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

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.

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

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*

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 services[4]. 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 GoI 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 GoI 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/populatin/icpd.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 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

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 increases[18], access to contraceptives is a growing health concern for young