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UNRAVELING THE FACTORS BEHIND THE GROWTH OF THE INDONESIAN FAMILY PLANNING PRIVATE SECTOR

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UNRAVELING THE FACTORS BEHIND THE GROWTH OF THE INDONESIAN FAMILY PLANNING PRIVATE SECTOR

ABSTRACT

Increasingly, donors and developing country health practitioners are calling for an expanded private sector role in the delivery of high-quality family planning and reproductive health services, but policy guidance on how to encourage greater private sector participation is scarce. As of the mid-1980s, however, Indonesia has been expanding the private sector's share of the nation's family planning service provision. In 1987, only 15 percent of women obtained contraception from the private sector; by 1997, the share had risen to 42 percent, marking a nearly three-fold increase. This case study documents Indonesia's family planning experience with a view to understanding the factors and conditions that led to the remarkable growth in the private sector's role in delivering family planning services. Indonesia's National Family Planning Coordinating Board (BKKBN) was instrumental in planning for the private sector's growth. It successfully generated nationwide demand for family planning, responded to changing consumer preferences over time, supported a new cadre of private sector service providers, and introduced an affordable line of contraceptive products. While Indonesia's private family planning sector expanded in response to several converging factors, the government's commitment to promoting the private sector as a source of family planning services was clearly prominent among all factors.

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ACRONYMS

BKKBN	National Family Planning Coordinating Board
CPR	Contraceptive Prevalence Rate
DHS	Demographic Health Surveys
IEC	Information, Education, and Communication
IUD	Intrauterine Device
KB Mandiri	Self-Reliant Family Planning
NGO	Nongovernmental Organization
PSP-*One*	Private Sector Partnerships-*One* Project
RH/FP	Reproductive Health and/or Family Planning
SMOS	Social Marketing Organization
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCDC	Village Contraception Distribution Center
YKB	Yayasan Kusumu Buana (nongovernmental organization)

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EXECUTIVE SUMMARY

INTRODUCTION

An increasing number of donors and developing country health practitioners agree that the private sector should play an expanded role in providing family planning/reproductive health (FP/RH) services. However, the policy guidance on how to facilitate growth of the private sector remains scarce. Nonetheless, many public health experts point to the Indonesian National Family Planning Board (BKKBN) as a model of what is required to motivate private sector participation in the delivery of family planning/reproductive health services. This case study (1) explains the policies and programs put into place by BKKBN to privatize family planning, (2) analyzes the impact of these policies, and (3) distills lessons that lend themselves to application in countries interested in fostering a larger role for the private sector in the FP/RH marketplace.

One of the challenges in recounting the Indonesian story is the term private sector. Typically, the private sector in the international family planning community is defined as everything that is not public sector, which includes nongovernmental organizations (NGOs), commercial firms, independent providers, and faith- and community-based organizations. In Indonesia, the definition of private sector is especially vague and imprecise. The literature describing the Indonesia family planning program does not consistently make the distinction between public and private sector providers, services, and products. Given that this case study is concerned with describing the growth of Indonesia's private sector in the delivery of family planning services, it defines private sector as any facility that delivers services and products outside the purview of government. With NGOs representing a small percentage of the Indonesian health sector, Indonesia's private sector is dominated by commercial, for-profit entities, which are the focus of this study.

BKKBN SUCCESSFULLY GENERATES DEMAND FOR FAMILY PLANNING

Formed in 1970, Indonesia's BKKBN was instrumental in spearheading the nation's family planning agenda as well as in laying the groundwork for an expanded and sustained private sector role in delivering family planning services. Beyond the delivery of contraception, the program also set out to change social norms, promote delayed marriage, and improve family welfare. A major feature of BKKBN's approach was its ability to generate political and social support for its programs.

The Indonesian National FP program succeeded in achieving a rapid decline in total fertility and a rapid increase in contraceptive use. From 1967 to 1987, the average number of children born to a woman decreased from 5.6 to 3.3 and then even further to 2.7 in 1997. Indonesia saw a corresponding increase in the contraceptive prevalence rate from 9 percent in 1973 to 48 percent by the mid-1980s to 57 percent by 1997. Some of the reasons cited for BKKBN's success include its capable and visionary leadership, adequate financing, strong political and social/religious support, decentralized design, use of research, and the promotion of normative values around the need for a small and prosperous family.

TOWARD SELF-SUFFICIENCY

As of the mid-1980s, the Indonesian government was shouldering as much as 90 percent of all costs related to the National FP program. In fact, the family planning program's burden on the national budget was significantly higher than that of other social programs. With increasing numbers of family planning users, BKKBN realized that the government could not indefinitely provide free family planning services for all.

At the same time, other factors influenced BKKBN's policy shift from a largely publicly orchestrated effort to a decentralized and mixed system involving both public *and* private sector providers. The range of factors included economic growth and improvements in social welfare, national deregulation policies, a steady increase in demand for family planning, and declining donor support. In addition, a survey undertaken by BKKBN revealed that women were skeptical about the public sector's quality of care; meanwhile, women were willing to pay for services but lacked information about private sources. In response to these converging political, economic, and demographic factors, BKKBN reoriented its government-led family planning programs toward privatization and, in 1987, launched *KB Mandiri.*

The objectives of *KB Mandiri* were (1) to replace government subsidies by increasing the share of community revenue generated for FP services and (2) to encourage those willing and able to pay for their family planning services to rely on private sector channels. BKKBN believed that as more people came to regard family planning as a personal need rather than as a government program, they would become more willing to pay for their own family planning services and commodities. The norm of a "small, happy family" that was socially embedded by BKKBN now also extended to the notion of self-reliance through *KB Mandiri.* BKKBN set an ambitious goal to privatize 50 percent the family planning program through *KB Mandiri* by 1994.

BUILDING A PRIVATE SECTOR FOR FAMILY PLANNING

To privatize family planning services, BKKBN recognized that it would have to facilitate private sector growth and augment a public sector that had traditionally provided all services. Consistent with its approach to experimentation, BKKBN structured *KB Mandiri* around four complementary strategies to operationalize its new private sector policy.

The first strategy called for the introduction of user fees in public service outlets to recoup costs and familiarize users with the practice of paying for family planning services and products. BKBBN, however, recognized that not all family planning users could afford to pay for services and commodities and therefore introduced protections to exempt selected users from paying in the public sector. Ultimately, while BKKBN was successful in normalizing the practice of making payments, the cost-recovery scheme did not generate sufficient funds to cover the cost of family planning services and products.

The second strategy, based on the identification of an expansive and underserved market of lower-middle-income consumers willing to pay for contraceptives and high-quality care but unable to afford commercial prices, called for the creation of a new cadre of private sector providers. In 1987, BKKBN launched the Service Provider Initiative under the Blue Circle campaign, with the objective to promote reliance on private sector FP providers, including doctors, midwives, and pharmacies. A critical component of the initiative was provider recruitment and training. BKKBN instituted regular provider training programs on how to offer high-quality family planning products and services, including IUD insertion and other clinical methods. The trained providers were permitted to display the Blue Circle

logo and dispense commercially procured contraceptives. An integrated communications program heavily promoted Blue Circle providers.

While the Blue Circle Service Provider Initiative successfully increased consumer knowledge of private providers offering FP services, few private doctors actively offered FP services and methods despite BKKBN's efforts. Consumers preferred midwives to doctors because their services were less expensive, and over time, midwives became the backbone of the private health sector. Recognizing consumer preferences, BKKBN invested heavily for more than 20 years to train, equip, and support midwives as the major cadre of private sector providers.

The third strategy called for launching a new line of high-quality family planning products targeted to lower- and middle-income couples at an affordable yet commercial price. The strategy not only focused on affordable products but also facilitated a shift from government-procured to commercial products, particularly in urban areas where there was a clear market niche: growing demand among consumers with the ability to pay for high-quality services and products.

In fact, four years after the Blue Circle campaign's launch, Blue Circle products were available through commercial distribution channels in 27 provinces in Indonesia. Moreover, the products succeeded in reaching targeted low- and middle-income consumers. Although sales increased dramatically, the campaign's success was mostly limited to urban areas, and the increase was attributed largely to new users rather than to a shift from public to private use. To address some of Blue Circle's limitations, BKKBN launched the Gold Circle campaign in 1992, diversifying the range of available products and broadening distribution coverage to rural areas through rural cooperatives. The Gold Circle campaign, however, undermined many of the successes achieved under the Blue Circle campaign; ultimately, Gold Circle did not meet its intended goals.

The fourth strategy focused on strategic communications to the public about the availability of affordable, high-quality products through private channels. Communications and public relations always featured prominently in BKKBN's policies, and were integrated into different phases of its interventions. The Blue Circle public relations efforts were particularly successful and encouraged two consumer behavior changes: (1) developing the habit of paying for FP services and products and (2) seeking private health sector providers to address FP needs.

SHIFT TO THE PRIVATE SECTOR: DID IT OCCUR?

The purpose of the Indonesian case study was (1) to discern if growth in the FP private sector actually occurred and (2) to determine the influence, if any, of BKKBN's policies and programs on expanding the private sector's involvement in the family planning marketplace. After analyzing the data and speaking with Indonesian experts, we conclude that the private sector indeed experienced substantial growth in the FP market. Over the 10-year period from 1987 to 1997 when BKKBN established and actively implemented private sector–oriented programs and policies, the percentage of women who turned to the private sector for contraception increased almost threefold, from 15 to 42 percent. This trend was especially pronounced in urban areas, where the private sector expanded its market share from 25 to 61 percent. But the private sector also penetrated rural areas and experienced important growth from 7 to 35 percent during the same period.

BKKBN's *KB Mandiri* policy and programs had several other downstream effects beyond expanding the private sector's role in the FP marketplace. First, greater private sector provision of FP influenced the method mix. In 1987, the predominant contraceptive methods were the IUD (33 percent), the pill (27

percent), and injectables (18 percent). After 10 years, while the three methods remained predominant choices, injectables grew gradually to become the preferred method (35 percent). Second, the Indonesian FP marketplace was segmented by educational level--a proxy for income groups--with the more educated portion of the population (presumably, women with higher income) seeking FP services and methods in the private sector. Third, the marketplace offered a wide range of prices for FP products targeted to women of different educational and income levels. The pricing data show an unmistakable delineation between private and public sector prices; the private sector charged consistently higher prices as compared with prices in the public sector and at other FP service delivery outlets. But there were also price differentials, indicating women from lower income groups could find affordably priced contraceptive methods in the private sector. The fourth, and possibly more troubling, impact of *KB Mandiri* was that a growing number of uneducated women increasingly paid for their methods in the private sector, particularly for injectables. That a decreasing number of poorer women could no longer receive free contraceptives in the public sector and came to depend on the private sector raises equity and efficiency issues for BKKBN.

GUIDELINES TO INCREASE PS ROLE

The case study examined what lessons can be learned from Indonesia for translation into general guidelines and principles for other countries setting out to increase the private sector's role in the FP/RH marketplace. Taking a cue from the marketing concept of the four Ps, we developed a similar schema to describe the private sector market conditions and policies that need to be in place if a private sector in FP/RH is to thrive.

P Is for Policy: Government's Role and Influence on the Private FP Sector

Although the government and BKKBN did not initially see a role for the private sector in the delivery of family planning services, the convergence of several social, political, and economic trends prompted decision makers to rethink their position. Accordingly, BKKBN decided to transform its government-dominated FP program into a more self-sufficient program that would motivate family planning users to become less reliant on the public sector. More specifically, BKKBN introduced a series of policies and programs aimed at expanding the role of the private sector in the delivery of family planning services. Some BKKBN initiatives were not intentionally designed to expand the private sector but were instead necessary conditions to make the Indonesian FP marketplace attractive to the private sector. For one, by successfully growing demand for family planning services and products, BKKBN was able to demonstrate a strong and predictable market and attract the attention of commercial product manufacturers. Second, by introducing user fees for FP products and services, it also demonstrated consumers' willingness and ability to pay for FP services and products.

P Is for Products and Price: Introducing Affordable Products Valued by FP Consumers

Initially, the Indonesian National FP program was a government-dominated program that offered fully subsidized and free services and products at no cost to the consumer. Over time, the program gradually introduced user fees for the FP services but still significantly subsidized products. When BKKBN started its private sector initiative, only free or heavily subsidized or commercially priced FP commodities were available in the market. As a result, there was a gap in the price range of FP products and tremendous market potential for moderately priced FP that would respond to lower- to middle-income groups that could afford to pay but did not have a product to purchase. Under the Blue Circle campaign, BKKBN successfully introduced a range of lower priced FP products familiar to consumers.

P Is for Providers: Establishing a New Cadre of Private Providers Offering FP

BKKBN determined that, to meet the needs of the enormous volume of new users entering the FP marketplace, it would have to increase the supply of both public and private sector services. When BKKBN decided to privatize FP services, almost all FP providers--except for the few private providers who cared for affluent Indonesians--were full-time government employees. BKKBN stepped in to help create a new and diverse cadre of private health professionals, including doctors, midwives and pharmacists, to offer FP services. Under the Blue Circle Service Provider Initiative, BKKBN trained existing private practitioners in the delivery of FP services and supplied them with contraceptive commodities. When the initiative resulted in only limited success, BKKBN turned to focus on midwives, continuing to offer them the same incentives available under the Service Provider Initiative. Eventually, midwives became the FP provider of choice in the private sector, as they were readily accessible to their communities and more affordable than physicians.

P Is for Promotion: Communicating to FP Consumers to Increase Demand for Private Sector Services and Products

Communications and public relations were fundamental to the expansion of the private sector as a provider of FP services and products. BKKBN had always used communications effectively to help change social norms to foster greater acceptance of smaller families and to stimulate demand for FP services and products. With the introduction of private sector providers, BKKBN adopted multipronged strategies--including advertising, public relations, and IEC activities--to communicate to FP users that they could now obtain FP services and products through qualified and trained private providers and pharmacies. The strategies carefully differentiated messages to various consumer groups based on local preferences, community relationships, local infrastructure, and other factors.

A FINAL NOTE

The case study of the Indonesian private sector FP market offers insights into the policies and programs that led to the evolution of the private sector as a major provider of family planning services. Though no single policy, program intervention, or player can be credited with Indonesia's dramatic expansion of the private sector, several macro-level economic and social changes converged with BKKBN's implementation of a range of private sector–oriented policies and programs that, over time, led to a pronounced market shift. Within this dynamic and complex RH/FP landscape, BKKBN played an instrumental role in setting the stage for private sector growth by creating conditions conducive to attracting and retaining the private sector as the dominant provider of family planning services and products.

As a final post script, the 1997 Asian economic crisis was not only a tipping point for but also a test of the overall resilience of Indonesia's private family planning sector. With the economic crisis, BKKBN did not have the foreign exchange to purchase family planning commodities and could no longer offer commodities such as pills and injectables for free or at minimal charge. Consequently, many FP consumers left the public sector to purchase their FP method in the private sector despite the rapid price increases occasioned by the economic crisis. The switch to the private sector was especially apparent in the case of injectables; BKKBN had created such high demand for the method that consumers switched to the private sector to obtain it. During the economic crisis, the private sector stepped in to fill the gaps created by a weakened public sector. Interestingly, contraceptive prevalence remained stable after the economic crisis, and FP consumers remained in the private sector despite increased prices.

1. INTRODUCTION

An increasing number of donors and developing country health officials agree that the private sector should play an expanded role in providing family planning/reproductive health (FP/RH) services and products. These key decision makers assume that the mere declaration of a policy or plan to expand the private sector's role will result in the private health sector's "automatic" response. But experience demonstrates that it takes more to motivate the private health sector to enter and/or remain in the FP/RH marketplace. Many public health experts point to the Indonesian National Family Planning Coordinating Board (BKKBN) as a model of what is required to motivate the private sector's participation in the delivery of family planning/reproductive health services. Although the Indonesian FP example has been well documented from the public sector's perspective, little information is available on what happened in the private health sector.

In this case study, PSP-*One* not only describes the policies and programs that BKKBN put into place to "privatize" family planning, but it also analyzes the impact of the policies on expanding the private health sector. Moreover, the case study examines lessons learned from the Indonesian example that lend themselves to translation into more general guidelines and principles for application by other countries interested in fostering a larger role for the private sector in the FP/RH marketplace. The authors used three approaches to gather data to complete the case study:

- A comprehensive literature review to develop the history of BKKBN and a description of its various FP programs and policy initiatives;

- A review of the Demographic Health Surveys from 1987 to 1997 to analyze changes in contraceptive prevalence and method and source mix during the period corresponding with BKKBN's policy reforms; and

- In-depth interviews with 10 individuals–both Indonesians and expatriates–to hear their version of what happened in the private health sector and why.

One of the challenges in recounting the Indonesian story is the term private sector. Typically, the private sector in the international family planning community is defined as everything that is not public sector and includes nongovernmental organizations (NGOs), commercial firms, independent providers, and faith- and community-based organizations. In Indonesia, the definition of private sector is especially vague and imprecise. The literature describing the Indonesia family planning program does not consistently make the distinction between public and private sector providers, services, and products. In reality, many healthcare professionals offer services through both public and private outlets. For example, some state-owned enterprises are incorporated as firms even though the Indonesian government is the major shareholder (Marzolf, 2002). Moreover, consumers had grown accustomed to paying for RH/FP services in both public and private delivery outlets, making it difficult to attribute a given price to a particular source.

Given that this case study describes the growth of the private sector's share of the larger Indonesian FP market, it defines the private sector as services and products delivered in facilities outside the purview of government. With NGOs representing a small percentage of the Indonesian health sector, the private sector is dominated by commercial, for-profit entities—the focus of this study.

The Indonesian case study is divided into five chapters. Chapter 2 provides an overview of the history and evolution of Indonesia's FP program, describing how BKKBN successfully generated sustained demand for family planning services--a critical component in efforts to interest the private sector in entering the FP marketplace. Chapter 3 describes the factors that contributed to the growth of the private sector and the rationale behind the KB Mandiri policy to achieve self-sufficiency. Chapter 4 describes how BKKBN experimented with a mix of polices designed (1) to encourage Indonesians to begin paying for family planning services and products and (2) to stimulate growth in the private sector role's in the delivery of FP services and products. Chapter 5 analyzes 10 years of Demographic Health Surveys (DHS) to determine how the alleged expansion of the private sector was reflected in consumers' experiences in receiving services. Finally, Chapter 6 concludes with lessons learned on how the public sector can create an enabling environment to foster private sector participation in the provision of FP/RH services.

2. BKKBN SUCCESSFULLY GENERATES DEMAND FOR FAMILY PLANNING

This chapter discusses the Indonesian National FP Program's transformation over time. It illustrates how BKKBN's leaders adapted and implemented the program in three phases between 1969 and 1983 in response to evolving and dynamic demographic and social conditions. A hallmark of BKKBN's management style was its data-based program design and evaluation. Even as BKKBN was expanding the public sector FP program, it was laying the foundation for the needed growth of the private health sector. In particular, BBKBN focused on creating and sustaining what turned out to be remarkable growth in demand for family planning services and products. Indeed, by the 1990s, family planning had become a universally accepted practice among all political, religious, and social groups in Indonesia (Hull, 2003).

2.1 FACTORS LEADING TO THE FORMATION OF A NATIONAL FAMILY PLANNING PROGRAM

The National Family Planning Board (PKBI) pioneered the concept of family planning back in the 1950s. The board received important donor support but held a tenuous position in the Old Order regime. PKBI was associated with the International Planned Parenthood Federation (IPPF) and was shaped by clinicians who sought to put family planning on the national health agenda (Hull, 2003). PKBI focused on improving maternal and child health without a concomitant emphasis on reducing population growth (Sarwano, 2003). Family planning interventions at this early stage took the form of health advocacy and information, education, and communication (IEC) campaigns delivered through clinics.

With the transition to the New Order regime in 1966, national policy on family planning and population took a new direction. Amid deteriorating economic conditions, an inflation rate of 400 percent, and per capita income at $50 per year, President Suharto looked to curb population growth as an important strategy for economic recovery and development (Lubis, 2003). Clearly, President Suharto's population-based economic development strategy was a response to pressures from within the government as well as from Indonesian technocrats trained in the West. In line with the new emphasis on rational economic planning, popular political opinion on birth control was also undergoing an important transformation.

When, together with 29 other heads of state, President Suharto signed the UN Declaration of State on World Population in 1967, he demonstrated strong political will to reduce population growth. At the same time, conditions were ripe to leverage foreign assistance from USAID and other key donors. For example, in furtherance of Indonesia's strategy to reduce population growth, the USAID Mission offered the country political support, highly qualified technical staff, and committed family planning resources and commodities (Piet, 2003). In 1968, Indonesia formed the Family Planning Institute and, in 1970, raised the institute to higher status as the National Family Planning Coordinating Board, whose Indonesian acronym is BKKBN. Attesting to BKKBN's political importance, family planning became an integral part of the Indonesia's first five-year development plan launched in 1969 (Lubis, 2003).

BKKBN was positioned directly under President Suharto and, unlike other health and social service ministries, enjoyed direct access both to him and administrative hierarchies (Shiffman, 2004). BKKBN Chair Haryono Suyono reported directly to the president and leveraged political opportunities for the family planning program. With his innovative leadership, Suyono orchestrated support from national, provincial, and district administrations as well as from social institutions and the Indonesian people themselves (Hull, 2003).

Beyond the political and administrative arenas, Indonesia's social norms were undergoing a shift that favored a prominent family planning agenda. Families were abandoning the belief that a large family was indicative of prosperity and instead were starting to accept a new norm: "Two children is enough, whether boy or girl." The factors contributing to the shift in belief systems were a declining child and infant mortality rate, increased valuation of children, and recognition that an important way to provide for the elderly was to invest in children and ensure their education (Sarwano, 2003). A limit on family size was starting to go hand in hand with prosperity.

Religious beliefs were also evolving, eventually leading to direct support of family planning initiatives. As in most countries with predominantly Islamic populations whose religious leaders oppose family planning, it was crucial to engage with Indonesia's clerics and modify policy in response to their concerns (Shiffman, 2004). To pave the way for the nation's ambitious and wide-scale family planning effort, President Suharto enlisted the support of religious leaders and organizations considered instrumental to the effort's expansion. As of the early 1970s, the opinion of the major Islamic groups and clerics was starting to change—albeit slowly; religious leaders permitted the use of contraception to space births and subsequently offered direct training to family planning motivators (Shiffman, 2004).

2.2 CHANGING ROLE OF THE NATIONAL FAMILY PLANNING PROGRAM

BKKBN was established in 1970 to improve maternal and child welfare and to create small, happy, and prosperous families (Suyono and Shutt, 1989). Ultimately, the goal of the family planning program was to reduce the total fertility rate by 50 percent before the year 2000 (Hull and Hull, 1998). Even with such an ambitious family planning target, the thrust of the program as spelled out in the Indonesian Law on Population was considerably broader than the delivery of contraception; the program set out to change social norms, delay marriage, and improve family welfare (Hull and Hull, 1998). One feature of BKKBN's approach was its ability to marshal political and social support for its programs. In its formative stages, BKKBN was directing the vision of the program, eliciting support from religious and social institutions, and managing foreign aid.

By 1978, BKKBN's original mandate was expanded from coordination to field operations. Working through a network of provincial and regional offices, BKKBN embedded the program in every administrative level of government--from the national level to the hamlet (Piet, 2003). Moreover, by gaining wide representation by sociocultural institutions, BKKBN brought about tremendous normative change in family planning practice across the country. Through its decentralized and carefully orchestrated structure, it successfully reached millions of married couples throughout the 67,000 villages in Indonesia's 27 provinces.

2.3 DYNAMIC IMPLEMENTATION STRATEGY: BBKBN'S STAGED APPROACH

One of the factors contributing to BKKBN's success was its implementation approach. Many members of BKKBN's senior management, including Director Dr. Haryono Suyono, had been educated abroad and had adapted Western-style approaches to program management to the Indonesian context. In particular, BKKBN effectively used data in program design and management and, from the outset, established an efficient reporting system that allowed rapid feedback and evaluation of program efforts (Hugo et al., 1987). The reporting system permitted BKKBN's management to respond and adapt to Indonesia's evolving sociopolitical environment and demographic needs.

The national FP program moved through three implementation phases, or *repelitas*, between the late 1960s and early 1980s. The phased implementation approach was aligned with the health needs and contraceptive prevalence rate of different population segments, with each phase's strategies varying by context. BKKBN set fertility targets for each *repelita* and sought efficient and practical service delivery channels to achieve them. The first phase, targeted to reach 3 million acceptors, was a clinic delivery model suited to dense urban areas; it was designed to graft easily onto existing delivery channels. The second phase used an integrated community-based model tailored to the needs of remote rural communities, addressing nutrition, agriculture, and income generation. The third phase moved toward a self-sufficient, decentralized family planning model with broad national coverage. BKKBN learned from its past practices as it designed each subsequent implementation phase.

2.3.1 *REPELITA* I: 1969–1974

During the first *repelita*, BKKBN focused on geographic areas where the health needs were highest. Between 1969 and 1974, BKKBN fieldworkers worked through existing Ministry of Health clinics to offer counseling and contraceptive services, primarily around mother and child health. The services were clinic-oriented and concentrated in the densely populated islands of Java and Bali. The initial success was significant: the number of acceptors rose dramatically from 50,000 in 1970 to 1.5 million in 1975. However, BKKBN officials recognized early on that a change in strategy was necessary to reach the vast majority of the estimated 14 million couples living in Java's and Bali's outer-lying villages. In addition, demand was growing for short-term methods such as the pill and condom, raising concerns about future drop-out rates and calling for a revised strategy (Lubis, 2003).

2.3.2 *REPELITA* II: 1974–1979

Entering the next *repelita*, BKKBN focused on extending its reach to villages and promoting longer-term methods that did not rely on continued re-supply (Lubis, 2003). BKKBN adopted a community-based approach in which responsibility was decentralized to the village level and tailored to different administrative structures. For example, in Bali, the second *repelita* used close-knit traditional forums for mutual aid called *banjars* as centers to identify new acceptors, map the community according to contraceptive use, and maintain lists of couples eligible for outreach (Lubis, 2003). In Java, BKKBN worked within a formal administrative hierarchy and gained support from provincial leaders before entering districts and villages.

Within its overarching strategy to mobilize rural areas, BKKBN relied on trusted community fieldworkers who were trained to lead promotion efforts (Lubis, 2003). BKKBN also drew on volunteers from social and political organizations (nearing 300,000) who mobilized and managed acceptor groups at the village level (Shiffman, 2004). Through peer pressure and financial incentives to

take advantage of revolving loans, acceptor groups of 15 to 60 members rapidly mobilized new acceptors and were self-perpetuating. The resultant rural expansion also called for revamping contraceptive supply, distribution, and monitoring systems. Established in 1975, independent Village Contraception Distribution Centers (VCDCs) stocked contraceptive supplies and assisted fieldworkers with their reporting forms and outreach strategy.

Together, the decentralized groups at the community level came to be known as *posyandus* or posts for integrated services. Suited to rural communities, they addressed family planning needs and general health services and offered social, religious, and political information (Suyono and Shutt, 1989). A cadre of family planning fieldworkers, health personnel, government representatives, acceptor groups, and other community stakeholders coordinated *posyandu* activities. The p*osyandus* relied on horizontal and vertical cooperation and, according to Hull, were the basis of a "systematic mobilization, without which the supplies nor the normative family planning message would have permeated virtually every village as they have today"(Hull, 1997).

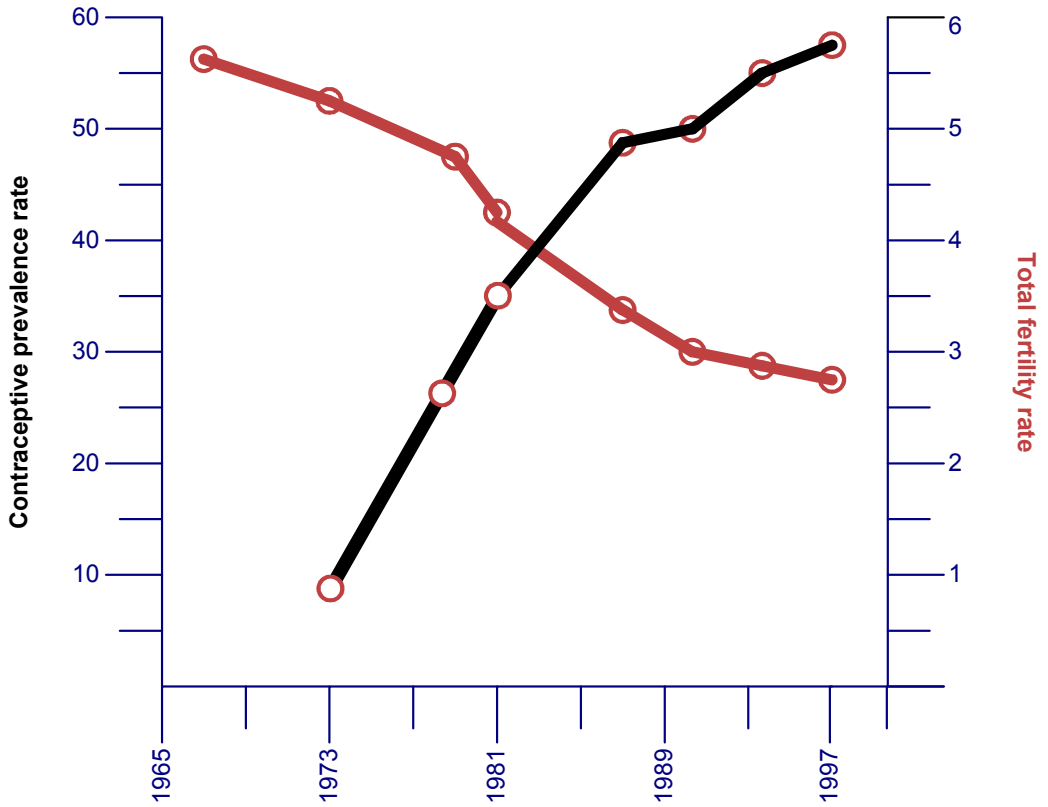
2.3.3 *REPELITA* III: 1979–1983

Entering the third *repelita*, BKKBN started to move into the outer islands (known as the Outer Islands II), where it had previously not laid any groundwork through community-based fieldworkers. The islands, which comprise 10 provinces, were more remote and less populated than those targeted during the previous *repelitas* (the Outer Islands I included Irian Jaya, Central Kalimantan, and East Timor. In addition to difficulties with access and poor infrastructure, the Outer Islands II presented challenges with respect to political concerns about extending the program to regions where separatist political views prevailed and where population control remained a sensitive issue. Ultimately, however, in line with its strategy to reach national coverage, BKKBN started to graft to its approach its previously tested strategies for developing local capacity in the outer provinces (Lubis, 2003).

2.4 GENERATING SUSTAINED DEMAND FOR FAMILY PLANNING

The Indonesian National FP program has a long and respected history in promoting family planning and is considered one of the most successful programs in the world, as demonstrated by Indonesia's rapid decline in total fertility and continuous increases in family planning use. Figure 1 shows changes in the total fertility rate (TFR) and the contraceptive prevalence rate (CPR) from the outset of the Indonesian family planning program in 1957 to the beginning of the economic crisis in 1997. In 1967, when President Suharto signed the UN declaration on world population, Indonesian women were giving birth, on average, to 5.6 children in their lifetime. Twenty years later, in 1987, the average number of children born to a woman had decreased to 3.3 and then declined even further to 2.7 in 1997 (Jones, 2003). This rapid fertility decline occurred over two decades of an active and expanding family planning program.

FIGURE 1. CONTRACEPTIVE PREVALENCE RATE AND TOTAL FERTILITY RATE IN INDONESIA, 1967 TO 1997



Source: U.S. Bureau of the Census, International Database.

One reason for Indonesia's fertility decline was the population's dramatic increase in contraceptive use. As Figure 1 shows, the contraceptive prevalence rate was only 9 percent in 1973. However, by the beginning of the mid-1980s, the rate had increased to 48 percent. By 1997, the CPR further increased to 57 percent.

The transformation in reproductive behavior and dramatic drop in total fertility are attributable, in large part, to the Indonesian National FP program. Despite Indonesia's late involvement in family planning relative to other developing countries in the region, BKKBN pursued its family planning goals with "great vigor and effectiveness" (Piotrow and Rimon, 1999) and was able to expand the program across the entire country, reaching virtually all population groups. Some of the reasons cited for BKKBN's success include:

- The capable leadership of Dr. Haryono Suyono and his senior management team;
- Adequate financing and strong political commitment from national and local leaders, including direct contact with President Suharto;
- Program emphasis on decentralized decision-making authority and the involvement of community leaders and members;

- Integration of a quantitative approach to program design and implementation combined with a normative approach that promoted the ideal of small family size; and

- Political skills that permitted consultation with Islamic religious leaders and adaptation of the FP program to the leaders' concerns.

Some argue, however, that Indonesia's demographic transition was the product of socioeconomic factors such as the 1970s oil boom that spurred development and social stability (Lubis, 2003), deeply rooted social networks and social norms receptive to family planning (Lubis, 2003), and proximate determinants of fertility, including higher levels of educational attainment among women, changes in family formation, and the growing financial cost of raising children (Edmondson, 1992). Regardless of the main reason behind Indonesia's fertility decline, BKKBN played a significant role in generating widespread acceptance of family planning and providing family planning services that responded to Indonesian women's fertility needs and family planning preferences.

3. TOWARD SELF-SUFFICIENCY

This chapter presents the range of factors that prompted BKKBN to reformulate its government-dominated family planning program into a self-sufficient program structured around private sector participation in the family planning sector. It was the confluence of economic, political, and demographic trends at a certain juncture that tipped the scale in favor of diversifying the family planning sector to include public as well as private sector providers and products. The convergence of trends convinced BKKBN that privatization of family planning services was inevitable; thus, BKKBN initiated the *KB Mandiri* policy in 1987 (Lubis, 2003).

3.1 FACTORS LEADING TO *KB MANDIRI*

Since the inception of the National FP Program, the public sector was the main source of FP funding. Family planning clients received services and commodities at no charge from government-run family planning service delivery points. As of the mid-1980s, the Indonesian government was shouldering as much as 90 percent of all costs related to the National FP program. In fact, the family planning program's burden on the national budget was significantly higher than that of other social programs (Jensen et al., 1994). With an increasing number of family planning users, BKKBN realized that the government could not indefinitely continue providing free family planning services for all. At the same time, still other factors influenced BKKBN to introduce a policy shift from a largely publicly orchestrated effort to a decentralized and mixed system involving the participation of both public and private sector providers.

3.1.1 ECONOMIC GROWTH AND IMPROVEMENTS IN SOCIAL WELFARE

Riding the wave of the oil boom of the 1970s, Indonesia experienced broad economic gains that started to set in by the early 1980s. The gains translated into dramatic improvements in socioeconomic conditions and educational attainment. In particular, Indonesia realized a steady increase in GNP of 7 percent annually and a rise in per capita income to approximately $1,000 (Weidemann, 1999). Meanwhile, poverty rates declined from 40 percent in the late 1970s to 22 percent in the late 1980s (Jensen et al., 1994), and real wages increased by 65 percent for women and by 40 percent for men between 1980 and 1987. The education system also rapidly expanded, drawing from and feeding into the economic boom. According to Jensen et al. (1994), enrollment rates increased from under 50 percent in 1961 and 60 percent in 1971 to 94 percent in 1985. Life expectancy also increased from 45 to 63 years by the early 1980s.

3.1.2 NATIONAL POLICY TO PRIVATIZE AND DEREGULATE

During the 1980s, privatization gained ground in Indonesia and in other parts of East Asia. In particular, the Indonesian government moved to deregulate and privatize state enterprises and the financial sector and to implement economic policies conducive to expanding private sector cooperation. It relaxed import and duty restrictions, streamlined customs operations, and offered tax and financial incentives to encourage private enterprise (Hull, 1997).

The broader health sector in Indonesia responded to the privatization movement with its own policies. In the 1980s, the health sector developed new priorities focused on increasing service quality, reforming

the financing system, and expanding the role of private health providers. In addition, the pharmaceutical sector and later the hospital sector underwent deregulation. The Indonesian Ministry of Health implemented a healthcare financing strategy (with the acronym DUKM) for the public sector to focus on cost recovery and cost controls, while allowing the private sector to focus on curative care. These measures allowed the Ministry to target its limited budget on the provision of priority preventive health services to vulnerable populations and to focus on creating a regulatory climate favorable to private participation (Marzolf, 2002).

3.1.3 SHIFT IN DONOR AND INDONESIAN GOVERNMENT FUNDING PRIORITIES

In light of Indonesia's political and economic advances throughout the 1980s, some donors-- particularly USAID--reevaluated their technical priorities and funding strategies. During the early years of the National FP program, USAID provided substantial funding and technical assistance to BKKBN. Indeed, the nature and magnitude of USAID support contributed greatly to BKKBN's ability to function and succeed (Piet, 2003). By the early to mid-1980s, however, USAID started to worry about contraceptive security and initiated discussions with BKKBN, encouraging it to become more self-reliant in procuring and paying for family planning commodities (Piet, 2003).

During this same period of reliance on government funding and declining donor support, BKKBN began experimenting with new programs to decrease dependence on public funds. It introduced fee-for-service clinics in urban areas that, before long, were self-sufficient, demonstrating Indonesian couples' willingness to pay for family planning services. In addition, USAID supported BKKBN's new social marketing condom program, Dua Lima, in the early 1980s. Dua Lima was the test case to see how Indonesian consumers would respond to a private sector product; the results were impressive. As a consequence, USAID started to push for more private sector involvement in delivering family planning services and products (Kingfield, interview, 2005; Riggs-Perla interview, 2005).

Given the favorable outcome of the Dua Lima pilot test, BKKBN eventually agreed to privatize family planning services through social marketing programs. But USAID and BKKBN each had its own perspective on the social marketing program's goal. On the one hand, USAID believed that the social marketing program was an effective strategy for increasing the private health sector's role in FP by offering FP products through commercial channels while decreasing the public sector's reliance on USAID-donated contraceptives. BKKBN, on the other hand, viewed social marketing as well as other private sector initiatives as another strategy to extend its family planning outreach. BKKBN never regarded the social marketing program as a means either to reduce its spending on FP commodities or to diversify the sources of family planning services (Lubis, interview, 2005; Kingfield, interview, 2005; Kantner, interview, 2005).

3.1.4 SHIFT IN FAMILY PLANNING NEEDS

Despite the remarkable growth in the number of family planning users during the 1970s, BKKBN recognized that contraceptive prevalence was lagging in urban versus rural areas. In 1980, BKKBN conducted a seminal survey in urban areas that indicated the need for another shift in program design and implementation. The survey found that:

- Quality of care was the main barrier to accessing public services. Government facilities were crowded, failed to provide adequate information, and offered limited contraceptive choice.

- Women lacked information about where private care was available. Many women presumed that private services were too expensive and did not know where to find a private provider.

- Women would patronize a fee-for-service program, provided that the hours were convenient and a wide range of contraceptives was available (Lubis, 2003).

The survey findings offered three insights into the potential for as well as the challenges of enlisting the private sector in urban areas to increase family planning use. First, individuals demonstrated a growing willingness to pay for family planning services and programs in return for quality and convenience. Second, a lack of adequate information posed a barrier to consumer reliance on the private sector despite an abundance of private providers--especially midwives and physicians--in urban areas. Finally, most women assumed that private sector fees were beyond their reach.

3.2 *KB MANDIRI* PROGRAM

In response to increased demand as well as declining donor funding for FP services, in 1989 BKKBN launched a nationwide program called *KB Mandiri* (family planning self-sufficiency). The objective of the program was (1) to replace government subsidies by increasing the share of community revenue generated for FP services and (2) to encourage those able and willing to pay for their family planning services to utilize private sector channels (Jensen et al., 1994). BKKBN believed that as more people came to regard family planning as a personal need rather than as a government program, they would become more willing to take responsibility and pay for family planning services. BKKBN understood, however, that a large portion of the population could not pay for needed FP services. Therefore, it introduced a three-tiered contribution program that corresponded to couples' socioeconomic status:

- *Full KB Mandiri.* Families that paid for specialized, clinical FP services in the private sector and bought commercial or socially marketed products. The full program targeted urban women.

- *Partial KB Mandiri.* Families that contributed to the costs of their FP services through partial payments or pooled community funds. The government procured and distributed commodities, with the program usually administered at the village or subvillage level.

- *Pra Mandiri.* Families that continued to rely on free government services available through public clinics and community fieldworkers.

BKKBN set forth an ambitious goal to privatize 50 percent of the program by 1994. To encourage the shift in behavior needed to achieve this goal, BKKBN recognized that it would have to implement a two-pronged approach: (1) introduce a cost-recovery program in the public sector and (2) privatize family planning services. The cost-recovery program involved several activities. For example, family planning workers encouraged individuals to make contributions appropriate to their income level toward initial and re-supply commodity costs and for services delivered. The government also called on community groups to generate funds to offset the costs of community-based distribution of services and commodities (Jensen et al., 1994). BKKBN introduced its cost-recovery program while refocusing mechanisms that were introduced in previous years, including decentralization and community involvement, family self-reliance, and recruitment of volunteers. Efforts to privatize family planning focused on multiple strategies are described in greater detail in Chapter 4.

In keeping with its ongoing approach, BBKBN linked its privatization policy to social norms and strategically framed the *KB Mandiri* program around the social belief of a "small, happy and prosperous family." According to BKKBN, a small and prosperous family (1) used contraceptives, (2) postponed the

age of marriage, (3) delayed the birth of the first child, (4) breastfed if possible, and (5) spaced the birth of its children (Weidemann, 1999). BKKBN promoted the underlying *KB Mandiri* policy so successfully that the policy became not only one of the pillars of the National FP program but also a social norm for the entire country (Lubis, 2003). BKKBN built on the popularity of this social norm to include the concept of self-reliance–that is, a *small, happy, prosperous and* ***self-reliant*** *family* contributes financially toward its FP costs. Because Indonesians identified with this norm, *KB Mandiri* was often referred to as a movement rather than as an FP policy or program. In fact, around 1995, the BKKBN officially changed the word "program" to *KB Mandiri* "movement"(Lubis, 2003).

4. BUILDING A PRIVATE SECTOR FOR FAMILY PLANNING

Once again, BBKN transformed the National FP program in response to changing political and social factors. It experimented with various complementary tactics to achieve program self-sufficiency. It did not follow a formal blueprint for rolling out the privatized program but rather tested interventions incrementally. BKKBN also recognized that a multipronged approach was appropriate to meeting the goal of self-sufficiency and addressing the differentiated contraceptive needs of urban women.

BBKBN relied on four broad mechanisms to operationalize the *KB Mandiri* policy: (1) introducing user fees in public service outlets to recoup costs and familiarize family planning users with the practice of paying for services and products; (2) creating a new cadre of private sector providers by strengthening providers' skills and capacity to deliver family planning services; (3) launching a new line of high-quality family planning products at an affordable yet commercial price targeted to lower- and middle-income couples; and (4) communicating to the public about the availability--through public sector channels--of affordable, high-quality products. This chapter illustrates how government decisions, policies, and programs create a favorable environment for the private health sector.

4.1 BREAKING THE PRICE BARRIER

Before its adoption of the *KB Mandiri* program and policy, BKKBN offered everyone free family planning services and commodities. Under *KB Mandiri*, however, BKKBN instituted user fees to recover costs in the public sector but recognized that not all family planning users could afford to pay for services and commodities. Therefore, it introduced a range of protections to exempt selected users from paying for public sector commodities. For example, *Surat Miskin*, or the poor letter program, was a waiver approved by a local official that entitled an individual to a full or partial fee waiver at each hospital visit. In addition, health funds (*Danas Sehat*) established in certain villages covered the cost of treatment for all fund members who made small regular payments. Another mechanism was the *Kartu Sehat*, or exemption card, that entitled an entire family to receive healthcare for free as needed. To reduce implementation costs, the *Kartu Sehat* was typically offered to an entire low-income community. While the various exemptions improved access to family planning services and commodities in villages where they were properly implemented, they failed to provide the necessary national coverage. Information about the exemptions was not widely available to the poor, and the lack of clear criteria for eligibility made it difficult to implement the exemptions in different provinces (Newbrander, 2000).

Ultimately, the cost-recovery scheme did not generate sufficient funds to cover the cost of family planning services and products. It was argued that the payments were intended as symbolic contributions toward products procured by the government and merely promoted the concept of self-reliance without covering the full costs of contraception (Molyneaux, 2000). Nonetheless, BKKBN succeeded in normalizing the practice of making payments--even if nominal--toward family planning services and products. By 1997, only 16 percent of contraceptives were distributed for free (DHS, 1998).

In 1992, BKKBN launched another initiative--the *Keluarga Sejahtera* (*KS*) program--that, in keeping with *KB Mandiri* philosophy, encouraged families to take the initiative to improve their well-being rather than relying on the government to do so. The *KS* program was a family-community interactive model that jointly identified and addressed family needs, aligning family planning objectives with social welfare goals and poverty alleviation. The program clearly represented an expansion of the BKKBN mandate into areas beyond family planning.

The program assigned families to one of four classes with tiered payment expectations for contraceptives. Pre-Welfare and Welfare 1classes received contraceptives at no charge, and Welfare 2 and 3 classes paid relatively higher market prices. The measures of welfare were not based on income alone but also on other social and religious indicators "to account for the economic, physical and spiritual welfare of families" (Winfrey, 1996). BKKBN established an elaborate system to collect and analyze data to support the *KS* program, gathering a massive amount of information on every family each year on, for example, newborn children, contraceptive use, *KS* criteria, the family "prosperity level" classification, and fertility preference (Weidman, 1999). However, comments from key informant interviews indicate that the data may not have been reliable or were biased in a positive way. Thus, the success of the *KS* program remains uncertain.

4.2 DIVERSIFYING THE FAMILY PLANNING MARKET

BKKBN identified an underserved and expansive consumer market willing to pay for its contraceptives--lower-middle-class consumers who could not afford existing commercial sector services and products but who valued high-quality care. BKKBN responded with a dual strategy to serve this growing market niche. On the one hand, it created a cadre of new private sector providers–mostly doctors and midwives–who were trained to offer high-quality FP services in a private setting. On the other hand, BKKBN launched two social marketing programs—the Blue and Gold Circle campaigns--that introduced commercial products at an affordable price, with products procured from and distributed through private channels.

4.2.1 CREATING A NEW CADRE OF FAMILY PLANNING SERVICE PROVIDERS

The first strategy called for expanding access to affordable, high-quality services through private providers. BKKBN improved provider capacity by working indirectly through intermediary organizations, including NGOs and community-based institutions, and by working directly with private providers. Various institutions created private provider clinic networks as a way to deliver training and ensure quality.

The *Yayasan Kusumu Buana* (*YKB*) was an NGO model that served a network of private physicians and midwife clinics in urban areas. As a family planning foundation, it worked under the auspices of BKKBN and received additional support from the United Nations Population Fund. *YKB* instituted user fees and targeted a specific urban clientele. Within four years, it became completely self-sufficient. Subsequently, it received support from USAID to set up an additional network of clinics in Jakarta that expanded its services beyond family planning to maternal and child health services. The network recruited private doctors and midwives and offered training in contraceptive technology and other related FP skills (Lubis, 2003).

In 1987, BKKBN, with assistance from USAID, launched a Service Provider Initiative under the Blue Circle Project. The objective of the initiative was to promote the provision of FP services by private

sector providers, including doctors, midwives, and pharmacies. A critical component of the initiative was provider recruitment and training. BKKBN instituted regular provider training programs on how to offer high-quality family planning products and services, including IUD insertion and other clinical methods. Providers who participated in the training earned the right to display the Blue Circle logo and dispense commercially procured contraceptives. In addition, Blue Circle's integrated communications program (see Section 4.3) heavily promoted Blue Circle providers. By 1989, the communication campaign had spread to all parts of Indonesia and effectively increased awareness of the Blue Circle logo and Blue Circle providers.

Although the Service Provider Initiative successfully increased consumer knowledge of private providers offering FP services, few private doctors in the late 1980s actively offered FP services and methods. Often, private physicians offered FP only upon client request. As a practical matter, most women who relied on the private sector for their FP methods turned to private sector midwives, who charged less than physicians for the same FP services and products (Strauss, 2004). As a result, a small percentage of women from the wealthiest socioeconomic group relied on a limited number of private physicians for FP services and products, while the vast majority went to private midwives.

Over time, midwives became the backbone of the private health sector. Their numbers grew in response to BKKBN's efforts to train, equip, and support them during the last 20 years (Lubis, interview, 2005; Kingfield, interview, 2005; Kantner, interview, 2005). Under the Service Provider Initiative, for example, BKKBN's Blue Circle trained both urban and rural midwives in how to provide FP services and products. At the same time, BKKBN continued to invest in expanding the number private midwives, particularly in rural areas. In addition to clinical training, BKKBN supported rural midwives with equipment and commodities, with the expectation that they would become self-sufficient after one year. The program enjoyed some success but was still plagued by high turnover rates (approximately 40 percent). Many of the private rural midwives were young and did not come from the rural communities where they served and thus faced difficulty in integrating into their service areas. Urban midwives, on the other hand, succeeded and developed thriving practices that served lower- and middle-income groups. But by all accounts, investments in both improving midwives' skills in FP planning and establishing private midwifery practices were particularly successful (Lubis, interview, 2005; Kingfield, interview, 2005; Kantner, interview, 2005). Approximately 60 percent of all midwives worked exclusively in the private sector while the remaining 40 percent worked in both the public sector and their private practice (Lubis, interview, 2005).

4.2.2 LAUNCHING AN AFFORDABLE RANGE OF CONTRACEPTIVE PRODUCTS

In 1988, BKKBN launched the Blue Circle product marketing campaign to complement and extend the Blue Circle Service Provider Initiative and to facilitate the shift from government-procured products to commercially procured products. More specifically, the marketing campaign's objective was to provide low- and middle-income Indonesian women with an affordable family planning product procured and distributed through private sector channels. The campaign focused on urban areas, which constituted a market niche for increased demand among consumers with the ability to pay for high-quality services. The Blue Circle marketing campaign was a sophisticated effort that promoted widespread recognition of a single brand and set out to develop favorable consumer attitudes toward privately procured contraceptives. It addressed both supply and demand issues by (1) providing a choice of products at affordable prices targeted to lower-middle-income consumers, (2) relying on an extensive distribution system of commercial sector retail outlets, (3) engaging private sector doctors, midwives, clinics, and NGOs as distribution points, and (4) using mass media advertising and broad promotional activities.

The Blue Circle campaign was a classic manufacturer's model. The campaign's four participating contraceptive manufacturers agreed to reduce the cost of their products by 40 to 50 percent; in exchange, they used the Blue Circle logo in packaging their products and received marketing support as part of Blue Circle's promotional activities. The manufacturers--Schering, Upjohn, Kamia Farma, and Mecosin--also agreed to contribute to a Return to Project Fund to sustain Blue Circle activities once USAID funding came to an end. The manufacturers offered products already available and popular in Indonesia: Microgynon pills from Schering, Depo Provera injectables from Upjohn, Copper T IUDs from Kamia Farma, and the Dua Lima condom from Mecosin.

The Blue Circle campaign was successful in meeting its objectives. Four years after its launch, Blue Circle products were available through commercial distribution channels in 27 provinces. Moreover, they reached the campaign's intended low- and middle-income consumers. Consumer profile studies indicated that 70 percent of Blue Circle IUD users were middle to lower class consumers as were 91 percent of Blue Circle injectable users and 87 percent of Blue Circle pill users. Blue Circle product sales grew dramatically during the campaign with the increase attributed mostly to new users rather than to a shift from public to private use (Maher, 1992).

Based on the Blue Circle campaign's success, BKKBN recommended that the campaign add more products to its existing line and extend its activities to remote rural areas. An Options II Project report described several challenges encountered by the Blue Circle campaign in reaching rural areas. First, rural consumers were less able to pay commercial prices for contraceptives. Second, Blue Circle products could not compete in rural areas with public sector Blue Lady products, which public facilities either offered for free or sold at a very low price. Third, the Options II report noted substantial leakage of Blue Lady products from the public to the private sector. Doctors, midwives, and community-based workers received a higher margin from public sector Blue Lady products and were therefore more inclined to sell those products instead of Blue Circle products. Finally, distribution to less organized and more geographically remote areas proved extremely costly and discouraged the involvement of commercial distributors. As a result, Blue Circle products did not reach rural areas, and the campaign remained primarily an urban project.

Despite Blue Circle's limited success in reaching rural areas, BKKBN launched the Gold Circle campaign in 1992 to diversify its range of products and broaden distribution to rural areas through Rural Cooperatives. In recognition that the size of the market was growing, the new campaign was designed to increase competition around Blue Circle products. BKKBN allowed the commercial sector to set prices for Gold Circle products; however, that practice undermined many of the successes achieved under Blue Circle and, ultimately, prevented Gold Circle from meeting its goals. The introduction of Gold Circle products confused consumers about the differences between Gold Circle and Blue Circle products. Moreover, the new products created uncertainty among private providers. For example, if a consumer wanted to be *mandiri*, what product was the provider to recommend? In addition, subsidized Gold Circle products created disruptions in the commercial market. Gold Circle essentially established a public sector alternative product that looked like a commercial product. Further, BKKBN offered discounts to low-income consumers by selling Gold Circle products at a lower-than-commercial price (called phased discounts). In effect, the discounts attracted clients away from fully commercial-priced products instead of motivating new clients to switch from free or low-priced products, creating direct competition between the two brands. Usually competition benefits the consumer through price reductions, but instead prices increased for the few consumers--the *mandiri* market--who could pay full commercial prices and therefore constrained expansion of the commercial market (Delatour, 1992).

4.3 STRATEGIC USE OF COMMUNICATIONS

Communications campaigns and public relations were prominent features of BKKBN's policies and programs. From the early years of the program, BKKBN focused on changing social attitudes and generating social acceptance for family planning, effectively using communication to shape public messages that responded to and influenced consumer perception of its programs. BKKBN's messages evolved as did its programs throughout the *repelitas*. Furthermore, BKKBN carefully tailored its mass media messages and public relations strategy to different communities to ensure that family planning was culturally embedded and widely practiced.

As BKKBN shifted its focus to the privatization of family planning services, it reinforced its communications efforts in conjunction with each intervention targeted to private sector growth. Within the framework of *KB Mandiri*, BKKBN consistently communicated a message of self-reliance through a variety of channels, including mass media. It reinforced this message through relationship building with social institutions and informal community networks. As noted, communications and public relations helped transform *KB Mandiri* from a government policy to a social movement. In addition, communications efforts helped increase FP users' receptivity to user fees and to the practice of making contributions at public and private sector services delivery outlets.

BKKBN applied its communication skills to marketing the Blue Circle provider and product campaigns by (1) supporting the introduction of a range of affordable, high-quality products, (2) appropriately pricing products targeted to lower-middle-income users, (3) expanding commercial distribution networks to a growing number of private sector retail outlets, and (4) effectively using mass media advertising and marketing research. BKKBN also combined its marketing activities with broad public relations and promotion activities that were critical in changing public perceptions by building a favorable image of the private health sector.

The Blue Circle public relations efforts focused on two target audiences. First, working through professional associations (the Indonesian Medical, Midwife, and Pharmacist associations), the Blue Circle public relations efforts successfully created a favorable image of family planning services among private doctors and midwives. The public relations efforts also helped recruit private doctors and midwives to participate in BKKBN-sponsored training programs and eventually offer FP services and products. Second, the Blue Circle public relations efforts targeted the general public with the objective of raising public awareness of a new cadre of private providers and the availability of new products. Promotional campaigns encouraged two consumer behavior changes: (1) developing the habit of paying for FP services and products and (2) seeking private health sector providers to meet their FP needs. With a dedicated Indonesian public relations firm conducting market research and guiding the communications strategy, the Blue Circle campaign gained prominence in urban markets and was clearly associated with high quality, choice, and affordable pricing. Several informants stated that Blue Circle's public relations activities were both effective and critical in informing the public about the new cadre of FP providers and the affordable products available through private sector delivery outlets (Kingfield, interview, 2005; Molyneaux, interview, 2005a).

5. SHIFT TO THE PRIVATE HEALTH SECTOR: DID IT OCCUR?

The difference between public and private provision of healthcare services and products in Indonesia is not easy to discern (Marzolf, 2002). Most Indonesian healthcare professionals provide both public and private services, making categorization into one sector or the other impossible. Furthermore, the literature describing Indonesia's family planning program does not distinguish between public and private providers. In addition, the official line between public and private has changed over time. To meet its policy target of privatizing the family planning sector by 50 percent, BKKBN--according to key informants--classified public sector visits, during which consumers paid for services and/or family planning products, as private sector visits. Another blurring of the definition is the reclassification of a major service delivery point in the DHS. This chapter attempts to address some of the ambiguities using DHS data to determine if an increase in private sector use occurred.

5.1 DIFFERENCES IN DEMOGRAPHIC AND HEALTH SURVEY CLASSIFICATION

The difficulty in distinguishing the private sector from the public sector in Indonesia extends to the data gathered from the DHS during *KB Mandiri* in 1987, 1991, 1994, and 1997.[1] Several public sector facilities–*PPKBD (*village family planning groups*), posyandus,* and *polindes*[2]– that were originally classified as public sector facilities in 1987 and 1991 were reclassified in the 1994 and 1997 DHS as private sector service delivery outlets[3]. Among the various public sector facility types, the predominant service delivery point was the *posyandu*, a monthly mother-child health clinic operated by the community with community resources, with support from the local *puskemas* (public hospitals) and a local village midwife (*bidan desa*) paid by BKKBN (Strauss et al., 2004). A review of the literature and key informant interviews indicate that the *posyandus* could be defined as parastatal (Strauss et al., 2004). Each *posyandu*'s manager shaped the individual facility, though *posyandus* were supposed to provide standardized services (Molyneaux, personal communication, 2005b). Thus, some *posyandus* accepted donations from private sources beyond the public funds they received while others relied solely on public funds. Moreover, they distributed contraceptives procured through government channels but charged almost full commercial prices (Lubis, interview, 2005). To account for the ambiguous classification of facility types, this chapter analyzes *PPKBD*, *posyandus*, and *polindes* as a separate group termed FP, health, and delivery posts. Conversely, the term private sector excludes these facilities from all analyses.

Figure 2 illustrates sources of contraception from 1987 to 1997. With *PPKBD*, *posyandu*s, and *polindes* categorized separately, the results show that the private sector expanded by nearly threefold over a 10-

[1] These DHS years were chosen for study because of their correspondence with *KB Mandiri*.

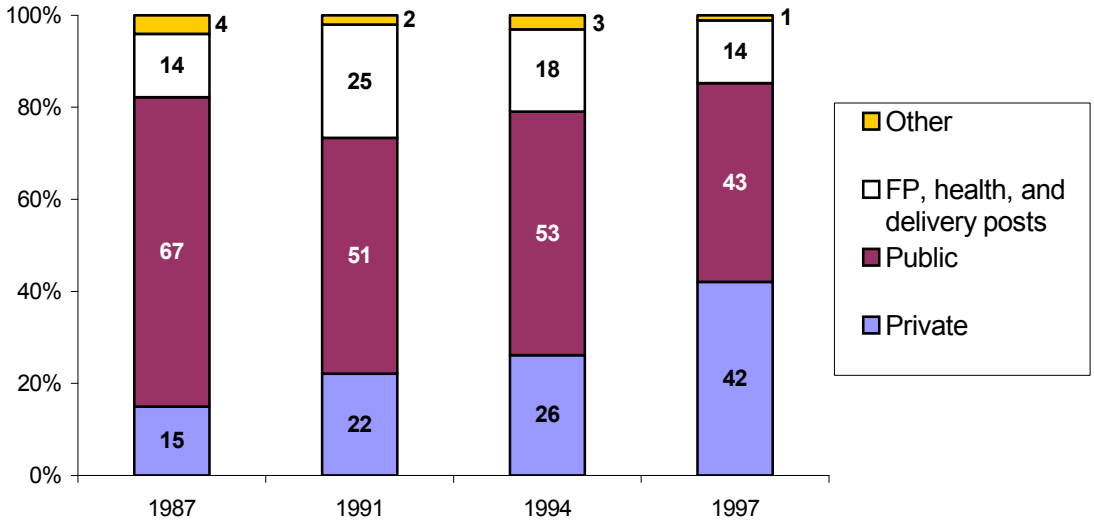
[2] *PPKBD*, *posyandus*, and *polindes* are also termed family planning, health, and delivery posts, respectively, in the DHS data. For ease of reporting, the terms are used in this chapter's discussion of the analyses.

[3] Annex A shows the source coding from each Demographic and Health Survey and the recoding for the purposes of these analyses. In the analyses, private sector includes private doctors, clinics, hospital, and midwives; pharmacies; and private health officers.

year period. In 1987, only 15 percent of women used the private sector to obtain contraception. By 1997, however, the percentage of women using the private sector expanded to 42 percent. During the same years, the percentage of women obtaining contraception in the public sector decreased by 24 percent (from 67 to 43 percent). Given that the family planning, health, and delivery posts and "other" percentages decreased slightly over the same period, most of the shift to the private sector resulted from a decline in public sector usage.

FIGURE 2. SOURCE OF CONTRACEPTIVES IN PRIVATE SECTOR; PUBLIC SECTOR; AND FAMILY PLANNING (FP), HEALTH, AND DELIVERY POSTS

1987 and 1997



Source: Indonesian Demographic and Health Surveys.

Urban versus rural reliance on the private sector, depicted in Table 1, reaffirms the trend toward increasing use of the private sector for contraception. The private sector grew steadily between 1987 and 1997 in urban areas, from 25 to 61 percent. Despite the difficulties in extending private sector programs such as Blue and Gold Circle to rural areas, the private health sector also gained more than a third of the family planning market share, providing 35 percent of rural women's contraceptive services and products in 1997.

TABLE 1. PERCENTAGE OF FAMILY PLANNING CLIENTS USING THE PRIVATE SECTOR TO OBTAIN CONTRACEPTION BY LOCALITY

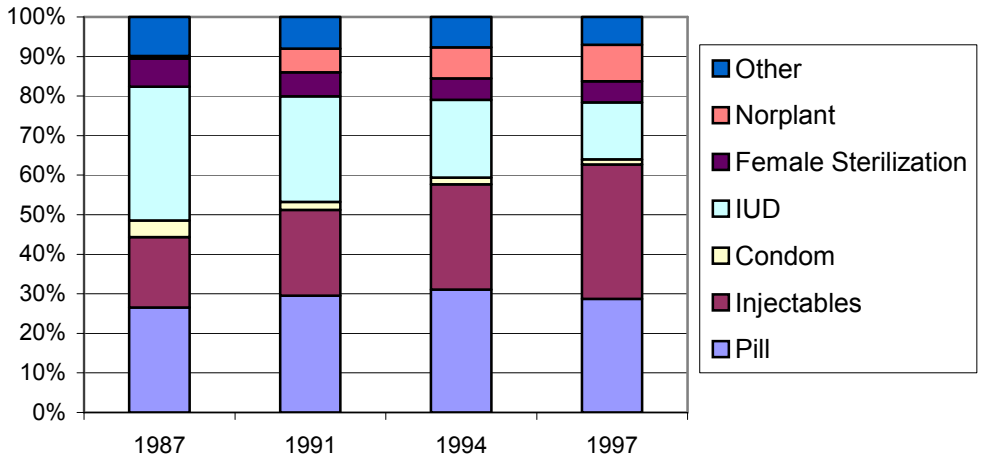
Year	Urban	Rural
1987	25	7
1991	41	13
1994	47	20
1997	61	35

Source: Indonesian Demographic and Health Surveys.

5.2 CHANGES IN SOURCE OF CONTRACEPTIVE METHODS

Before examining sources of contraceptives by method, it is useful to consider how the method mix changed over time. Figure 3 presents the contraceptive method mix from 1987 to 1997. In 1987, the predominant contraceptive methods were the IUD (33 percent), the pill (27 percent), and injectables (18 percent). After 10 years, these three methods were still the predominant choices, but injectables grew gradually to become the preferred method (35 percent), in part because IUD users switched to injectables owing to IUD side effects and related health concerns and the strong promotion of injectables in both the public and private sectors (Kak, 1999).

FIGURE 3. CONTRACEPTIVE METHOD MIX: 1987 TO 1997



Source: Indonesian Demographic and Health Surveys.

Table 2 shows the percentage of women obtaining their respective contraceptive by source. An important shift in the public versus private supply of contraceptive methods occurred between 1987 and 1997. In 1987, condoms were the only method for which the private sector claimed 50 percent or more of market share. By 1997, the share grew to 75 percent. The percentage of pill users obtaining contraception from the private sector increased considerably between 1987 and 1997, from 5 to 32 percent, while the private sector share of IUDs also experienced a substantial increase, growing from 10 to 32 percent over this time period. The most marked change, however, occurred with injectables. In 1987, only 23 percent of women obtained injectables through the private sector. By 1997, the percentage grew almost threefold to 61 percent.

Overall, the private sector share of all contraceptive methods, except for female sterilization, increased over the 10-year period and may be linked to the increasing number of private sector providers as well as to the greater availability of contraceptive products in the private sector through the Blue and Gold Circle programs (Weidemann, 1999; Strauss et al., 2004). In addition, increases in the contraceptive prevalence rate (see Figure 1) indicate that growth in the private sector may be partially attributable to new family planning users.

TABLE 2. PERCENTAGE OF WOMEN OBTAINING THEIR CONTRACEPTIVE METHOD FROM THE GIVEN SOURCE

Stratified by Method and DHS Year

Method	Source	1987	1991	1994	1997
Condom	Private	58	54	66	75
	Public	27	28	20	16
	FP, health, and delivery posts	11	16	13	*
Pill	Private	5	10	15	32
	Public	43	28	32	34
	FP, health, and delivery posts	35	57	42	30
Injectables	Private	23	39	50	61
	Public	67	47	42	31
	FP, health, and delivery posts	8	13	7	7
Norplant	Private	*	4	8	17
	Public	80	82	78	71
	FP, health, and delivery posts	*	12	12	11
IUD	Private	10	21	25	32
	Public	81	69	66	60
	FP, health, and delivery posts	7	9	7	8
Female sterilization	Private	*	29	27	29
	Public	93	71	71	70
	FP, health, and delivery posts	0	0	0	0

Source: Indonesian Demographic and Health Surveys.

The percentages of users obtaining contraceptives through family planning, health, and delivery posts was low and remained relatively steady for all contraceptives except for the pill. In 1987, more than a third of pill users obtained their method through family planning, health, and delivery posts, and, by 1991, the share had increased to 57 percent of pill users. However, as the private sector became a more popular source over the years, the percentage of pill users obtaining their contraception from these posts decreased to 30 percent by 1997.

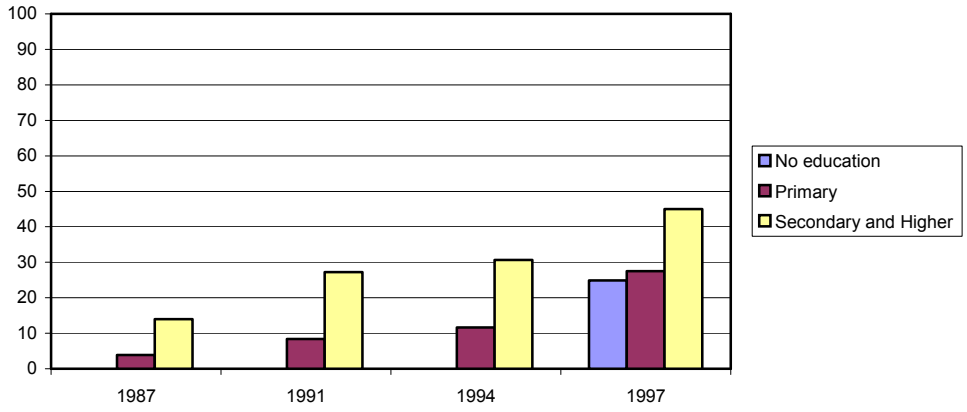
As a consequence of rising reliance on the private sector for contraceptives and the relatively steady percentages of reliance on family planning, health, and delivery posts, dependence on the public sector for contraceptives declined. In 1987, 67 percent of women obtained injectables through a public sector facility, but, 10 years later, only 31 percent of women did so. Pill users also switched in large numbers from the public to private sector to obtain their method. It is interesting to note that even long-acting methods, which are traditionally the domain of the public sector, experienced a decline in favor of the private sector. Thus, across all contraceptive types, much of the increase in private sector use resulted from substantial declines in reliance on the public sector for contraceptives.

5.3 CHANGES IN SOURCE OF CONTRACEPTIVE METHODS BY EDUCATION

The breakdown of contraceptive source by socioeconomic status is typically used for segmenting the contraceptive market for marketing and pricing purposes. Given that the Indonesian DHS lack a standardized measure of socioeconomic status, we substitute education as a proxy for socioeconomic status.[4] Graphs 4, 5, and 6 show the range of private sector use of the pill, injectables, and IUD by educational level, respectively.[5]

Between 1987 and 1997, women of all educational and socioeconomic levels turned to the private sector to obtain the pill with greater frequency. Graph 4 shows that, in 1987, 4 percent of women with a primary education and 14 percent of women with a secondary education or higher obtained the pill from the private sector. By 1997, women with no education were also turning to the private sector to obtain the pill in almost equal percentages as women with a primary education (25 versus 27 percent), and 45 percent of women with a secondary education or higher obtained the pill from the private sector.

FIGURE 4. PERCENTAGE OF PILL USERS OBTAINING THEIR METHOD IN THE PRIVATE SECTOR BY EDUCATIONAL LEVEL: 1987 TO 1997



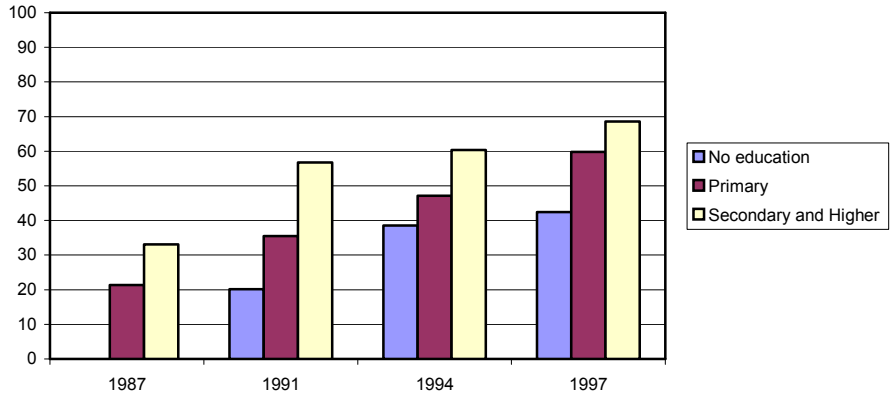
Even more dramatic than the pattern of pill use is the pattern among injectables users relying on the private sector. Graph 5 shows that, in 1987, approximately 35 percent of women with a secondary or higher education obtained injectables from the private sector while women with no education did not use injectables at all. The percentages quickly grew, however, and by 1997, more than 40 percent of women with no education and almost 70 percent of women with a secondary education or higher obtained injectables from the private sector. A possible explanation for the striking increase is that BKKBN purchased fewer products from Upjohn, the main supplier of injectables; therefore, the public sector could not satisfy the demand for injectables (Molyneaux, interview, 2005a). Another reason for the shift is that price differentials between sectors were increasing (see Table 4) so that women instead

[4] Ideally, we would want to examine trends disaggregated by socioeconomic status. However, there is no standardized measure of socioeconomic status across the Indonesian DHS; therefore, we substituted education as a proxy for socioeconomic status. Annex B displays results of a cross-tabulation of wealth and education in the 2002-2003 Indonesia DHS, justifying use of education as a proxy.

[5] The graphs omit categories with fewer than 25 respondents in any given year.

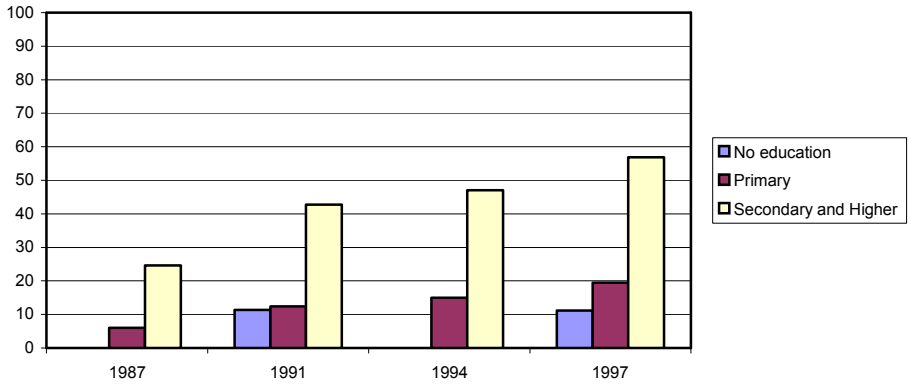
purchased injectables for a similar price in the private sector, perhaps perceiving greater convenience and higher product quality.

FIGURE 5. PERCENTAGE OF INJECTABLE USERS OBTAINING THEIR METHOD IN THE PRIVATE SECTOR BY EDUCATIONAL LEVEL: 1987 TO 1997



In contrast, a low percentage of IUD users with no education or a primary education used the private sector between 1987 and 1997, reconfirming earlier findings that the majority of women continued to obtain their IUDs from the public sector. The same period, however, saw an important increase in reliance on the private sector for IUDs among women with a secondary or higher education, from 25 percent in 1987 to over 50 percent in 1997 (see Figure 6).

FIGURE 6. PERCENTAGE OF IUD USERS OBTAINING THEIR METHOD IN THE PRIVATE SECTOR BY EDUCATIONAL LEVEL: 1987 TO 1997



Source for Graphs 3, 4, and 5: Indonesian Demographic and Health Surveys.

Figures 4, 5, and 6 demonstrate that women with higher educational levels and possibly greater economic means relied on the private sector for their contraceptive methods in larger numbers than women with lower educational levels and, presumably, limited resources. The pattern was consistent regardless of contraceptive method. Greater use of the private sector was a positive trend considering that BKKBN's policy goal was to encourage more Indonesian couples who could afford to pay, assume

financial responsibility for the purchase of their FP methods and services in the private sector. A second, and possibly more troubling, trend was that a growing number of women with lower educational levels and potentially limited economic means relied increasingly on the private sector for their FP methods, particularly for injectables. Such a trend raises equity and efficiency issues for BKKBN.

5.4 PRICE AND SEGMENTATION AMONG DIFFERENT SOURCES

Though the analysis of contraceptive source by education--a proxy for income--provides a description of who is relying on the private sector for family planning services, the results do not allow for price comparisons between contraceptive sources, which can reveal the true similarities between sources. Furthermore, contraceptive source differentiation may be examined through the percentage of contraceptive users who obtained their product for free, which can show to what extent a given source subsidizes products and how well the market is segmented by income groups. A well-segmented contraceptive market is characterized by high percentages of the wealthier, able-to-pay portion of the population (or, in this case, the more educated portion) patronizing the private sector while the poorest segments of the population obtain contraceptive products from the public sector, whose subsidized products cost customers relatively little.

An analysis of price permits us to see the differences between public and private sector prices for these three methods. Tables 3, 4, and 5 present the mean cost of pills, IUDs, and injectables, respectively, by education level. The same tables present the percentages of women who obtained the products for free by source and further disaggregate the percentages by DHS year and educational level in order to explore segmentation in greater depth.

In Table 3, several findings emerge on the cost of the pill. First, the average price paid for the pill remained higher in the private sector than in the public sector and at FP, health, and delivery posts throughout all years and across all levels of education (income level). For example, the mean price paid by a pill user with a primary education in 1987 was 1,713 rupiah in the private sector versus 275 rupiah in the public sector. The same pattern held in 1997, with women with a primary education paying an average 1,216 rupiah in the private sector and 856 rupiah in the public sector. Second, private sector prices increased across all educational levels as compared with prices in the public sector and at FP, health, and delivery posts. Third, women with no education or a primary education–presumably those with the least economic means--experienced the most dramatic price increases in the public sector and at FP posts. Finally, public sector prices began to converge with private sector prices for women with no education. One reason for the convergence may be the decline in the volume of subsidized product available at FP, health, and delivery posts in the early/mid-1990s (Molyneaux, personal correspondence).

TABLE 3. MEAN COST OF PILL (IN RUPIAH) AND PERCENTAGE OF WOMEN WHO OBTAINED PILLS FOR FREE FROM THE PRIVATE SECTOR; PUBLIC SECTOR; AND FP, HEALTH, AND DELIVERY POSTS ACCORDING TO DHS YEAR AND EDUCATIONAL LEVEL: 1987 TO 1997

	1987			1991			1994			1997		
	No Education	Primary	Secondary and Higher	No Education	Primary	Secondary and Higher	No Education	Primary	Secondary and Higher	No Education	Primary	Secondary and Higher
Cost (rupiah)												
Private sector	753	1,713	2,902	1,057	869	2,236	740	1,017	2,212	887	1,216	2,266
Public sector	225	275	832	401	500	863	494	642	644	700	856	1,020
FP, health, and delivery posts	121	149	146	256	288	296	399	464	466	753	707	757
Obtained free (percent)												
Private sector	1.7	1.5	3.2	1.1	1.3	4.4	0.4	1.3	3.9	1.0	1.3	1.6
Public sector	23.2	38.7	51.3	13.5	10.5	17.1	8.8	6.8	10.8	2.7	2.5	4.8
FP, health, and delivery posts	27.7	29.9	23.3	24.6	18.4	15.0	8.9	7.1	6.1	3.6	3.0	2.5

TABLE 4. MEAN COST OF INJECTABLES (IN RUPIAH) AND PERCENTAGE OF WOMEN WHO OBTAINED THEM FOR FREE FROM THE PRIVATE SECTOR; PUBLIC SECTOR; AND FP,HEALTH, AND DELIVERY POSTS

	1987			1991			1994			1997		
	No Education	Primary	Secondary and Higher	No Education	Primary	Secondary and Higher	No Education	Primary	Secondary and Higher	No Education	Primary	Secondary and Higher
Cost (rupiah)												
Private sector	1,923	3,051	3,400	3,044	3,286	4,063	3,741	3,922	5,217	4,694	4,497	5,333
Public sector	1,209	1,437	1,897	2,524	1,926	2,079	2,650	2,688	3,019	3,965	4,160	4,331
FP, health, and delivery posts	500	833	1,868	1,621	1,411	1,313	2,086	2,525	2,571	3,580	3,805	3,788
Obtained free (percent)												
Private sector	0.0	1.0	1.0	1.2	0.6	3.7	1.1	0.6	1.8	0.2	0.8	1.3
Public sector	27.6	24.6	15.6	10.9	4.9	7.9	4.6	3.4	4.2	2.0	1.3	1.6
FP, health, and delivery posts	6.8	1.8	2.0	5.6	2.2	0.7	2.5	1.1	0.6	1.0	0.5	0.2

*Highlighted cells indicate fewer than 25 cases.

TABLE 5. MEAN COST OF IUDS (IN RUPIAH) AND PERCENTAGE OF WOMEN WHO OBTAINED THEM FOR FREE FROM THE PRIVATE SECTOR; PUBLIC SECTOR; AND FP, HEALTH, AND DELIVERY POSTS

	1987			1991			1994			1997		
	No education	Primary	Secondary and Higher	No Education	Primary	Secondary and Higher	No Education	Primary	Secondary and Higher	No Education	Primary	Secondary and Higher
Cost (rupiah)												
Private sector	7,336	14,679	22,355	6,562	16,568	33,440	7,012	16,524	32,843	9,911	28,049	42,079
Public sector	199	2,967	11,332	1,538	1,790	4,406	1,692	2,302	7,840	3,344	4,825	10,671
FP, health, and delivery posts	NA	NA	NA	711	1,117	17,650	534	899	1,937	NA	3,005	2,741
Obtained free (percent)												
Private sector	1.4	1.3	2.2	5.3	4.2	5.2	2.8	4.2	7.3	5.4	5.3	6.6
Public sector	74.4	72.9	54.6	57.7	51.4	35.3	56.7	54.1	26.6	42.3	46.0	19.7
FP, health, and delivery posts	8.2	9.2	1.5	9.6	11.6	2.5	5.8	7.2	3.4	16.2	5.8	1.2

Source for Tables 3, 4, and 5: Indonesian Demographic and Health Surveys.

*Highlighted cells indicate fewer than 25 cases.

In terms of the percentage of pill users who obtained their product for free, a very low percentage of users obtained free pills from the private sector where it is expected that they paid for pills irrespective of educational and, presumably, income level. Over time, the public sector and FP, health, and delivery posts came to resemble the private sector, with fewer and fewer women obtaining their pills for free from these outlets. Originally, results indicate the public sector, FP and health and delivery posts were subsidizing women who could potentially afford to pay. In 1987, for example, more than half of women with secondary education or higher obtained their pills in the public sector for free, and greater than 20 percent in FP posts received their method for free. This pattern shifted over the 10 year period, and by 1997 less that 5 percent of women from this same income group received their pills for free from the public or family planning, or health and delivery post.

More troubling, however, is the decline of free and/or subsidized pills available to women who cannot afford to pay for them. In 1987, more than one-fifth of pill users with no and/or primary education obtained their method for free in the public sector and FP, health and delivery posts. By 1997, less than 5 percent of poor women received the pill for free while the majority of women in this income group paid commercial level prices for this method in the private sector.

Table 4 shows that the average private sector injectable cost remained consistently higher than costs in the public sector and at FP, health and delivery posts. Equally, during the survey years, average prices paid by injectable users with a secondary education or higher were greater than the prices paid by users with a primary or no education. By 1994, the pattern began to change as the average price for injectables in the private and public sectors started to converge. By 1997, the average price for injectables purchased in the public sector more closely mirrored prices in the private sector.

Similar to the pill, the percentage of injectable users who obtained their method for free declined over the ten-year period. Almost no one received an injectable method for free in the private sector. In 1987, only 15% of women with secondary or higher education and 28% of women with no education received injectables for free in the public sector. Even fewer women received free injectables in FP, health and delivery posts. By 1997, the vast majority of women were paying for injectables. This transformation is primarily attributed to public sector decrease in injectable.

In comparison, price trends for the IUD differ markedly from the other two methods (see Table 5). Across all years and educational levels, average IUD prices are several thousands of rupiah higher in the private versus public sector. Moreover, the average prices paid by IUD users were well segmented in both the public and private sectors by education throughout all survey years; women with higher educational attainment and, presumably, economic means paid more for the IUD than women with less education. Finally, FP, health, and delivery posts played a minimal role as an IUD supplier as indicated by the low cell sizes for all years.

Similar to the pill and injectables, fewer women received a free IUD from the public sector. Originally, 54 percent of women who could presumably pay received a free IUD in the public sector. This number dropped dramatically to less than 20% by 1997. However, women who had the least resources – with no or primary education- received fewer free IUDs. In 1987, almost ¾ of women with no or primary education received the IUDs free compared to less than ½ in 1997.

6. CONCLUSION: WHAT CAN WE LEARN

The purpose of the Indonesian case study was (1) to discern if the growth in the FP private sector actually occurred and (2) to determine the influence, if any, of BKKBN's privatization policies and programs on expanding the private sector's involvement in the family planning marketplace. After analyzing the data and speaking with Indonesian experts, we conclude that the private sector indeed experienced substantial growth in the FP market. Over the 10-year period from 1987 to 1997 when BKKBN established and actively implemented private sector–oriented programs and policies, the percentage of women who turned to the private sector for contraception increased almost threefold, from 15 to 42 percent. The trend was especially pronounced in urban areas, where the private sector expanded its market share from 25 to 61 percent. But the private sector also penetrated rural areas and experienced important growth of 7 to 35 percent during the same period.

BKKBN's *KB Mandiri* policy and programs had several downstream effects beyond expanding the private sector's role in the FP market. First, greater private sector provision of FP influenced the method mix. In 1987, the predominant contraceptive methods were the IUD (33 percent), the pill (27 percent), and injectables (18 percent). After 10 years, the three methods were still the predominant choices, but injectables grew gradually to become the preferred method (35 percent), in part because IUD users switched to injectables.

Second, the Indonesian FP market was segmented by educational level--a proxy for income groups--with the more educated portion of the population (presumably, women with higher income) seeking FP services and methods in the private sector. Among women with a secondary education or higher, the percentage relying on the private sector increased substantially for the three most popular contraceptive methods. The increase in private sector reliance demonstrates the success of *KB Mandiri* in encouraging couples able to pay to move from the public to the private sector and assume financial responsibility for their FP methods.

Third, the marketplace was well segmented by price, and offered a wide range of prices for FP products targeted to women of different educational levels. Based on pricing data, the findings show distinct price averages paid by women purchasing the three dominant contraceptive methods in the public and private sectors and at FP, health, and delivery posts, pointing to an unmistakable delineation between public and private sector prices. Throughout the 10-year period, the private sector charged consistently higher prices as compared with the public sector and FP posts. But even within the private sector, more educated women paid a higher price for their contraceptive methods as compared with women with no education, indicating that uneducated women, who presumably represent a lower income level, could find an affordably priced FP method in the private sector. While women of different educational levels paid at different price levels for most FP methods, the price of injectables in public sector outlets and at FP posts tended to converge with those in the private sector. However, a possibly more troubling impact of *KB Mandiri* was that a growing number of uneducated women increasingly relied on the private sector for their FP methods, particularly for injectables. That an increasing percentage of women with low educational attainment and limited ability to pay came to depend on the private sector raises equity and efficiency issues for BKKBN.

While the case study clearly demonstrates the growth of Indonesia's FP marketplace, conducting the research also underscores the difficulty in defining Indonesia's private sector in the FP context. In particular, the reclassification of health facilities and providers confounds what is meant by private sector. As developing countries and donors try to foster greater private sector participation in health, the international community--including donors and developing country Ministries of Health--should keep in mind the need for a clear and consistent definition of private sector. Moreover, future program design, documentation, and research should incorporate essential terms related to the private sector to create a common language for discussing private sector entities and initiatives.

6.1 GUIDELINES AND PRINCIPLES FOR A PRIVATE SECTOR FP MARKETPLACE

The case study also examined what lessons can be learned from Indonesia for translation into general guidelines and principles for other countries setting out to increase the private sector's role in the FP/RH marketplace. Taking a cue from the marketing concept of the four Ps, we developed a similar schema to describe the private sector market conditions and policies that need to be in place if a private sector in FP/RH is to thrive. They are:

P is for **P**olicy

P is for **P**roduct and **P**rice

P is for **P**roviders

P is for **P**romotion

6.2 P IS FOR POLICY: GOVERNMENT'S ROLE IN AND INFLUENCE ON THE PRIVATE FP SECTOR

Although the government and BKKBN did not initially see a role for the private sector in the delivery of family planning services, the convergence of several social, political, and economic trends prompted decision makers to rethink their position. Accordingly, BKKBN decided to transform its government-dominated FP program into a more self-sufficient program that would motivate family planning users to become less reliant on the public sector. More specifically, BKKBN introduced a series of policies and programs aimed at expanding the role of the private sector in the delivery of family planning services (described more fully in the next sections). The policy shift coincided with a broader health sector privatization initiative during the 1980s that focused on improving service quality, reforming the financing system, and increasing the role of private providers.

Other BKKBN initiatives were not intentionally designed to expand the private sector, yet they helped foster the conditions necessary to make the Indonesian FP marketplace attractive to the private sector. Most notably, BKKBN succeeded in demonstrating a strong and predictable market, as Indonesia underwent a fundamental shift in social and normative values around the need for family planning and exhibited new fertility preferences and new attitudes toward contraception. Rapidly declining fertility combined with dramatic and sustained increases in CPR enabled BKKBN to capture the attention of private sector contraceptive manufacturers. In addition, with the introduction of user fees in the private sector, BBKBN gradually introduced the concept of payment for FP products, a concept further

reinforced by BKKBN's *KB Mandiri* message that self-reliant families contribute financially to their FP costs. By the mid-1980s, Indonesia had institutionalized the practice of payment for services and products by rich and poor alike.

The Indonesian case study underscores the fact that expansion of the private sector often depends on the actions of the public sector. BKKBN was the architect that spearheaded and built the private sector. Ideally, public sector entities should (1) promulgate policies and regulations conducive to the private health sector's involvement in the delivery of family planning services, (2) capitalize on its regulatory role to facilitate growth of the private health sector, and (3) enter into partnerships with the private health sector to achieve public health goals. But it is unrealistic and, in many cases, not necessary for the public sector to take an active role in creating and/or facilitating a private sector for family planning services and products. In instances with a strong private health sector, such as Ukraine and Pakistan, the public sector merely did not oppose or block private sector involvement in providing FP/RH services and products.

6.3 P IS FOR PRODUCTS AND PRICE: INTRODUCING AFFORDABLE PRODUCTS VALUED BY FP CONSUMERS

Initially, the Indonesian National FP program was a government-dominated program that offered fully subsidized services and products. Over time, BKKBN introduced user fees for FP products but still deeply subsidized the products. When BKKBN started its private sector initiative, only free or heavily subsidized or commercially priced FP commodities were available in the marketplace, leaving a gap in the price range of FP products but signaling tremendous market potential for moderately priced FP products that would respond to lower- to middle-income groups that could afford to pay but did not have a product to purchase.

Under the Blue Circle campaign, BKKBN negotiated with four pharmaceutical manufacturers to reduce their prices for a range of pills, Depo, and injectables familiar to consumers. Blue Circle reached its intended consumer niche, and, for the first time, Indonesian consumers were able to purchase high-quality FP products at moderate prices. As the pricing data demonstrated, even women with limited economic resources could find affordably priced FP methods in the private sector. Eventually, the private sector consolidated its market presence and, by 1998, became the dominant provider of pills and injectables. Indeed, Indonesian consumers were so accustomed to purchasing their FP methods in the private sector that, despite the economic crisis of 1997 and associated price increases, they continued to purchase their methods from the private sector.

The Indonesian example demonstrates that a FP marketplace offering both public and private sector products must sell a full range of products at different price ranges. Initially, when the public sector offers FP products, it must fully subsidize the products and offer them for free to those unable to pay. To help "jump start" the introduction of private sector products, many countries rely on a social marketing program or NGOs that already offer FP products, with the public sector and/or donors subsidizing the price at a sufficiently low level to attract new and paying FP users. As demand takes hold, the marketplace needs to offer an affordable range of FP products to meet the needs of low- to middle-income groups. As a more mature FP marketplace evolves, for-profit manufacturers import, distribute, and deliver commercially priced FP products, the consumer bears the full cost of the product, and the vendor earns a profit on the purchase. A fully mature FP marketplace eventually offers a range of FP products at different price points for different segments of the population.

6.4 P IS FOR PROVIDERS: ESTABLISHING A NEW CADRE OF PRIVATE PROVIDERS OFFERING FP

BKKBN determined that, to meet the needs of the enormous volume of new users entering the FP market, it would have to increase the supply of both public and private sector services. When BKKBN decided to privatize FP services, almost all FP providers--except for the few private providers who cared for affluent Indonesians--were full-time government employees, supported by a large number of community-based volunteers. With the introduction of user fees, the definition of public versus private provider became somewhat blurred; some public sector providers in the *posyandu* posts were charging fees for services and commercial prices for products but were still supervised by the public sector. However, very few truly private providers offered FP services and products. To address this gap, BKKBN offered incentives to motivate private sector providers to add FP services and products to their portfolios. Under the Blue Circle Service Provider Initiative, BKKBN trained existing private practitioners in the delivery of FP services and provided contraceptive commodities. When the initiative resulted in only limited success, BBKBN turned to midwives, offering them the same incentives available under the Service Provider Initiative. Eventually, midwives became the FP provider of choice in the private sector. They were readily accessible to the communities they served and more affordable than physicians.

A fully functioning FP marketplace needs a wide range of FP providers and services. In the case of Indonesia, BKKBN stepped in to help create a new cadre of private health professionals offering FP services. A mixed marketplace offers a choice of providers to meet the health and socioeconomic needs of different population groups. Providers range from full-time government employees offering free services to the poorest population groups, to nonprofit and NGO providers offering affordable services to low-and mid-income groups, to private, for-profit providers.

6.5 P IS FOR PROMOTION: COMMUNICATING TO FP CONSUMERS TO INCREASE DEMAND FOR PRIVATE SECTOR SERVICES AND PRODUCTS

Communication and public relations were fundamental to Indonesia's successful expansion of the private sector. BKKN had always used communications effectively to help recast social norms to foster greater acceptance of smaller families and to stimulate demand for FP services and products. Later, in an effort to encourage self-reliance, it used similar communications approaches to foster Indonesians' acceptance of payment for FP services. With the introduction of private sector providers, however, BKKBN recognized that it had to inform consumers--accustomed to relying on public sector providers--about changes in the marketplace. To that end, the program adopted multipronged strategies at various phases--including advertising, public relations, and IEC activities--to communicate to the national audience that consumers could now obtain FP services and products through qualified and trained private providers and pharmacies. The strategies carefully differentiated messages to various consumer groups based on local preferences, community relationships, local infrastructure, and other factors. The Blue Circle campaign was particularly effective in its communications strategy; beyond simply promoting a specific brand, it changed consumer perceptions concerning the private sector in general.

In a public sector–dominated marketplace, the government assumes full responsibility for communicating public health messages to the public. As new actors enter the FP marketplace, communications remains the responsibility of the public sector. As the marketplace matures, however, the government steps out of public health communications and turns to NGOs and SMOs to undertake a significant share of the

communications function, targeting specific groups and promoting specific brands. At the same time, an increasing number of private and for-profit companies brand and promote their commercial products. In an integrated FP marketplace, generic communications is institutionalized as part of health education--without significant public support.

6.6 A FINAL NOTE

The case study of the Indonesian private sector FP market offers insights into the policies and programs that led to the evolution of the private sector as the provider of family planning services. Though no single policy, program intervention, or player can be credited with Indonesia's dramatic expansion of the private sector, several macro-level economic and social changes converged with BKKBN's implementation of a range of private sector–oriented policies and programs that, over time, led to a pronounced market shift. Within this dynamic and complex RH/FP landscape, BKKBN played an instrumental role in setting the stage for private sector growth by creating conditions conducive to attracting and retaining the private sector as the FP provider of choice.

As a final post script, the 1997 Asian economic crisis was not only a tipping point for but also a test of the overall resilience of Indonesia's private family planning sector. With the economic crisis, BKKBN did not have the foreign exchange to purchase family planning commodities and could no longer offer commodities such as pills and injectables for free or at minimal charge. Consequently, many FP consumers left the public sector to purchase their FP method in the private sector despite the rapid price increases occasioned by the economic crisis. The switch to the private sector was especially apparent in the instance of injectables; BKKBN had created such high demand for the method that consumers switched to the private sector to obtain it. During the economic crisis, the private sector stepped in to fill the gaps created by a weakened public sector. Interestingly, contraceptive prevalence remained stable during this period (Frankenberg et al., 2003; Strauss et al., 2004). After the economic crisis, FP consumers remained in the private sector despite the price increases.

ANNEX A: CONTRACEPTIVE SOURCE CODING FROM THE DEMOGRAPHIC AND HEALTH SURVEYS AND RECODING FOR STUDY ANALYSES

Year of DHS	DHS Contraceptive Source coding (v326)	Recoding for study analyses
1987	1 Klinik KB 2 PLKB Petugas Lapang 3 POS KB (FP Post) 4 TKBK (Mobile Unit) 5 Safari (Campaign) 6 Apotik (Pharmacy) 7 Dokter Swasta (Priv) 8 Bidan (Midwife) 9 Posyandu (Hlth Post) 10 Dukun (Trad. Healer) 11 Lainnya (Other) 97 Inconsistent 98 Don't know 99 Missing	Private sector 6 Apotik (Pharmacy) 7 Dokter Swasta (Priv.) 8 Bidan (Midwife) Public sector 1 Klinik KB 2 PLKB Petugas Lapang 4 TKBK (Mobile Unit) 5 Safari (Campaign) FP, health, and delivery posts 3 POS KB (FP Post) 9 Posyandu (Health Post)
1991	10 PUBLIC SECTOR 11 Government hospital 12 Health center-Pusk 13 Health post-Posyandu 14 FP post/VCDC/Paguyu 15 Fieldworker-PLKB 16 FP mobile-TKBK/TMK 17 "P Safari 20 MEDICAL PRIVATE SECT 21 Private hospital 22 Private clinic 23 Private doctor 24 Private midwife 25 Pharmacy/drugstore 30 OTHER PRIVATE 31 Tradit. healer-Dukun 32 Friends/Relatives 40 OTHER 41 Other 42 Nowhere 98 DK 99 Missing	Private sector 20 MEDICAL PRIVATE SECTOR 21 Private hospital 22 Private clinic 23 Private doctor 24 Private midwife 25 Pharmacy/drugstore Public sector 10 PUBLIC SECTOR 11 Government hospital 12 Health center-Pusk 15 Fieldworker-PLKB 16 "P mobile-TKBK/TMK 17 FP Safari FP, health, and delivery posts 13 Health post-Posyandu 14 FP post/VCDC/Paguyu

1994	10 PUBLIC SECTOR 11 Government hospital 12 Health center-Pusk 13 Fieldworker-PLKB 14 FP mobile-TKBK/TMK" 15 Other government" 16 Village official" 20 PRIVATE MEDICAL" 21 Private hospital" 22 Private FP clinic" 23 Private doctor" 24 Private midwife" 25 Pharmacy/drugstore" 26 Other private" 30 OTHER PRIVATE" 31 Deliv. post/Polindes" 32 Health post-Posyandu" 33 FP post/PPKBD" 34 "Tradit. healer-Dukun" 35 Friends/Relatives" 96 Other" 98"DK" 99 Missing"	Private sector 20 PRIVATE MEDICAL 21 Private hospital 22 Private FP clinic 23 Private doctor" 24 Private midwife" 25 Pharmacy, Drugstore" 26 Other private" Public sector 10 PUBLIC 11 Government hospital 12 Health center-Pusk 13 Fieldworker-PLKB 14 FP mobile-TKBK/TMK 15 Other government 16 Village official FP, health, and delivery posts 31 Deliv. post/Polindes 32 Health post-Posyandu 33 FP post/PPKBD
1997	10 PUBLIC" 11 Government hospital 12 Health center-Pusk 13 Fieldworker-PLKB 14 FP mobile-TKBK/TMK 15 Other government 16 Safari KB 17 Village official 20 PRIVATE MEDICAL 21 Private hospital 22 Private FP clinic 23 Private doctor 24 Private midwife 25 Pharmacy/drugstore 26 Other private 27 Health Officer (Mantri Kesehatan) 30 OTHER PRIVATE 31 Deliv. post/Polindes 32 Health post-Posyandu 33 FP post/PPKBD 34 Tradit. healer-Dukun 35 Friends/Relatives 96 Other 98 DK 99 Missing	Private sector 20 PRIVATE MEDICAL 21 Private hospital 22 Private FP clinic 23 Private doctor 24 Private midwife 25 Pharmacy/drugstore 26 Other private 27 Health Officer (Mantri Kesehatan) Public sector 10 PUBLIC 11 Government hospital 12 Health center-Pusk 13 Fieldworker-PLKB 14 FP mobile-TKBK/TMK 15 Other government 16 Safari KB 17 Village official FP, health, and delivery posts 31 Deliv. post/Polindes 32 Health post-Posyandu 33 FP post/PPKBD

ANNEX B: PERCENTAGE OF TOTAL POPULATION IN EACH SOCIOECONOMIC QUINTILE BY EDUCATION, INDONESIA 2002/2003

Annex B displays a cross-tabulation of socioeconomic quintiles by level of education. Results show that people with low levels of education are found in the poorer and poorest segments of the population ($p < .000$). Of those respondents with no education, 53.3 percent fall into the poorest category and 23.0 percent fall into the poorer category. Over 50 percent of respondents with a primary education are also in the poorer or poorest quintiles. Conversely, 28.8 percent of respondents with a secondary education and 69.4 percent who have a higher than a secondary degree are in the richest quintile. Thus, we feel this information validates the use of education as a proxy for socioeconomic status in analyses of Indonesian DHS data from 1987 to 1997.

	No education	**Primary**	**Secondary**	**Higher**
Poorest	53.3	38.1	15.0	1.8
Poorer	23.0	24.2	15.3	4.6
Middle	13.6	17.0	18.3	7.9
Richer	6.1	12.6	22.5	16.4
Richest	3.9	8.2	28.8	69.4
Total	100.0	100.0	100.0	100.0
	Chi-square: $p < .000$			

Source: Demographic and Health Survey

ANNEX C: BIBLIOGRAPHY

Central Bureau of Statistics (CBS) [Indonesia], State Ministry of Population/National Family Planning Coordinating Board (NFPCB), Ministry of Health (MOH), and Macro International, Inc. (MI). 1998. *Indonesia Demographic and Health Survey 1997*. Calverton, MD: CBS and MI.

Central Bureau of Statistics (CBS) [Indonesia], State Ministry of Population/National Family Planning Coordinating Board (NFPCB), Ministry of Health (MOH), and Macro International, Inc. (MI). 1995. *Indonesia Demographic and Health Survey 1994.* Calverton, MD: CBS and MI.

Central Bureau of Statistics (CBS) [Indonesia], State Ministry of Population/National Family Planning Coordinating Board (NFPCB), Ministry of Health (MOH), and Macro International, Inc. (MI). 1992. *Indonesia Demographic and Health Survey 1991*. Calverton, MD: CBS and MI.

Central Bureau of Statistics (CBS) [Indonesia], State Ministry of Population/National Family Planning Coordinating Board (NFPCB), Ministry of Health (MOH), and Macro International Inc. (MI). 1988. *Indonesia Demographic and Health Survey 1987*. Calverton, MD: CBS and MI.

Delatour, L. 1992. "Economic Aspects of the Gold Initiative," in *Indonesia Social Marketing: The Role of the Blue Circle and the Gold Circle Initiatives*, ed. Maher, S. OPTIONS II Project. Washington, DC: Futures Group International.

Edmondson, J. 1992. *Bali Revisited: Rural Economy, Intergenerational Exchanges, and the Transition to Smaller Family Sizes, 1977-90.* Den Pasar, Indonesia: Universitas Udayana.

Frankenberg, E., Sikoki, B., and Suriastini, W. 2003. "Contraceptive Use in a Changing Service Environment: Evidence from Indonesia during the Economic Crisis." California Center for Population Research, On-line Working Paper Series. Los Angeles: University of California.

Hugo, J., Hull, T., Hull, V., and Jones, G. 1987. *The Demographic Dimension of Indonesian Development.* East Asian Social Monograph. Singapore: Oxford University Press.

Hull, T. 2003. "The Political Framework for Family Planning in Indonesia: Three Decades of Development," in *Two Is Enough: Family Planning in Indonesia under the New Order 1968-1998*, eds. Neihof, A., and Lubis, F., pp. 57-82. Leiden, The Netherlands: KITLV Press.

Hull, T., and Hull, V. 1998. "Politics, Culture and Fertility: Transitions in Indonesia," in *The Continuing Demographic Transition*, eds. Jones, G., Douglas, R., and D'Souza, R. pp.383-419. Oxford: Clarendon Press.

Hull, T. 1997. "Fertility Decline in Indonesia: An Institutionalist Interpretation." *International Family Planning Perspectives*, 13(3):90-5.

Jensen, E., Kak, N., Satjawinata, K., Nyoman, W., Nangoy, N., and Suproyoko. 1994. "Contraceptive Pricing and Prevalence: Family Planning Self-Sufficiency in Indonesia." *International Journal of Health Planning and Management*, 9:349-359.

Jones, G. 2003. "Family Planning, Demographic Change and Economic Development," in *Two Is Enough: Family Planning in Indonesia under the New Order 1968-1998*, eds. Neihof, A., and Lubis, F., pp. 151-163. Leiden, The Netherlands: KITLV Press.

Kak, N. 1999. "Service Delivery Expansion Support Project Evaluation: Key Findings." Jakarta: Pathfinder International.

Kantner, A. 2005. Telephone Interview, July 3.

Kingfield, K. 2005. Telephone Interview, March 30.

Lubis, F. 2005. Telephone Interview, July 27.

Lubis, F. 2003. "History and Structure of the National Family Planning Program," in *Two Is Enough: Family Planning in Indonesia under the New Order 1968-1998*, eds. Neihof, A., and Lubis, F., pp. 31-55. Leiden, The Netherlands: KITLV Press.

Maher, S. 1992. "Indonesia Social Marketing: The Role of the Blue Circle and the Gold Circle Initiatives." OPTIONS II Project. Washington, DC: Futures Group International.

Marzolf, J. 2002. "The Indonesian Private Health Sector: Opportunities for Reform. An Analysis of Obstacles and Constraints to Growth." Washington, DC: World Bank.

Molyneaux, J. 2005a. Telephone Interview, July 25.

Molyneaux, J. 2005b. Personal Communication, November 2.

Molyneaux, J. 2000. "The Evolution of Contraceptive Pricing in Indonesia: A Final Report to the POLICY Project." The POLICY Project. Washington, DC: Futures Group International.

Newbrander, W., Collins, D., and Gilson, S. 2000. "Equity in Indonesia," in *Ensuring Equal Access to Health Services: User Fee Systems and the Poor.* Boston: Management Sciences for Health.

Piet, D. 2003. "The Significance of Foreign Assistance to the Indonesian Family Planning Program," in *Two Is Enough: Family Planning in Indonesia under the New Order 1968-1998*, eds. Neihof, A., and Lubis, F., pp. 83-106. Leiden, The Netherlands: KITLV Press.

Piotrow, P., and Rimon, J. 1999. "Asia's Population and Family Planning Programmes: Leaders in Strategic Communication." *Asia Pacific Population Journal,* 14 (4):73-90.

Riggs-Perla, G. 2005. Telephone Interview, June 28.

Sarwano, S. 2003. "Family Planning in Indonesia under the Old Order," in *Two Is Enough: Family Planning in Indonesia under the New Order 1968-1998*, eds., Neihof, A., and Lubis, F., pp. 19-30. Leiden, The Netherlands: KITLV Press.

Shiffman, J. 2004. "Political Management in the Indonesian Family Planning Program." *International Family Planning Perspectives,* 30(1):27-33.

Strauss, G., Beegle, K., Dwiyanto, A., Pattinasarany, D., Satriawan, E., Sikoki, B., Sukamdi, and Witoelar, F. 2004. *Indonesian Living Standards: Before and After the Financial Crises, Evidence from the Indonesia Family Life Survey.* Santa Monica, CA: Rand Corporation.

Suyono, H., and Shutt, M. 1989. "Strategic Planning and Management: An Indonesian Case Study," in *Strategic Management of Population Programmes*, eds. Ness, G., and Sattar, E., pp. 257-284. Kuala Lumpur: ICOMP.

Weidemann, A. 1999. "The Indonesian Family Planning Program and the International Conference on Development and Population: A Comparative Follow-up Field Study." Program on Population and Development. *PROP Report* (26). Lund, Sweden: University of Lund.

Winfrey, W., and Heaton, L. 1996. "Market Segmentation Analysis of the Indonesian Family Planning Market: Consumer, Provider and Product Market Segments." OPTIONS II Project. Washington, DC: Futures Group International.