

# Domestic Resource Flows

## Report of a case study in Indonesia

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The views expressed in this report are those of the mission and not necessarily those of the United Nations Population Fund.

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# Preface

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In the Programme of Action, adopted at the International Conference on Population and Development (ICPD) in Cairo on 5-13 September 1994, countries have committed themselves to attain specific goals in the field of population and sustainable development. Measuring financial resources, which countries commit to population activities is an important way to monitor the progress of the implementation of the Programme of Action of the ICPD.

UNFPA is collaborating with the Netherlands Interdisciplinary Demographic Institute (NIDI) to develop and maintain an updated system for the collection, analysis and dissemination of information on both international and domestic financial resource flows for population activities.

The classification of population activities in this study closely reflects the principles of the ICPD. For operational reasons, it was decided to restrict data collection to the 'ICPD costed package' mentioned in paragraph 13.14 of the Programme of Action. This means four categories of population activities:

- family planning services;
- reproductive health services;
- STD and HIV/AIDS programmes;
- basic research, data and population and development policy analysis.

In paragraph 13.15 of the same document, it is estimated that, in developing countries and countries with economies in transition, the implementation of programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analyzing population data will cost \$ 17.0 billion in 2000, and increase to \$ 21.7 billion in 2015. Two-third should be paid by the recipient countries, one-third will be paid by the international donor community.

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The case study in Indonesia was conducted from 10/08/1997 to 30/08/1997, and forms part of the UNFPA-NIDI project which measures global financial resource flows for population activities. For this purpose, questionnaires have been mailed in 1997 to public and private donor organizations in developed countries, and to government departments and national NGOs in developing countries. Collecting all this information from a broad range of respondents requires in-depth attention to issues of definitions, classifications, response rates and time lines. To better understand and resolve these problems, seven case studies will take place during 1997 and 1998. Indonesia was the first of these studies. The case studies will complement our knowledge about financial flows for population activities which were obtained through the mail enquiry.

Due to the complexity of international and national resource flows in population assistance, and the relative short duration of the study, it is possible that this report contains significant omissions or errors. The authors will welcome any comments or corrections.

Special thanks to Mr. Nesim Tmkaya, UNFPA representative, Mr. Peter Hagul, national project professional at the Jakarta UNFPA office, and to Mr. Asaad Malik, our research assistant during this period.

Frank Eelens and Marja Exterkate,

September 1997

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# 1. Demography of Indonesia

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With an estimated 200 million inhabitants, Indonesia has the world's fourth largest population after the People's Republic of China, India, and the United States.

Table 1 provides some basic demographic indicators for Indonesia during the last 25 years. Since the 1970s population growth in Indonesia has fallen constantly. Currently the annual growth rate is estimated as 1.5 per cent. The rate of growth between the various provinces and islands varies significantly. For example during the period 1985-1990, Java grew at an annual rate of 1.7 per cent, while Sumatra and Sulawesi saw their population increase annually by 2.7 per cent. During the last 25 years, fertility has dropped by nearly one half: from 5.6 births per woman in 1971 to 2.9 in recent years. An increase in the age at marriage accounted for part of the decline, but the major reason has been the rapid increase of contraceptive use. In 1971 less than ten per cent of married women used contraception. Nowadays this has increased to a level of 55 per cent. Also, mortality has declined significantly during this period. An important achievement of the first long-term development plan (1969-1994) was the reduction of infant mortality through integrated health and family planning services.

*Table 1. Basic demographic indicators*

	1971 census	1980 census	1990 census	1990-1995
Population (million)	119.2	147.5	179.4	200.45*
Annual growth rate	2.1	2.32	1.98	1.5
Per cent Urban	17.3	22.3	30.9	34**
Crude Birth Rate	40.6	35.5	27.9	25
Crude Death Rate	19.1	13.1	8.9	8
Total Fertility Rate	5.6	4.7	3.3	2.9
Infant Mortality Rate	142	112	70	58
Maternal Mortality Ratio			450***	425
Life expectancy at birth				
male	45	50.9	57.9	61
female	48	54	61.5	65

\* 1996.

\*\* World Development report, 1997.

\*\*\* 1986, Source: Unicef, master plan of operations, p. 4.

Sources: DHS, 1994.

1990-1995 data: Basic Social Services for all, 1997 and World Population, 1996.

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Within a period of twenty years (1970-1990), infant mortality was reduced by 50 per cent (142 per thousand to 70 per thousand). Reductions have continued during the nineties and currently the infant mortality is estimated to be 58 per thousand. Relative to its economic and social development Indonesia still faces high maternal mortality. These high levels remain a cause of serious concern. According to estimates by WHO/UNICEF, currently maternal mortality is as high as 650 per 100,000 births. One in 89 women in reproductive age dies of maternal causes. Women also suffer from a number of non-life threatening but serious reproductive health problems including anemia, infections and other obstetric complications (World Bank, 1997-2, p. 27).

Demographic changes in Indonesia have to be seen against the background of rapid economic growth and significant reduction in poverty. During the period 1987-1995, GNP per capita has increased from a level of 980 US\$ to 1410 US\$ (World Bank, World Development report, 1997, p. 214). With a GNP per capita of \$ 1410 (1995), Indonesia is classified as a 'Middle income economy'. In 1970, 54.2 million people were living below the poverty line. This implied a poverty rate of 40.1 per cent (38.8 per cent in urban areas and 40.4 per cent in rural areas). The poverty rate decreased to 11.4 per cent in 1996. About 22.6 million persons were considered to live below the poverty line. In 1996 the poverty line was established as 914 Rp. per day per person in the rural areas and 1,275 Rp. per day per person in the urban areas (Priyono Tjiptoherijanto, 1997, p.10).

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## 2. Methodological issues

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Data for this report were gathered in August 1997 by two staff member of the UNFPA/NIDI Resource Flows Team: Mr. F. Eelens and Ms. M. Exterkate. Valuable help was provided by Mr. Nesim Tümkaya, the UNFPA Representative and Mr. P. Hagul, UNFPA National Project Professional. The RF-team was assisted by Mr. Asaad Malik, from BKKBN, to collect the information.

The specific objectives of the case study in Indonesia are:

- to fine-tune and refine data collection procedures for estimating financial resource flows for population activities. These procedures can be used at a later stage in the global mail enquiry;
- to provide more information on how resource flows are directed towards population activities within the country and, to some extent, how the ICPD Programme of Action is implemented;
- as benchmarks for studying the quality of data gathered through the mail enquiry in other countries;
- to investigate the roles of NGOs and the private sector in the field of population activities;
- to study possible methods for sustainability used within the country: e.g. cost recovery in public programmes;
- to gather more information on financial sources in relation to the implementation of the Programme of Action of the ICPD: are there any changes in priority at the government or at the donors' level; has the ICPD Plan of Action influenced the population policy and programmes within the country? And how?
- to study co-ordination between and among government departments, NGOs and donors.

The Indonesian case study was planned during the global data collection period to gather data on financial flows for population activities for 1996. This was done to get more affinity with the process of data collection and to get acquainted with problems faced during this stage. During the week before the arrival of the international consultants questionnaires were distributed by the research assistant to three government departments and 19 Indonesian NGOs.

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From 10/08/97 to 31/08/97 interviews were held with representatives from ministries, international donors (bilateral, multilateral, private), and national and international NGOs in Jakarta and Yogyakarta. A total of ten national

NGOs were visited (seven in Jakarta, three in Yogyakarta), six government departments in Jakarta, and 20 field offices of international donors/NGOs/UN organizations (all in Jakarta). Annex 1 provides a list of all persons and organizations contacted during the case study.

With a few exceptions, the cooperation of all respondents was very positive. All government departments which received a questionnaire provided information and 16 out of 19 NGOs filled in the questionnaires.

To optimize the quality of the information, the team followed as much as possible a standard strategy:

- data were collected through the questionnaires;
- questionnaires were controlled and internal and external quality checks were done;
- during the interview with representatives from the organization, inconsistencies and uncertainties in the data were clarified;
- if necessary information was corrected or adapted, in some cases a second visit was made to the organization;
- written documentation about activities and the financial situation of the organization were collected as much as possible;
- in-depth oral information was gathered about various activities of the organization such as: historical overview of funding, implementation of the ICPD Programme of Action, future plans and activities, future financial outlook, et cetera.

The team is confident that the information obtained in the case study is of high quality. The fact that many of the organizations provided official financial overviews for 1996 or audited accounts has certainly improved the quality of the data. In many cases respondents had to invest considerable amounts of time and effort to come up with exact figures on financial aspects of their operation.

During the case studies it became clear that some aspects of the data collection pose some problems and that there is still further room for improvement in the coming years:

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- within the Resource Flows-project the population categories as defined in paragraph 13.14 the ICPD 'Programme of Action' (United Nations, ICPD94, vol. 1, p. 70) are used. An important problem is formed by the fact that the four population activity groups which are used to categorize financial flows are not completely mutually exclusive. Especially the lines between reproductive, health, family planning and sometimes HIV/AIDS prevention activities are not always obvious. Various respondents complained that, for instance, a condom distribution programme could easily be seen as a family planning or HIV/AIDS prevention programme. Equally, a project to promote longer periods of breast-feeding can be seen as a reproductive health activity, but equally has a natural family planning dimension;
- another problem is more of a political nature and was encountered by the team in its measurement of global financial flows. Many agencies, governmental and non-governmental, bring 'reproductive health' into their agenda whether or not it is in context. Sometimes the word 'population' in its broader sense is simply replaced with 'reproductive health' (for some interesting examples see Alaka M. Basu - 1997, p. 9);
- indirect national expenditures on staff, housing, utilities and so forth are often ignored, as well as other indirect financial mechanisms like e.g. television and radio broadcasting time for messages on population and family planning;
- the complexity of the funding of government health and family planning services, make it difficult to estimate exact expenditure figures;
- data on private sector sales are very hard to get. Estimates for this were mainly derived from the 1994 DHS survey.

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## 3. Official Population Policy and Programmes

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### 3.1 | Government Population Policy

The main responsibility for drafting the economic and social plans lies with the National Development Planning Board (BAPPENAS), which prepares the five-year plans. Since its inception in 1970, the National Family Planning Coordination Board (BKKBN) and the Department of Health have been responsible for implementing the policies aimed at reducing fertility and mortality respectively. In the past, the responsibility to formulate population policies was divided among different institutions (BKKBN, BAPPENAS and the Departments of Transmigration, Health, Manpower and Education). In 1983, with the appointment of a State Minister of Population and Environment, a clear mandate was given to one government agency to formulate the population policy. A major institutional change occurred in 1993. The responsibility of the State Minister was divided and two new ministers were added to the government: the Minister of Population and the Minister of Environment. Dr. Haryono Suyono was appointed State Minister of Population. Up to this moment he also continues his function as Chairman of BKKBN (UNFPA-PRSD, p. 15).

In Indonesia, the national development strategy is based on the ‘Trilogy of Development’: growth, equity and stability. Since 1987, the government was able to sustain a solid and rapid economic growth of about seven per cent per year. Although this growth has brought prosperity to many Indonesian families and economic benefits have trickled down to many more, the income gap between better off and less well off has widened. The government is fully aware of this situation and has launched several programmes since 1993 to narrow the uneven income distributions. These programmes include mutual partnership between large-medium-small scale businesses, improving the quality and quantity of cooperation, loan scale programmes, et cetera. Also, the prosperous family programme, which is being implemented by the BKKBN and which promotes the small and happy family, forms part of the government actions to battle poverty and to reduce income inequality.

Family Planning activities were initiated in Indonesia in 1957 by a Non Governmental Organization (PKBI) working under auspices of the International Planned Parenthood Federation (Central Bureau of Statistics, 1995, p. 4). It provided family planning advice and services as well as maternal and child health care.

The National Family Planning Programme was initiated soon after the installation of the New Order Government in 1966. During the first five year development programme (*Repelita I*, 1969-1974) family planning programmes were started in the six provinces of Java and Bali. In 1970, the family planning programme was launched by Presidential decree (State Ministry of Population, 1993, p. 32). This decree established the National Family Planning Coordinating Board (NFPCB or BKKBN). The BKKBN is a non-departmental body, and the Chairman reports directly to the President (Central Bureau of Statistics, 1995, p. 4). Family planning programmes of the BKKBN are integrated in Indonesia's five year development plans (*Repelita's*). Specifications of the population policy have been extended throughout the *Repelita's*.

The first Long Term Development Plan (PJPT 1: 1969-1994) included five *Repelita's*. At the beginning of *Repelita I* (1969-1973), the family planning programme was still a national programme organized by the private organization, with support from the government (State Ministry of Population, 1993, p. 34). Family planning was integrated with the health chapter. The main objectives were (UNFPA, 1995, p. 13):

- to improve the health and welfare of mothers and children as well as their families and the nation as a whole;
- to improve living conditions by decreasing the birth rate so that population growth would not outstrip productive capacity.

During *Repelita II* (1974-1978), the family planning programme was separated from the health chapter, and expanded to ten other provinces. The programme was guided by various targets for the number of new acceptors and of staff training. Under *Repelita III* (1979-1983), the family planning programme was extended to the whole country. The long term objectives were to reduce the fertility rate, increase life expectancy at birth, and reduce the mortality rate.

In *Repelita IV* (1984-1988), the institution of program management by the community was developed. *Repelita V* (1989-1993) envisaged increased community participation in and management of the programme, along with

greater self-reliance (UNFPA, 1995, p. 13/14), so that the family planning programme becomes a community movement (State Ministry of Population, 1993, p. 34). During the *Repelita V*, the Indonesian Family Planning programme followed three main policies (State Ministry of Population, 1993, p. 38 and UNFPA, 1995, p. 14):

- programme expansion: increase knowledge and awareness of family planning, and to enlarge coverage and accessibility of a network of community institutions managed by the people themselves; encourage people to adopt self-reliance or *KB Mandiri* and expand the role of the private sector;
- programme maintenance: integration of family planning acceptors with local activities, carried out by local women's organizations such as the Family Welfare Movement (PKK) or other rural development institutions, and through IEC efforts to make family planning a normal part of life;
- programme institutionalization: increasing participation of the local community, social organizations, and the business community in the management of the family planning programme.

*Repelita VI* is the first *Repelita* in the second Long Term Development Plan (PJPT 2, 1994-2019), which is described as taking Indonesia to a 'take-off' point or bringing the nation to the ranks of the Newly Industrializing Countries (USAID Indonesia, p. 1). Table 2 gives some quantitative goals during the second Long Term Development Plan.

In *Repelita VI* (1994-1998), the 'family approach' was introduced. This was to motivate community participation in the national family planning movement. The concept of 'family planning' has changed into 'small, happy and prosperous families'. Family planning is to be integrated with efforts to improve family welfare through economic and social development, public health and education with efforts to raise the age at marriage. The government is fully aware of the high levels of maternal mortality and has included the battle against mortality of young mothers as one of the major goals for *Repelita VI*. The aim to reduce maternal mortality by 50 per cent in the year 2000 will be a major challenge for the Ministry of Health.

*Table 2. Main targets in the second long term development plan, 1994-2019*

	Repelita V (1989-1993)	Repelita VI (1994-1998)	Repelita VII (1999-2004)	Repelita VIII (2005-2009)	Repelita IX (2010- 2014)	Repelita X (2015- 2019)
Growth rate (%)	1.66	1.51	1.37	1.2	1.01	0.88
CBR	24.5	22.6	20.9	19	17.2	16.1
CDR	7.9	7.5	7.2	7.1	7.1	7.4
IMR	58	50	43	37	31	26
Life expectancy	62.7	64.6	66.3	67.8	69.3	70.6
MMR	425	225	189	143	108	80
TFR	2.8	2.6				

Source: Repelita VI, Indonesia's sixth five-year development plan, p. 101.

In general, one can say that the family planning policy of the Indonesian government has evolved from a pure family planning and demographically target-driven approach towards a 'demand fulfillment' strategy. Focal points of this new strategy are the increase in the quality of services and an integrated reproductive health approach.

The aim of the Indonesian Family Planning Programme has been moving from a programme of 'family planning by the government for the people' to a programme of 'family planning by the people'. The programme aims to be responsive to demand for services from clients, rather than being dependent on motivation from the government (USAID, 1997, p. 3). Improving the quality of life of the population is now one of the main topics. In the view of the government, the 'small family' was reached during the first phase of the programme. Nowadays, the policy is focused on reaching the 'happy and prosperous family'. The government programme will be more and more directed towards poverty alleviation (the target in *Repelita VI* is to reduce the number of people living in absolute poverty to six per cent of the population), reproductive health, including increasing quality of care of family planning, reduction of maternal mortality, and the concern for the spread of HIV/AIDS and other Sexual Transmitted Diseases (STDs).

### **3.2 | Self reliance**

In *Repelita VI*, the aim of self-reliance of private persons in family planning was further stressed. In the earlier years of the family planning programme, the government provided most of the contraceptives and services through public health care facilities. Only a small number of acceptors went to private practitioners or commercial outlets. The programme has grown enormously over the years, and the demand for family planning services has become much higher. In order to expand the availability and choice of contraceptives and services, and to reduce the dependency from government and public services, the government policy has evolved towards promoting more self reliance. The government has set a goal to increase the share of the private sector in contraceptive distribution to 50 per cent by the year 2000, and envisages that eventually 80 per cent of the family planning users will obtain their services through the private sector, leaving only the poorest 20 per cent to be served by the government (UNFPA, 1995, p. 21). To meet this goal, the government has developed several programmes to promote the use of the private sector in family planning products and services (State Ministry of Population, 1993, p.134).

In 1987, the BKKBN launched the Blue Circle campaign to promote the use of private sector family planning providers. Especially doctors, midwives and pharmacies were seen as important agents in the delivery of family planning services. By 1989, this campaign has spread to all parts of Indonesia and had resulted in a high awareness of the Blue Circle logo (USAID, 1995, p. 3). External support for the Blue Circle came through USAID. At that time, BKKBN began a related campaign to promote self-sufficiency or *KB Mandiri*, with the objective to encourage the public to take responsibility (and pay) for their own family planning services and products. The Blue Circle Campaign became synonymous with the *KB Mandiri* campaign. Contraceptives were sold at 50 per cent of the market price.

In 1992 BKKBN launched the Gold Circle programme; an effort to expand the choice of contraceptives and their distribution, especially to rural areas (USAID, 1995, p. 3). This programme included a more 'complete' line of private sector contraceptives and services. The Gold Circle was totally funded by BKKBN.

### **3.3 | Social Welfare Programme**

Annually, family enumerations are held in villages, in order to monitor the progress of the prosperous family development. Based on a set of indicators, each family is categorized in one of five prosperity stages (pre-prosperous, prosperous I, II, III, III plus). Pre-prosperous families are indicated by being unable to fulfill the minimum basic needs such as spiritual needs (cannot perform the religious prayers according to their respective religious denominations), food (minimal two meals a day), clothing (more than one pair of clothing), and housing (larger portion of the floor is not earthen), health and family planning (brought to the health center in the case of illness). A family in prosperous stage I is able to meet their minimum physical needs, but has not fulfilled the social and psychological needs such as family interactions, neighbourhood interactions, and jobs which determine a good living standard. As soon as the data are collected, they are transferred to a 'working chart' developed to assist families throughout Indonesia to become self-reliant (Tjiptoherijanto, 1997, p. 19).

In December 1995, the government launched two important poverty alleviation programmes: 'Prosperous Family Savings' and 'Prosperous Family Business Loan' for poor families (stages pre-prosperous and prosperous I). These programmes were created to educate the Indonesian families on savings awareness. Loans provided by the government can be used to establish a small family business, through 'prosperous family income generating programs'.

In October 1996, the family planning and prosperous family programmes have been expanded and are combined (BKKBN, 1996, p. 66):

- family reproductive movement: family planning activities (towards self-reliance; including NGO and private sector involvement), safe motherhood (reduction of maternal mortality), STD and HIV/AIDS;
- family economic movement: empowerment of the family: through income generating projects. This includes the poverty alleviation;
- family resilient movement (social focused): resilience of family welfare: empowerment of those families with children under five and elderly people;
- empowerment of families through 'peer-counseling'.

The degree of services provided by these movements to a family depend on the stage this family has reached on the prosperity ladder: pre-prosperous and prosperous I families will be provided with free-of-charge family planning services. Families categorized as prosperous II, III, or III plus, will have to use self-reliant services (BKKBN, 1996, p. 81).

### **3.4 | Mother Friendly Movement**

In Indonesia, the maternal mortality ratio is higher than to be expected for a country with such an economic development. Besides, the level has been constant during the last ten years, (according to government estimates around 450 maternal deaths per 100.000 live births). In a sense, the family planning and health care delivery systems have failed to meet the reproductive health needs of Indonesian women at several levels. The high maternal mortality is caused by several factors. First, nearly 80 per cent of women give birth at home, frequently only attended by insufficiently trained traditional birth attendants and midwives. Second, most women do not seek or receive adequate pre- and post-natal services. Third, approximately 55 per cent of pregnant women are mildly or moderately anaemic, and many have reproductive tract infections which are not diagnosed and treated (USAID, 1997, p. 5).

On 22 December 1996 the National Mother Friendly programme was launched, with the objective to reduce maternal mortality in Indonesia. The programme has two major components:

- the mother friendly hospital initiative:  
to ensure that women's needs are included in district hospitals. It aims at improving the clinical aspects of hospital care and improving the availability of services of hospitals;
- the mother friendly subdistrict initiative:  
to create awareness in the community (men as well as women) to recognize 'at risk' pregnancies.

The National Mother Friendly programme is planned throughout the second long term development plan. Targets are to reduce maternal mortality by 50 per cent in 2000 to a level of 225 per 100.000 births, and to reach a level of 80 maternal deaths per 100.000 live births in 2015.

### **3.5 | HIV/AIDS, and other STD activities**

As of November 1996, 466 cases of HIV infection (112 of these AIDS) were officially reported by the Government of Indonesia. The actual number of infections is many times higher. A recent UNICEF report estimates that HIV infections have increased from 45,000 in 1993 to 144,000 in 1996. The World Health Organization estimates 95,000 HIV infections in 1996 (USAID, 1997, p. 7). The Government of Indonesia has begun to address HIV/AIDS as a national priority. In 1994, a national AIDS Strategy was

developed. Key programme areas in the Strategy are the following (Indonesian National Aids Strategy, 1994, p. 9):

- *Information, education, and communication.* The primary groups to reach by these activities are: the general public, health care providers, individuals and institutions with a special role (teachers, community and religious leaders as well as the mass media), women and adolescents, people with high risk behavior, people living with AIDS;
- *Prevention.* The primary objective is to ensure that all necessary supplies, services, information and support are available for all those who want to protect themselves and others. The government considers a close cooperation with NGOs and the international community essential to be successful. Other important activities in the field of prevention are blood testing from every donor, action against STD's, empowerment of women and protection against sexual exploitation;
- *Blood testing and counseling.* The objective is to determine a person's HIV status and provide moral support to those who are infected and their families. The government stresses that determining a person's HIV-status should be voluntary, confidential and accompanied by pre- and post-test counseling;
- *Treatment, service and care.* The government wants to ensure that treatment, service and care should be non-discriminatory, prompt and appropriate. Special attention should be dedicated to those providing service to people living with HIV/AIDS;
- *Research and study.* Research and study should aim at developing and improving HIV/AIDS policy, strategy and programming, monitoring the epidemiology of the disease, identify and develop alternative solutions to technical, medical and social problems.

Despite the strong political commitment for the prevention of HIV/AIDS, in the past the promotion by the government for the widespread use of condoms for HIV prevention was limited. It was argued that the promotion of condom use would give the impression that the government would condone promiscuity. Strengthening of individual moral and religious values was more appropriate as prevention against the epidemic. In early 1996, it seems that there has been more news regarding popular support for the use of condoms (Tuncer, 1996, p. 5). Still, the distribution of condoms to high risk groups in society is mostly done through NGO-channels.



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## 4. Financial Flows

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Figure 1 illustrates a framework of domestic financial flows in Indonesia. As can be seen the flows of financial means for population activities is complex. The main actors in this field are involved in many roles and their activities are intertwined by many links. For instance, the government is funding its own activities, functions also as a primary donor for local NGOs (and to some extent for multilateral agencies), but is also a final recipient of international funds for some of its programmes. Moreover, the government can also be seen as a kind of intermediate donor through which funds from the international community are channeled to third parties (NGOs and the private sector) to sponsor their activities in this field. Ideally, one should be able to quantify each of the flows presented in figure 1. There is no doubt that this would be a most interesting exercise, from which many important conclusions could be drawn. However, the data requirements to quantify all the financial links are huge and would need a much higher degree of internal consistency. Indonesia is a complex country where many population activities are going on. The time needed to gather all the necessary data, to check for internal consistency and to analyse the different flows would probably take more than half a year rather than several weeks.

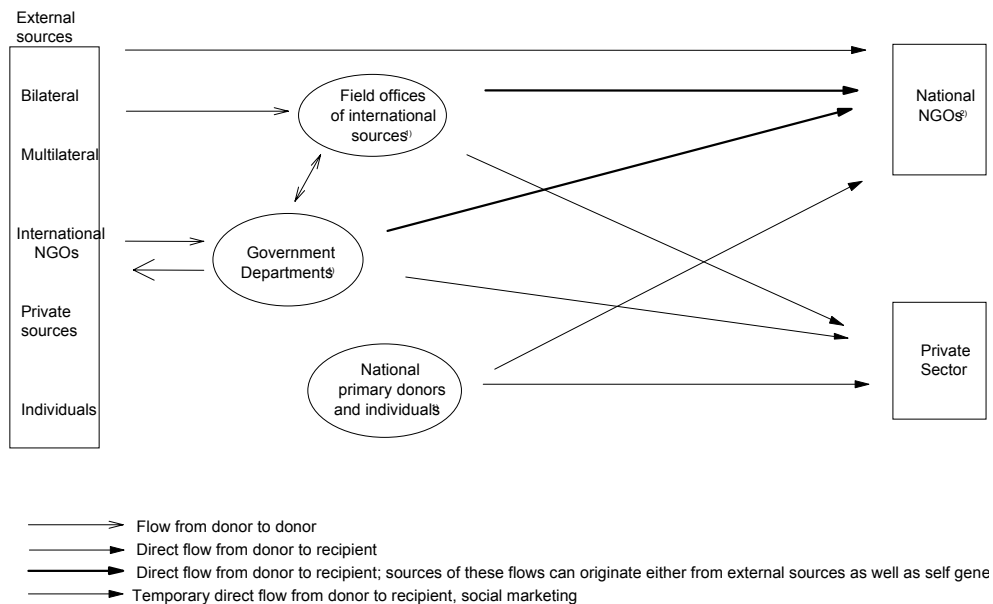
In section 4.1. we will first focus on the level and trends of international donor assistance to population activities in Indonesia. Then, we will pay attention to the role of the government and national NGOs in financing population activities (sections 4.2 and 4.3). Finally, an estimate is made of the role of the private sector in the Indonesian family planning programme.

### **4.1 | The Role of the International Donor Community**

#### *4.1.1. Historical Overview*

Over the last two decades, there have been several notable developments in the level and focus of external assistance channelled to the Indonesian Population and Family Planning Programmes:

*Figure 1. Framework of domestic financial flows in Indonesia*



<sup>1)</sup> Internal flows do exist as well: e.g. from the Ministry of Health to the Ministry of Population, or from USAID field office to PATH field

<sup>2)</sup> National NGOs receive funds for institutional strengthening and their Projects can be executed within each of the squares or

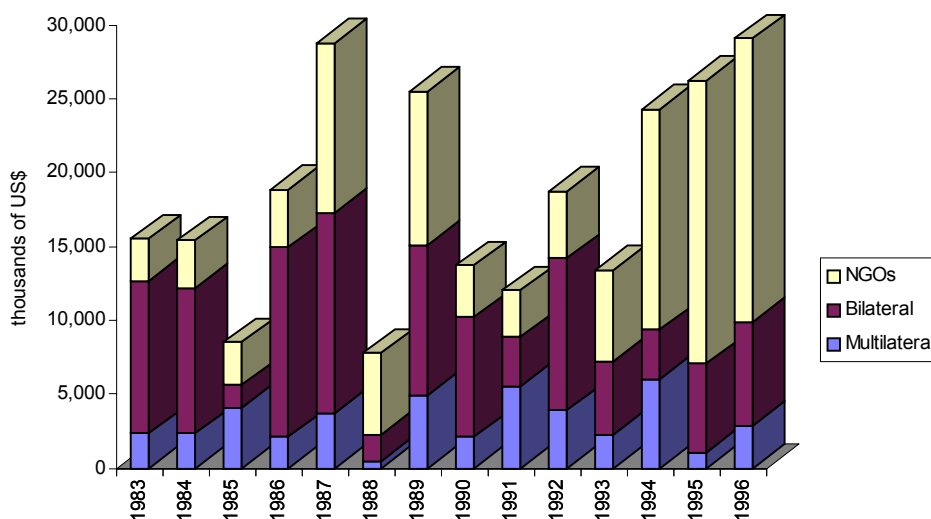
- since the 1980s, external assistance for the government population programme has declined significantly, and the portion paid from the government's own sources is now about 80-90 per cent of the total programme cost (State Ministry of Population, 1993, p. 134). About 10 to 20 per cent is funded by international donors (bilateral as well as multilateral). The international donors also finance a number of national population NGOs (State Ministry of Population, 1993, p. 134). Indonesia is almost self-sufficient in contraceptive production, except for Norplant. Currently, about 90 per cent of contraceptives in Indonesia is locally produced (UNFPA, 1995, p. 34);
- the focus of external assistance has evolved from basic support for institutional development and the expansion of the programme to assistance in more advanced programmatic areas. Much attention is now dedicated to the self-reliance and sustainability of population programmes (UNFPA, 1995, p. 34);
- population programmes are now seen in a much broader context as before. In recent years, donors seem to dedicate more and more funds to population programmes with multi-sectoral interventions, in which clear links are built in to other social (e.g. position of women, poverty alleviation) and environmental factors (UNFPA, 1995, p. 34);

- in recent years, with more insight gained and responding to new realities, other focal points have been incorporated in population such as: reproductive health needs of adolescents, HIV/AIDS prevention and maternal mortality. Donors have responded to these new points of attention and have made resources available to support necessary interventions.

Within the last ten years, yearly international financial assistance for population activities in Indonesia has fluctuated between US\$ 7.8 million in 1988 to US\$ 29 million in 1996 (excluding loans from the World Bank). The channel of funding fluctuated as well between bilateral, multilateral, and NGOs. Since 1993, however, a trend can be noticed that more funds have been distributed through international and national NGOs.

Figure 2 gives an overview of financial assistance in Indonesia by channel of distribution during the last ten years. In earlier years, international donors mainly worked with BKKBN. Over time this trend has changed. More recently, donors have broadened the scope of their assistance and now work with the Ministries of Health, Women's Affairs, and with national NGOs and private companies.

Figure 2. International assistance for population activities in Indonesia by channel of distribution, 1983-1996 (in thousands of US\$)



Source: GPAR reports, resource flows data base.

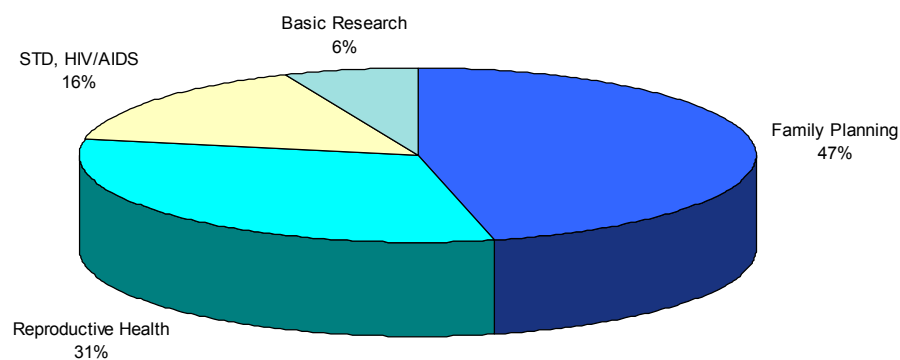
Despite some fluctuations, one observes that during the nineties the total amount of foreign assistance to population activities in Indonesia has increased. In 1994, Indonesia received 24.1 million US\$ in donor assistance. In 1995 and 1996 this amount increased to respectively 26.3 and 29 million US\$. In 1996, 66 per cent of the funds were distributed through national or international NGOs, 24 per cent through bilateral channels, and ten per cent multilaterally.

Figure 3 shows the distribution of these funds in 1996 over the four main ICPD categories. In 1996, family planning activities almost counted for half of the expenditures, with another third for reproductive health activities and the remaining 22 per cent for STD, HIV/AIDS and basic policy research activities.

#### *4.1.2 Main International Donors in the Field of Population and Development*

Many international donors are active in Indonesia. Some are primary donors: developed country governments and foundations of independent means. Others are intermediate donors, which receive most of their income from primary donors or from other intermediate donors. Among intermediate donors one can distinguish between multilateral organizations such as UNFPA or WHO, and international NGOs such as Pathfinder International and AVSC.

*Figure 3. External population assistance by category, Indonesia, 1996*



Source: RF96 Donor database.

In the following sections we will describe the activities of a number of primary and intermediate donors. The list of donors described is not exhaustive. The major international donors in Indonesia are UNFPA, Worldbank, and USAID.

### **A. Donor countries**

Over the years many developed countries have assisted Indonesia to develop and maintain its population programme. In the past the Netherlands has taken a special place in the development assistance to Indonesia. Through its historical links with Indonesia, the Netherlands played a major role among the other members of the donor community. Because of diplomatic discords, the Indonesian government has suspended all development links with the Netherlands since April 1992.

#### **USAID**

USAID has supported family planning activities in Indonesia since 1968, providing a total of nearly US\$ 250 million (UNFPA, 1994, p. 43) for technical assistance, training, contraceptives and policy and programme support. The assistance to the government has been centred around two main purposes: the expansion of family planning services in the country and the strengthening of the institutional capacity of BKKBN.

Population activities form an important aspect of development cooperation between the USA and Indonesia. In the past USAID support to population programmes was geared towards reaching the following programme outcomes (USAID, 1997, p. 11):

- increased use and quality of family planning services;
- increased use and quality of STD/HIV/AIDS and reproductive services;
- developing and implementing national AIDS and reproductive health policies;
- improving the balance of public and private sector provision of health and family planning services.

In 1996, 38 per cent of USAID's development aid in Indonesia goes into population activities. Its current activities have to be seen against the background of its plan to pull out of Indonesia in the beginning of the next century (2003). The first sector of the mission to close down is the population sector. USAID has developed a phase-out strategy to minimize the effects of the pull-out. The plan outlines a timetable for a two stage phase-out: 1996-2000 and 2001-2005.

USAID's assistance during the transition stage will focus on three 'result packages':

- increase use, quality and sustainability of family planning and other reproductive health services;
- increase use and quality of effective STD/HIV/AIDS prevention programs and sound policies development;
- sustainable financing of health services.

Table 3 provides more financial information about USAID's Transition Plan. USAID's financial commitments for population activities in Indonesia will be reduced from a level of US\$ 18.9 million in 1996 to US\$2.5 million during the last year of the programme. Reductions in funds will be most severe in fiscal years 1998 and 1999, when assistance will be reduced by US\$ 11 million.

USAID channels most of its population funds in Indonesia through US based international NGOs and private companies, which act as contractors, while national NGOs or government agencies (such as BKKBN) in many cases act as subcontractors. At the moment, many of these international NGOs have liaison offices in Jakarta (Population Council, Pathfinder International, JHPIEGO, AVSC). Most of their activities are almost exclusively sponsored by USAID. There is no doubt that with the withdrawal of USAID from the population field in Indonesia, most of these agencies will also have to reduce their activities or close their offices.

Since 1993, USAID family planning efforts have focussed on increasing the contraceptive prevalence rate (CPR) in heavily populated provinces and among hard-to-reach segments of the population, increasing availability and utilization of long-term methods and increasing sustainability and impact of family planning services delivered through commercial and non-governmental sectors (PRSD, p. 43). USAID's main programmes are:

- private Sector Family Planning Project (1990-1995): This bilateral project supported the BKKBN with the aim of increasing the use of private sector family planning products and services, especially longer-term contraceptives (IUDs, implants, sterilization). The total project budget was \$US 28 million through a US\$ 10 million grant to BKKBN, a US\$ 10 million contract with the University Research Corporation (URC), and US\$ 8 million was contributed by the Indonesian government. The project consisted of four, inter-related components:

*Table 3. Estimated budget for USAID/Indonesia Transition Plan (in thousand US\$)*

	1996	1997	1998	1999	2000	2001
Increased use, quality and sustainability of family planning and other reproductive health services	14,156	10,750	4,814	0	0	0
Increased use and quality of effective STD/ HIV/AIDS prevention programmes and sound policies development	1,040	6,100	8,300	6,100	3,000	2,500
Sustainable financing of health services	3,725	1,150	750	900	0	0
Total	18,921	18,000	13,864	7,000	3,000	2,500

Source: USAID/Indonesia, April 1997.

- social marketing, made up of the Blue Circle Products campaign;
  - community based distribution of contraceptive products and services;
  - strengthening of private sector family planning services;
  - promotion of long-term contraceptive methods.
- service Delivery Expansion Project (1994-1999): US\$ 50 million through Pathfinder International. This project promotes NGO and private sector involvement in efforts to improve programme quality, promote long-term family planning methods and expand the coverage of services to isolated areas. The programme works at two levels: the first one at government level through BKKBN, which receives 70-75 per cent of the funds, and the second level is through national NGOs, which receive 25-30 per cent of the money.
  - other smaller projects for strategic planning and operational policy development, private sector service delivery, provision of long term methods, survey research and programme evaluation (PRSD, p. 43). The major cooperating agencies are:
    - The Futures Group, to provide technical assistance for policy development and analysis, and social marketing;
    - AVSC, to strengthen the availability, quality and use of voluntary surgical contraction;
    - JHPIEGO, to provide technical support to the BKKBN national programme for IUD and NORPLANT clinical training;

- Deloitte and Touche, to promote sustainable family planning in the private and commercial sector;
  - Macro International for the Demographic Health Survey III;
  - John Hopkins University Population Communication Services, to promote the International Training Programme of the BKKBN through the production of videos and to provide technical assistance on IEC to the SDES programmes;
  - East-West Centre, for analysis of demographic and family planning data;
  - RAND Corporation, for the Indonesian Family Life Survey; and
  - Family Health International for the Women's Studies Project (Impact of family planning programs on women's lives);
  - Population Council: research and technical assistance;
- HIV/AIDS and STD Prevention Project (HAPP) (1995-2000): A US\$ 20 million project (plus a contribution of the Indonesian government of US\$ 6.7 million) to be implemented by the Ministry of Health with technical assistance from AIDSCAP and the Centre for Disease Control. All project activities will be integrated into the Indonesian National AIDS Program, guided by the National AIDS Strategy and five-year plan of action. It has four components: policy support, IEC for behaviour change, STD/HIV control and management, and condom social marketing.
  - Mother Care project: US\$ 0.5 million, through John Snow Inc.

### **AUSAID**

Actual annual disbursements of net official Australian development assistance to Indonesia for the 1996-1997 financial year was estimated to be US\$ 85 million. AUSAID's population activities in Indonesia form part of its broader health assistance sector. Most health activities supported by the Australian government are concentrated in the Eastern provinces. Especially the provinces of East Nusa Tenggara, West Nusa Tenggara, Irian Jaya and East Timor. These provinces are amongst the poorest in Indonesia. Through its programme Australia is providing assistance for maternal and child health programmes, family planning services and has launched a major project to combat the spread of HIV/AIDS (AUSAID, 1996). In the past, Australian aid to family planning programmes have been somewhat hampered by a conservative faction in the Australian parliament. The total amount allocated to health problems for financial year 1996-1997 is US\$ 6.5 million. Of this amount approximately US\$ 6 million could be considered population activities. In addition, through its 'Indonesian-Australian Specialized Training Project', the Australian government has allocated US\$ 13.7 million over three years to provide a programme of short term

specialized training courses. One of the three main components of this programme will focus on health training. Among others a training course for midwife trainers will be organized.

It is important to note that two population projects in Indonesia belong to the ten largest projects implemented by AUSAID worldwide. These projects are:

- The 'Women's Health and Family Planning' (1994-1996): US\$ 5.5 million. This project in East and West Nusa Tenggara provinces, aims to assist the Department of Health to enhance the quality of reproductive health care services and through BKKBN, to promote safe, voluntarily and accessible family planning services (AUSAID, 1996, p. 13). At the time of this study, AUSAID had disbursed US\$ 1.7 million to the project. The allocation for financial year 1996-1997 amounts to US\$ 2.3 million. The next phase of the project is planned for the coming years, and about US\$ 9.4 million would be allocated for this;
- HIV and STD prevention and care project (1994-1999): US\$ 16 million, of which US\$ 14.1 million will be contributed by AUSAID, and US\$ 1.9 million is counterpart money from the Indonesian government. The objective of this five year project is to improve the capacity of the Government of Indonesia to design and implement effective multi-sectoral HIV prevention strategies nationally, with emphasis on three Eastern provinces. The amount allocated for the current financial year is US\$ 3.4 million.

In the future AUSAID wants to continue its commitment to Indonesian population activities. Among others, special emphasis will be placed on maternal and child health. During our interview with the AUSAID population expert, it was indicated that in the coming years more activities will be executed through multilateral channels. Currently, the administration is preparing a collaborative project with UNICEF in this field in the provinces of Irian Jaya and West Java.

### **German Development Cooperation**

The German cooperation is particularly active in the field of HIV/AIDS prevention. The Kreditanstalt für Wiederaufbau (KfW) is undertaking a US\$ 14 million bilateral project over three years which commenced in 1996. Sites for the project include Jakarta, Surabaya and Bali. The project is centred around three components: blood safety, public sector IEC activities and condoms social marketing. Equipment will be provided to the Indonesian Red Cross to manage their blood banks. The condom social marketing component has been contracted to DKT. The country manager

began work in Jakarta in early 1996. This project forms part of the HIV Prevention Measures Programme of the Ministry of Health.

Total project costs for the HIV prevention measures programme are US\$ 14.1 million, which consists of US\$ 8.3 million from the KfW, US\$ 1.2 million from DKT, and US\$ 4.6 million is contributed by the Government of Indonesia.

## **B. International NGOs and Foundations**

### **Pathfinder International**

Pathfinder works in Indonesia since 1969. Between 1970 and 1980 Pathfinder worked closely with the BKKBN and two Muslim NGOs (Muhammadiyah and Nadhatul Ulama) to help legitimize the family planning programme.

In the early 1980's Pathfinder has been involved in the establishment of floating clinics in very remote areas. These boats provide family planning and primary health care services to people living along rivers, lakes and on islands. BKKBN has replicated this concept.

In 1994, they started the Service Delivery Expansion Support (SDES), a five year programme funded by USAID US\$ 50 million. The programme works at the government level, which receives 70-75 per cent of the money, and through ten national NGOs, which receive 25-30 per cent of the money.

The SDES project is implemented in eleven provinces, with the aim to assist Indonesia to reduce the TFR to less than 2.1 in 2005 (from 2.6 at present).

Objectives:

- increase accessibility of family planning services;
- increase quality of family planning services at delivery points;
- increase utilization of family planning services at delivery points;
- increase participation of national NGOs;
- increase long-term methods for family planning users;
- improve planning and monitoring system of BKKBN and national NGOs.

The major activities of the SDES project are:

- expanding service delivery points: hospitals, midwives, health posts, sub-centres;
- distribution and developing of IEC materials (through JHU/PCS);
- training of doctors/midwives/village workers for inserting IUDs, Norplant, and counseling techniques (through JHPIEGO);

- institutional development;
- research and development of innovative pilot projects.

Other projects of Pathfinder:

- family planning services through PKBI clinics, with emphasis on HIV/AIDS prevention and commercial sex workers (funded by Mauria Foundation, a private foundation in the USA);
- emergency contraception (ECP): developing a pilot demonstration (funded by the International Consortium of ECP, an ad-hoc group of seven international organizations);
- coordination of South-South Training Programmes;
- with John Snow Inc., a project in South Kalimantan with the aim of strengthening the role of midwives.

Before 1994, Pathfinders' annual expenditures were at a level of US\$ 500,000, including salaries and administration costs (ten per cent for salaries and administration; 90 per cent project costs). From 1994 onwards, when the SDES project started, their annual expenditures reached a level of around US\$ 10 million annually.

### **PATH (Program for Appropriate Technology)**

PATH has worked in Indonesia for about 15 years, managing health programs and introducing health technologies in collaboration with government departments, local NGOs, and private sector organizations. Its main areas of focus are transferring technology in areas of child survival, AIDS and STD initiatives, micro nutrient deficiencies, immunization, reproductive health, and strengthening institutional development. Originally, PATH only worked through the BKKBN. As more and more was taken over by the 'local agenda', and when things like 'promoting quality of care' became more important on the 'foreign agenda', PATH started working with national NGOs and private companies. They developed a new injectable, which is now delivered only through the private sector. Furthermore, they are promoting emergency contraception.

In the past the programme were managed vertically, nowadays, the approach is much more horizontally: multiple types of services are integrated (multiple subjects, but also the private sector approach). Because of this integration, it is only possible to make a very rough estimate of expenditures over the several population categories: 1/3 for nutrition, 1/3 for reproductive health (including neo-natal care), and 1/3 for HIV/AIDS.

For its activities, PATH receives funding from AUSAID, USAID and private foundations and companies. In 1996 approximately US\$ 800.000 has been spend in Indonesia.

### **DKT**

DKT began its social marketing project in Indonesia in 1996, as part of the HIV Prevention Measures Programme of the Ministry of Health. DKT contributes US\$ 1.2 million to this HIV prevention measures programme.

### **Ford Foundation**

The Foundation's work in Indonesia started with research and training in demography and other social sciences related to population issues and the development of management techniques during the late 1960s to early 1980s. Gradually the research focussed on child survival and community epidemiology during the eighties. Since the late eighties, reproductive health became the main agenda, first from an epidemiological perspective, later the womens' rights point of view.

At present, one of the main goals of the Ford Foundation in Indonesia is to enhance women's reproductive health, livelihoods, and access to opportunities. They are not involved in clinical practices of FP/RH, but more into women's rights, and work mainly through womens' activist groups, and publishers for publication of books related to reproductive health. In 1996, new projects in the Reproductive health programme in Indonesia amounted to US\$ 1.8 million of which US\$ 700,000 was spent on HIV/AIDS projects.

## **UN Organizations**

### **UNFPA**

UNFPA has started its activities in Indonesia in the early 1970s, by joining the Worldbank in financing the first five-year project. Up to now it has contributed a total of US\$ 116.2 million to population related programmes. UNFPA has worked in collaboration with the government, which has executed more than 50 per cent of the activities, NGOs, and United Nations agencies and organizations (UNFPA, 1995, p. 36). The aim of this programme was to strengthen the family planning programme in selected provinces and to increase the capacity of BKKBN to implement the programme (UNFPA, 1995, p. 36). UNFPA contributed US\$ 13.2 million for the implementation of the first programme.

The second country programme (1979-1984) was an extension of the first and amounted to US\$ 30 million. The third country programme (1986-1990) focussed on strengthening the quality of family planning services in eleven provinces of the Outer Islands and in the organized sectors of urban areas, with the aim of promoting the 'small, happy, and prosperous family norm' (UNFPA, 1995, p. 36). This programme amounted to US\$ 18 million. In 1991, the fourth country programme (1991-1994) started, with the focus on the needs of target audiences, to improve the quality of services and to incorporate women's concerns. This fourth programme was approved for US\$ 25 million.

The fifth country programme started in January 1995. The UNFPA assistance for the fifth programme amount to US\$ 30 million for a period of five years, of which US\$ 25 million would be programmed from UNFPA regular sources. The balance of US\$ 5 million is a combination from UNFPA regular resources and other financial means, such as multi-bilateral resources. The present five year programme is working towards a high degree of self-reliance on the part of the Indonesian government. An important element of the programme is directed to the further development of 'South-South' capabilities of the Indonesian population programme. Because of its successful population programme Indonesia should be able to share its experiences with other developing countries. Because of the maturity of the local population activities, the UNFPA support is mainly directed towards sophisticated activities in the fields of reproductive health and family planning, women, population and development; youth and the country's growing elderly population (UNFPA, 1995, p. 4).

Table 4 provides more information about the programming situation of the fifth country programme as of August 1997. As can be seen, a large majority of the available funds are earmarked for reproductive health activities. Out of a total of US\$ 30 million for the total programme, US\$ 18 million are allocated to the reproductive health programme area. Of this amount US\$ 11.2 belong to ongoing projects or projects which are in the pipeline. The HIV/AIDS prevention project (1.4 million) falls under the reproductive health programme. Moreover, most other projects belonging to other programme areas are in fact closely linked to reproductive health activities. For instance, in the youth programme area two ongoing projects deal with adolescent reproductive health, the South-South cooperation is exchange of information on reproductive health.

### **UNAIDS**

The new joint United Nations Programme on HIV/AIDS began formally on 1 January 1996. It brings together WHO, UNICEF, UNESCO, UNDP, UNFPA and the World Bank to improve UN coordination and support national actions to combat the spread of HIV/AIDS. Indonesia was one of the countries selected for UNAIDS support.

UNAIDS plays an important role in Indonesia for the coordination of HIV/AIDS programmes. This includes a UNAIDS country officer who works closely together with the Executive Secretary of Coordinating Ministry of People's Welfare. This activity is sponsored by UNAIDS for an amount of US\$ 200,000 for a period of two years.

An informal donor exchange meeting, chaired by the Executive Secretary of the Coordinating Ministry of People's Welfare is being held every three months.

### **WHO**

WHO implements two major projects in Indonesia, which are:

- The National STD and HIV/AIDS Programme, consisting of two sub-projects: STD case management and STD/HIV/AIDS surveillance and ensuring the quality and safety of condoms. This is a two-year project, of which the 1996 budget is roughly US\$ 300,000;
- Safe Motherhood, a two-year project, of which the 1996 budget is US\$ 458,000.

Table 4. UNFPA fifth country programme, programming situation per category

Programme areas	Budget	Ongoing & Pipeline	To be planned
A. Ongoing Projects			
B. Pipeline Projects			
<i>Reproductive health</i>			
Regular resources	15,000,000		
Multi-bi	3,000,000		
Ongoing projects		11,129,401	
Pipeline projects			
Sub Total	18,000,000	11,129,401	6,870,599
<i>Gender, Population and Development</i>			
Regular resources	3,000,000		
Ongoing projects		2,067,775	
Pipeline Projects			
Sub Total	3,000,000	2,067,775	932,225
<i>Youth</i>			
Regular resources	2,000,000		
Multi-bi	1,000,000		
Ongoing projects		1,734,175	
Pipeline Projects			
Sub Total	3,000,000	1,734,175	1,265,825
<i>Elderly</i>			
Regular resources	1,000,000		
Multi-bi	1,000,000		
Pipeline Projects		500,000	
Sub Total	2,000,000	500,000	1,500,000
<i>Pop. &amp; Environment</i>			
Regular resources	1,000,000		
Pipeline Projects		1,000,000	
Sub Total	1,000,000	1,000,000	0
<i>South-South Coop.</i>			
Regular resources	1,000,000		
Ongoing projects		943,210	
Pipeline Projects			
Sub Total	1,000,000	943,210	56,790
<i>Programme Reserve</i>			
Regular resources	2,000,000		
Ongoing projects		1,396,560	
Pipeline Projects			
Sub Total	2,000,000	1,396,560	603,440
<i>Grand Total</i>	30,000,000	18,771,121	11,228,879

**UNICEF**

UNICEF has no activities concerning family planning per se, but they are involved in reproductive health, in cooperation with UNFPA and WHO. They assist the MOH in decentralizing maternal and child health activities.

**D. Development Bank****World Bank**

Between 1972 and 1996, the World Bank was involved in five major population and family planning projects. In the first four population projects, all loans were provided to BKKBN in order to develop its family planning programme. Two third was used for providing hardware, e.g. infrastructure, buildings, equipment and vehicles. The first population project (1972-1978) amounted to US\$ 13.2 million, and aimed at assisting BKKBN to improve client motivation and family planning service delivery, and to strengthen BKKBN's capacity to coordinate the national family planning programme effectively. In addition to the Banks' loan, the Government of Indonesia contributed another US\$ 6.6 million. In 1977, the second population project started with a loan of US\$ 24.5 million for five years. The project focussed on assisting BKKBN in improving service delivery. The GOI contributed another US\$ 74.0 million to this project. In the third population project (1980-1985) assistance of BKKBN concentrated on decentralization of the management of the family planning programme. The IBRD loan was approved for US\$ 35 million, the GOI contribution of US\$ 37.6 million.

The fourth projects' (1985-1992) focus was to reduce the 1971 fertility rate by 50 per cent in 1990 and to reach all of the population of Indonesia through an intensive population education campaign. A budget of US\$ 46.0 million was approved.

The fifth population project (1992-1997), Family Planning and Safe Motherhood, is budgeted for US\$ 104 million, plus US\$ 44.4 million from the GOI. The project aims at decreasing fertility and maternal mortality, and includes two parts: the first one strengthens the family planning programme under BKKBN and the second part assists the MOH in strengthening its policy and training capacity for the deployment of midwives at the village level.

Another World Bank project, the third community health and nutrition project (1993 to 1996) aims at elevating infant, child and maternal health status by improving the effectiveness of community health and nutrition interventions in five provinces in Indonesia. The IBRD loan amounts to US\$ 93.5 million, the GOI contribution US\$ 52.1 million, and the KfW contributes another US\$ 18.5 million.

Future projects are:

- HIV, AIDS, STD prevention and management project (1996-1999): US\$ 24.8 million;
- GOI counterpart money: US\$ 10.4 million. This project assists in operationalizing and implementing the Indonesian national AIDS strategy, through the use of intensive pilot efforts to develop institutional mechanisms and interventions capable of reducing transmission of STDs and HIV in Indonesia;
- Safe Motherhood Project: A partnership and family approach (1997-2003): US\$ 42.5 million. GOI counterpart money: US\$ 19.4 million;
- Since the fifth population project, the Worldbank shifted its emphasis gradually from hardware to software: in the fourth population project, 70 per cent of the finances was spent on hardware; in the fifth 35-40 per cent; and in the Safe Motherhood project only 10-20 per cent of the finances is allocated for hardware.

### **Asian Development Bank**

The Asian Development Bank assists the Indonesian government in financing integrated population and health projects. From 1985 to 1995, two integrated health and population projects which aimed at improving delivery of health care and of family planning services were implemented with the MOH and the BKKBN. The first loan was approved for US\$ 41.6 million, the second US\$ 39.3 million. The GOI contributed US\$ 28.4 million to the first project, and US\$ 10 million to the second. A third integrated project, the Rural Health and Population Project (1994-2000) was financed for US\$ 40 million, in addition to the GOI contribution of US\$ 26.7 million, and aimed at raising the health status of the population in general, and in reducing IMR, MMR and TFR in selected areas in Sumatra.

Last year, a family health and nutrition project was approved (1996-2002) with the objective to improve the health status of the population and to ensure that this improved health status is maintained. Of the total loan of US\$ 45.0 million, US\$ 8 million is allocated for the population components.

## 4.2 | Role of the Government of Indonesia

Three government departments are involved in population activities as defined in this project: BKKBN, which is the major actor regarding family planning activities, part of the Ministry of Health, and the Ministry of Women Affairs, which started activities in 1987. With the formation of the State Ministry of Population in 1983, a broader view of population is being promoted at the national level. Recent estimates show that the family planning programme obtains about 0.5 per cent of the total national budget (State Ministry of Population, 1993, p. 133). If one includes other sectors related to population, the estimated budget of the entire population programme during *Repelita V* was 22 per cent of the total country budget (State Ministry of Population, 1993, p. 133).

The pattern of funding government health and family planning services in Indonesia is complex (USAID Indonesia, p. 47, and personal communication). The national, regional, and the village levels have autonomous budgets.

Funds for Health Services are derived from:

- The budget at the national level, which consists of:
  - APBN DIP: central government development budget;
  - APBN DIK: central government routine budget;
  - National reserves;
  - International loans/grants.
- The budget at the provincial level (27 provinces), which consists of:
  - APBD1 DIP: provincial health department development budget;
  - APBD1 DIK: provincial health department routine budget;
  - Provincial net income;
  - Provincial reserves;
  - (Sometimes) international loans/grants.
  - The budget at the district level (about 320), which consists of:
    - APBD2 DIP: district health department development budget;
    - APBD2 DIK: district health department routine budget;
    - District net income;
    - District reserves.

The development budgets (DIP) are used for equipment, materials, land purchase, construction, honoraria, and incentives. The routine budgets (DIK) support recurring costs, such as salaries, maintenance, utilities and supplies.

Funds for Family Planning Services are derived from:

Government funding to BKKBN for the national family planning programme is less complex; this comes only from three centralized sources: APBN DIP, APBN DIK, and foreign aid. Funds from these sources are disbursed from the central BKKBN to its provincial and district administrative units for all investment and recurrent expenditures incurred by the national family planning programme.

### **BKKBN**

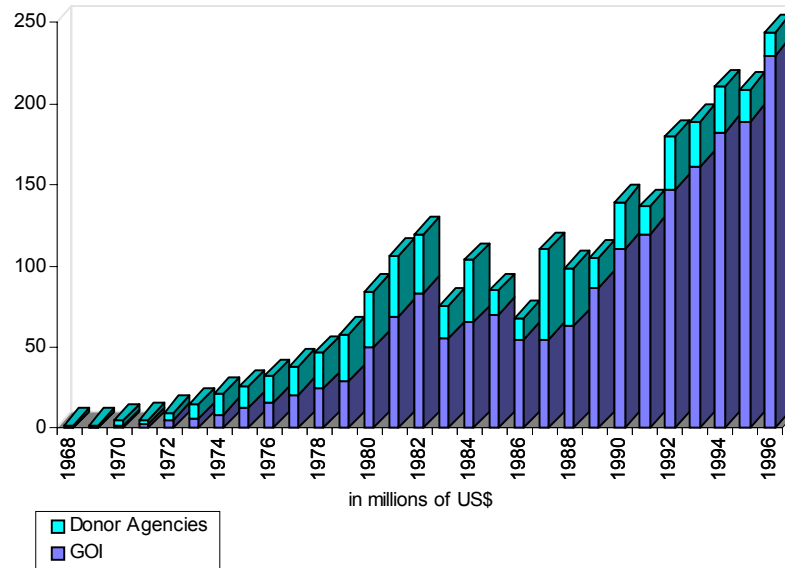
Figure 4 gives an overview of financial resources of BKKBN for Indonesia's population and family planning program.

The amount spent on Indonesia's population and family planning program in 1970 was nearly US\$ 5 million, of which 72 per cent originated from external sources. In 1980 the total amount had increased to \$US 84,5 million, of which 41 per cent originated from outside.

Major declines in both government and international funding can be noticed in 1983 and 1986. The decline in 1986 can be explained by the collapsing oil prices which resulted in a decline in government income in general. In 1990, total funding reached a level of \$US 139 million of which only 21 per cent was paid by the international community.

In 1996, the total allocations of BKKBN were around 572 billion rupiah, which is around US\$ 229 million. This amount includes re-current costs like salaries, maintenance, and routine costs. Excluding this post, 345 billion rupiah (or US\$ 137 million) is allocated for the development of activities and procurement of contraceptives. Only ten per cent of this money comes from external sources (USAID/Pathfinder, UNFPA, Asian Development Bank, World Bank, and AUSAID).

Figure 4. Government and donor funding for Indonesia's population; family planning programme, 1968-1997.



Sources: PRSD, Indonesia and BKKBN annual financial reports

For 1996 US\$ 282 million has been allocated. Looking at the expenditures, we see that 326 billion rupiah (US\$ 130 million) has been spent, of which only five per cent originates from external sources.

An interesting aspect of the population programme of BKKBN is that in the past ten years, it has been able to share its own experiences with other developing countries. The International Training Program (ITP), established in 1987, is a special non-profit unit in the BKKBN. ITP emphasizes the features of the Indonesian community level-program. Its main activities consist of the following elements:

- Observation Study Tours: Consultancy and advice. A group of about 30 to 40 consultants have gone to 25-30 countries to give advice, training, target setting, et cetera;
- internship: one participant from another country comes to Indonesia and works with the local staff in a village. About 50 people, mostly from African countries have joined this programme.

ITP enrollment is impressive. By mid-1996 over 2700 persons had participated in Observation Study Tours organized by the Programme. ITP has been supported by many different sponsors through bilateral, multilateral, private and development bank channels. Sponsors including USAID (50 per cent), UNFPA (25 per cent), UNDP, Asian Development Bank, World Bank, WHO, FAO, ESCAP, UNICEF, UNESCO, IPPF, JICA, British Council, Danida, JOICFP, the Government of the Netherlands, CEDPA, Population Council, Asia Foundation, SPAFH, JSI, Futures Group, PT Organon, as well as the Government of Indonesia (BKKBN, s.d., p. 16). ITP is a non-profit organization which tries to cover part of its expenses by charging tuition fees for scheduled and non-scheduled study tours. Tuition fees vary from 1,500 US\$ for a 10-day study tour, to 1800 US\$ study tour for a three week course.

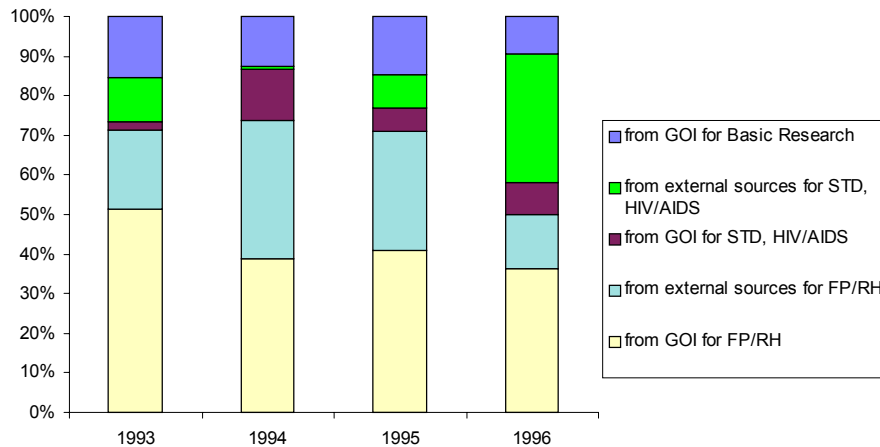
### **Ministry of Health**

The share of the four ICPD categories in the budget of the Ministry of Health is small: between 1993 and 1996 on average 2 to 2.5 per cent was allocated by the Ministry of Health to one of these four ICPD categories. The total amount for these four categories has increased from US\$ 6 million in 1993 to US\$ 11 million in 1996. When we look at the total budget of the Ministry of Health, including international financial assistance, we can see that the budget for these four categories has increased from US\$ 9 million to US\$ 22 million.

The contribution of the International Community (mainly World Bank, Asian Development Bank, USAID, AUSAID, and Germany) has increased from 31 per cent in 1993 to 46 per cent in 1996.

During 1993-1995, around 70 per cent of the population related budget has been allocated for Family Planning/Reproductive Health, around 13 per cent for STD, HIV/AIDS, and 14-15 per cent for Basic research. In 1996, this changed: 50 per cent was allocated for Family Planning/ Reproductive Health, 40 per cent for STD, HIV/AIDS, and ten per cent for basic research. It can be noted that the International Community has shifted its emphasis away from Reproductive Health as such towards STD, HIV/AIDS activities. Figure 5 gives a breakdown of the population related budget of the Ministry of Health by these four categories, and the source of funds.

Figure 5. Contributions of ICPD categories to the population segment of the Ministry of Health budget, Indonesia, 1993-1996



Source: Ministry of Health.

### Ministry of Women's Affairs

The Ministry of Women's Affairs was established in 1987. The ministry has a coordinating task and is not a line ministry. It sets out a policy concerning women's affairs, focussing on:

- policy on improvement of family welfare;
- policy on women workers: promote productivity and welfare;
- policy on training for women;
- policy on socio-cultural aspects of the development of the role of women.

The Ministry of Women's Affairs was the coordinating body behind the Mother Friendly Movement. During 1996, the Ministry of Women's Affairs spend approximately for US\$ 1.2 million on projects, and received all this funding from the international community (UNFPA, UNICEF, WHO, USAID, the Development Banks). During this study, no information was available on projects which were financed by the government.

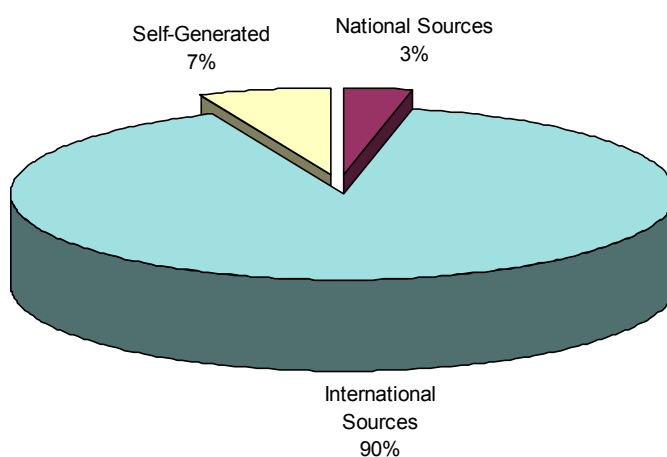
### 4.3 | Role of national NGOs

There are many national NGOs in Indonesia, distributed all over the country. NGOs emphasize the quality of services and pay a lot of attention to counseling. Some of them have a pioneer function, or work with special target groups (e.g. youth or commercial sex workers).

Indonesian NGOs are largely dependent on international financial sources. The total income in 1996 from the 16 NGOs which filled in the questionnaires, amounted to US\$ 3.9 million. As can be seen in figure 6, 90 per cent of the income comes from international sources (mostly UNFPA, or USAID through executing agencies). This creates a dependent relation, and contributes to an insecure future of Indonesian NGOs, especially in light of the phasing out of USAID, which is the major sponsor, either directly or indirectly (through US based organizations like Pathfinder, Path, AVSC).

In table 5 we can see, that although only two per cent of the total national expenditures made in the field of population activities goes via national NGOs, their activities do supplement the government. NGOs can play a pioneering role, they can focus their activities on special target groups, or in special areas, e.g. in the field of STD, HIV/AIDS activities, and basic research and population and development policy analysis.

*Figure 6. Sources of income of national NGOs, Indonesia, 1996*



Source: RF96 Domestic database.

*Table 5. Estimated final expenditures by category and source, Indonesia, 1996*

	National NGOs	Government departments	Total
Total (in thousands of US\$)	4,720	239,260	243,980
	%	%	%
Family planning	50	68	67
Reproductive Health	17	26	25
STD, HIV/AIDS	19	4	4
Basic Research	14	3	3

Source: RF96 Domestic database.

Some of the major National NGOs are:

**PKBI: Perkumpulan Keluarga Berencana Indonesia**

(IPPA: The Indonesian Planned Parenthood Association)

PKBI was founded in Jakarta at the end of 1957. In 1968 it became a member of the International Planned Parenthood Federation. PKBI played and still plays a pioneering role in Family Planning activities in Indonesia. Their work is focussed in four strategic areas (IPPA, 1995, p. 8):

- reproductive Health for Adolescents: development and preparation of information, education, motivation, training, advocacy and reproductive health care for adolescents through the Youth Club and other activities;
- quality of Care: Provide opportunities to develop the quality of reproductive health care for the community through the main network and its units;
- gender Equality: Seek cooperation with other parties to develop several programs for the promotion of gender equity;
- organizational empowerment: foster the culture of planned and sustainable education under a self-supporting system derived from available resources and independent organizational capacities.

Although PKBI is active in 24 provinces, their contribution to the national family planning programme is relatively small: PKBI serves only two per cent of the total number of users. 49 per cent of the expenditures in 1996 were used for family planning activities, 22 per cent for reproductive health, seven per cent for STD, HIV/AIDS prevention activities, and 22 per cent for basic research. Income and expenditures of the PKBI increased from a level of US\$ 1.6 million in 1988 to approximately US\$ 3 million in 1996. In 1996, about 45 per cent of PKBI's income of roughly US\$ 3 million, originated from IPPF London, 40 per cent from internal sources (fees-for-

services), and 15 per cent from external sources. This will change in the future, as IPPF London will decrease the contribution to 26.5 per cent of the 1995 budget.

### **PKMI: Perkumpulan Kontrasepsi Mantap Indonesia**

(Indonesian Association for Secure Contraception)

Established in 1974 with the aim to promote health of the family through voluntary surgical contraception. The organization has five clinics: in Medan, Jakarta, Semarang, Surabaya, and Palembang. The main activities are:

- information, Education and Communication;
- service delivery: print materials for doctors/midwives about tubectomy and vasectomy;
- training of doctors in hospitals in 27 provinces. PKMI provides all training in this field. The certificates issued are approved by the MOH;
- research/statistics.

Their income comes solely from external sources (from 1977 to 1994 mainly from AVSC, and since 1994 from Pathfinder). Since 1994, their income has been decreasing steadily from US\$ 1.3 million in to US\$ 820,000 in 1996, and only US\$ 256,795 is allocated for 1997/98. Expenditures in 1996 amounted to US\$ 555,000 solely for family planning.

### **IBI: Ikatan Bidan Indonesia**

(Indonesian Midwives Association)

IBI was founded in 1951, to improve the qualifications and capabilities of midwives. 65,000 midwives are member of the Association, providing family planning and other reproductive health services to 16 per cent of all family planning users (USAID, 1997, p. 3). Of these midwives 20 per cent works in the private sector. IBI's role is advisory, advocacy and technical support. Their income comes from the private sector, membership dues, government departments, and from external sources (UNFPA, USAID, Pathfinder). More than one third of the 1996 expenditures of US\$ 359,00 went to family planning activities, 38 per cent for reproductive health, six per cent to STD, HIV/AIDS and 19 per cent for basic research.

### **IDI: Ikatan Dokter Indonesia**

(Indonesian Medical Association)

IDI is an organization for medical practitioners. 33,412 doctors are member of the Association. The main projects at the moment are:

- service Delivery Expansion: funded by Pathfinder, and UNFPA: promotion of private practitioners: training of private practitioners in Family Planning, Reproductive Health, and STD, HIV/AIDS;
- public Awareness for HIV/AIDS prevention through mass media activities: funded by Family Health International.

For these two projects, US\$ 362,000 in 1996 was spent, of which roughly 60 per cent for family planning and 40 per cent for STD, HIV/AIDS prevention activities.

#### **4.4 | Role of Private Sector**

As said earlier, the family planning programme in Indonesia is implemented by the government with participation by the community and the private sector. The policy is directed towards more self-reliance, as the concern raises for a tremendous family planning budget increase, which the government cannot readily afford. The government has set a goal to decrease the share of the public sector in contraceptive use up to 50 per cent by the year 2000, and that eventually 80 per cent of the family planning users will obtain their services through the private sector, leaving only the poorest 20 per cent to be served by the government (UNFPA, 1995, p. 21). To meet this goal the government has been developing several programmes, i.e. promoting the use of the private sector in family planning products and services (State Ministry of Population, 1993, p. 134). Prices for contraceptives do vary per province or per area (urban/rural).

An expansion of the private sector can be beneficiary for family planning programmes, because of the available resources and flexibility of private organizations.

With private sector we mean:

- unsubsidized services and product through the commercial sector (pharmacies);
- unsubsidized services and product through the private sector (midwives, doctors);
- subsidized services and product through the social marketing (pharmacies, midwives, doctors).

Table 6 shows that in 1995, there were an estimated 23 million users of family planning, of whom 66 per cent obtained their methods and services from government clinics, 34 per cent from private sources. Of all users, 73 per cent paid for their methods and services. This percentage is 64 per cent for users of government facilities, en 91 per cent of private sector users.

In Indonesia, the family planning programme is implemented by the government with participation by the community and the private sector. The policy is directed towards more self-reliance.

In annex II, an estimate is made of the amount spent in 1995 by current users who pay for their family planning methods and services in government clinics and from private sources (midwives, pharmacies, private physicians). Those who make use of government sources to obtain contraception pay an estimated 35 million US\$. Those who depend on the private sector for contraceptive supply pay around 47 million US\$.

*Table 6. Percentage of current users who obtain family planning methods and services for free and who pay by source, Indonesia, 1995*

	Number of users	Free %	Pay %
Total	22,832,722	27	73
Obtain method and services from:			
Government sources	15,094,203	36	64
Private sources	7,738,519	9	91

Sources: BKKBN: Kumpulan Data. Data Collection of Population and Family Planning. 1996, p. 18.  
DHS-Indonesia. 1994, p. 88.



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## 5. Concluding Remarks

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The role of international donors is decreasing as the Government of Indonesia takes over more and more. Still, donor input will be needed, especially in the field of international cooperation, like the South-South Cooperation (cooperation among developing countries in the field of population and family planning), and for supporting of national NGOs.

Funding of national NGOs comes for 90 per cent from international donors, and for seven per cent through self generated income. Although only three per cent of their income originates from government contributions, the role of national NGOs is very important as some of them have a pioneer function, or work with special target groups (e.g. youth or commercial sex workers).

Pulling out of some major international donors, e.g. USAID might not influence the government policies so much, but surely will have a major impact on national NGOs, as they are very much dependent from international finances.

### **5.1 | ICPD and the Indonesian population programme**

For grass-root activities, ICPD was more a confirmation of what was going on in the country already. The evolvement of family planning towards reproductive health is a natural evolvement.



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**Annex II.**

*Total expenditure of current family planning users for one year of contraceptive protection, by method and source Indonesia, 1995*

	Mean cost per unit		Amount spent by current users (in rupiah) for one year of protection		Amount spent by current users (in US\$) for one year of protection	
	Government Sources	Private Sources	Government Sources	Private Sources	Government Sources	Private Sources
Female sterilization	103,736	337,496	3,664,000,647	7,596,968,833	1,564,162	3,243,146
Male sterilization	N.A.	20,000		173,342,826	0	74,000
Implant	5,878	7,780	806,321,215	778,339,003	344,219	332,273
IUD	8,489	34,051	3,663,832,051	18,695,947,033	1,564,090	7,981,300
Injection	2,765	4,367	47,458,239,119	40,934,132,556	20,259,922	17,474,781
Pill	621	1,532	26,701,427,267	39,310,646,368	11,398,839	16,781,715
Condoms	N.A.	250		2,918,969,367	0	1,246,108
<b>Total cost</b>			<b>82,293,820,300</b>	<b>110,408,345,986</b>	<b>35,131,232</b>	<b>47,133,323</b>

Exchange rate: 1US\$ = Rps2,342

Sources: DHS-Indonesia. 1994, p.88

BKKBN: Kumpulan Data. Data Collection of Population and Family Planning. 1996, p.18