBN and to other intitutions. Another, the Indonesians Association for secure contraception (PKMI), has been very active in designing standards and training for sterilization. Still another institution, *Raden Saleh* Clinic, conducts training on the insertion and removal of implants. All of these and most other private organizational efforts, are closely coordinated with BKKBN. Often 'coordination' takes more substantial forms than simply sharing information; BKKBN may provide additional support, such as equipment, supplies, or funds.

One measure of extent of private sector involvement in the family planning program is the proportion of people who know receive their contraceptive services outside the government sector. This statistic - currently 29.8 % - is a mix of very differents items, such as people paying private practitioners at full cost, people paying private practitioners at partially - subsidized cost, comunity financing schemes paying for contraceptives and / or services, factory or platation clinics, and NGO clinics. Nevertheless, its rapid growth over the past few years presages a future when the bulk of the indonesian people will really have 'taken responsibility' for their own family planning requirements.

11 "Feedback report : Field Control for February 1994 ", Bureau of Reporting and statistics, 29 March 1994.

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