

# Success of the Indonesian Population Program: Lessons for India

**Ashok Barnwal**

Indian Administrative Service

*Among developing world population programs, Indonesia's has been among the most successful. It has contributed to a significant decline in the birth rate in a relatively short time frame. Two factors that have contributed to the success of the program - generating social acceptance and creating a strong government-society link - carry special importance, as they can be applied to programs in democratic countries such as India. This paper analyzes the Indonesian experience to draw lessons for the Indian program.*

## Introduction

The world's population, 2.5 billion in 1950, rose to 6.1 billion in 2000 and may increase to 8.9 to 10.6 billion by the year 2050 (UNDP). For developing countries, increasing population has put constraints on limited resources. Many countries have adopted population control programs. Indonesia – the fourth most populated country in the world after China, India and the United States – adopted a program in 1970. Among developing countries, Indonesia's population control program is considered to be one of the most successful, having contributed to bringing down the total fertility rate from nearly 6 when the program began in 1970 to 2.59 in 1999 (BPS). This achievement is even more remarkable when we consider the fact that almost ninety percent of the population is Muslim. Even societies that have experienced much greater socioeconomic transformation than Indonesia have not had such significant fertility-related change (Shiffman, 2002).

India, though a pioneer among developing countries in adopting a population control policy, has not been as successful in controlling its population growth. While many demographers consider the Indian program to be a success, the fact remains that the country is still struggling with a total fertility rate far above the replacement level of 2.1.

Indonesia and India differ on many dimensions, including political structure. However, two of the most important aspects of the Indonesian program - developing social acceptance for the program and creating strong government-society links that enable active involvement and participation of the community - can be adopted by India and other countries to enhance the effectiveness of their programs.

## Indonesian Program – History

The initial stages in the family planning program in Indonesia concentrated only on the supply side. The approach was to establish contraceptive service capacity with personnel in the health clinics with an expectation that women and men would travel to these clinics to have their family planning needs met. Program leaders assumed that if they set up more and more centers across the country, they could meet demand for contraception and the

number of users nationally would rise (Shiffman, 2002). They presumed this would be a cost-effective strategy, since there already existed a country-wide maternal and child health center network which the family planning program could co-opt. The result was the establishment of more than 2200 clinics in the first plan (1969-73) with focus on the heavily populated islands of Java and Bali (Hull, Hull & Singarimbun, 1977). However, each clinic had been given a target of just eight new acceptors every month. The other parallel strategy was a slightly more proactive approach of community outreach through field workers, promoting pill and IUD use, which was applied initially in a selected area (Suyono et. al., 1976).

As the number of field workers rose, the outreach also expanded with new users joining the program. However, the preference for pills rather than IUD by new users put heavy pressure on the supply system (Shiffman, 2002). The programmers were forced to change their strategies because monitoring old users and ensuring continuous use of contraception was a major challenge. The BKKBN, the government agency in charge of implementing the program, developed the idea of the village family planning group in 1974. However, the BKKBN gave flexibility to the provinces to adopt their own strategies to ensure re-supply. The result was adoption of different re-supply methods in different provinces. In some provinces the state organization created new social institutions; in others it worked through existing structures. It managed to co-opt local government institutions or social leaders in support of the program in all the provinces. The state organization also gained the active participation of higher levels of the provincial government in many provinces.

The re-supplies to the groups were done through the field implementers. As Warwick notes:

The chief field implementers were the village head; his wife, who was often in-charge of the village contraceptive distribution center; other village officials, elders and administrators; the family planning field worker from the sub-district; the midwife from the health clinic; informal leaders; members of the acceptors' groups; and other staff from government offices (Warwick 1986, p. 463).

In the initial years of the village family planning group system, the number of contraceptive users rose considerably across all the provinces in which it

was employed, suggesting that this strategy of social penetration was working. Hence, the BKKBN officially adopted the village family planning group concept as national policy in 1976 (Shiffman, 2002). A uniform village family planning group recording and reporting system was also created. This system gave the state organization a capacity to monitor the individual contraceptive practices of villagers across the country. With the success of the idea, more and more responsibility was assigned to these groups. In the 1980s, apart from monitoring contraceptive use and helping with re-supply, the groups started working on recruitment of new users, helping the users with side effects and assisting in community development activities such as nutrition, income generation and maternal and child health. These groups penetrated all levels of village society: village family planning groups at the village level, sub-village family planning groups at the hamlet level and acceptor groups at the neighborhood level (Shiffman, 2002).

During the 1980s, the population policy in Indonesia witnessed a major change as the focus was expanded beyond contraception. As Weidemann describes it:

A reduction of the fertility rate was still an objective, but also a higher life expectancy and a reduction of the mortality rate were included in the objectives. The family planning program was intensified along with the transmigration program, the former by the objectives of (1) increasing the FP acceptors, (2) extending the program to the entire social strata, and (3) by further instituting the norm of a "small, healthy, prosperous and happy family". Also, the FPP began to be more privatized, relying on commercial concepts rather than free distribution of contraceptives (Weidemann, 1998, p.10)

In 1987 the government announced the policy of privatization of hospitals in Indonesia. This meant that no more funds would be allocated to finance government hospitals. This was the beginning of putting a price on contraceptives for selected user groups.

In 1990, the BKKBN codified the whole system in order to pay special attention to the quality of the village family planning groups. Seven duties were specified for the groups to perform - effective self-management; motivating others to use contraception; the provision of contraceptive service and advice; regular meetings; data collection on the demographics and family planning practices of the community; social and economic development activities for the community; and activities to become financially independent. "Beginning groups" were those able only to perform the first two of these duties - self-management and motivational activities; "basic groups" duties one through five; "developing groups" duties one through six; and "self-sufficient" groups all seven duties. The focus on quality is evident from the fact that almost 91.5% of the village family planning groups in 1996 have been recorded as advanced groups and only 8.5% were recorded as beginner groups (BPS). The total number of groups rose from 14,037 in 1975 to 1,102,124 in 1996.

The 1997 economic crisis and political changes in the state led to some fears that the program would be affected adversely. However, as Terrence Hull (2002) indicates in his research, there was virtually no decline in contraceptive use, and little change in the pattern of method choice. All political, religious and social groups accepted the family planning practices. The strength of the BKKBN in planning, administration, and evidence-based policy-making helped it in identifying areas that needed, immediate support for intervention. Donors came forward for help in providing supplies. Any immediate crisis was avoided (Hull, 2002). Thus the program has worked on a sustained basis and has also been successful in creating an environment where dependence on government is no more a necessity.

### Indian Program - History

In 1952 the Indian government became the first in the developing world to organize a family program designed to reduce population growth. The early concept of population policy did not focus on fertility alone but also covered mortality. There was also recognition of the need to improve the quality of life of the people by lowering the burden of disease, promoting universal primary education and eradicating illiteracy, exploitation and poverty.

The effective date of adoption and implementation of a clear family planning program is often put at 1966, when the 'extension-education approach' to the promotion of family planning throughout the country replaced the earlier clinic-oriented approach (Visaria, 2000). The earlier approach seeking to set up a large number of family planning clinics was based on the experiences of concerned social workers and professionals in urban areas who were trying to initiate a major program of social engineering without any precedents to follow. A 'time-bound' target of reducing the crude birth rate from about 39 to 25 per 1000 population in 10 to 12 years was adopted under this policy, a goal India is still struggling to achieve. The Indian model of setting up of demographic goals and targets to be achieved by the health department was aptly named the HITTS model by K. Srinivasan: health department-operated, incentive-based, target-oriented, time bound and sterilization-focused (Srinivasan, 1998).

The Fourth Five-Year Plan saw the proportion of outlays on the family planning program reaching the maximum of 1.8 per cent. The family planning program was integrated with the maternal and child health (MCH) program. It was implemented through the primary health centers in rural areas and through urban family planning centers in towns (Maharatna, 2002). One male and one female multi-purpose worker were to be engaged for every five thousand people. The early 1970s saw the beginning of a "camp approach" in which sterilization (mainly vasectomy) camps were organized on a mass scale to ensure that "these facilities are available for men in their own geographic proximity and the services of skilled surgeons could be optimally utilized" (Srinivasan, 1998). The Medical Termination of Pregnancy Act, 1972

and a law raising the minimum age of marriage among girls to 18 years were also introduced in this period.

The mid-1970s was a time of turmoil for the Indian family planning program. The Indian Health Minister raised the slogan – “development is the best contraceptive” - at the International Population Conference in Bucharest, Romania in 1974, but the very next year India adopted a completely different approach. The political emergency of 1975-76 saw organization of mass sterilization camps all over the country. According to Pravin Visaria, the reason for this special drive and about face was slippage in achievement of the unrealistic goal of a crude birth rate of 25 per thousand and the frustration arising out of this slippage (Visaria, 2000). The backlash from this special drive was phenomenal. For almost two decades, politicians and community based development organizations became wary of public association with the family planning program (Sen, 2003).

The Population Policy Statement in 1977, using the newly-coined term “family welfare program” (FWP) proposed to rely more on education and motivation for achieving demographic goals. It also reaffirmed the entirely voluntary nature of the program, and it appeared to be totally against compulsory sterilization (Maharatna, 2002). The sixth Five-Year Plan set up another ambitious target – a net reproduction rate (NRR)<sup>1</sup> of one by the year 1996 for the country and by 2001 for all the states. The target has yet to be realized.

India’s commitment to the reproductive health goals of the 1994 International Conference on Population and Development in Cairo brought a much desired paradigm shift in Indian population policy. The centralized fixing of targets was abolished and a “target free” reproductive and child health (RCH) care approach adopted in 1996. This approach later came to be known as “Community Need Assessment” (CNA). The paradigm shift led to an apparent drop in the reported number of acceptors of different methods of contraceptives. However, this result was later attributed to a reduction in falsification of statistics (Visaria, 2000). According to Nanda (2004), Executive Director of the Population Foundation of India and former Health Secretary:

The RCH approach has opened a new vista with “a decentralized planning approach” and a more comprehensive and holistic vision of “women’s health” throughout the life cycle. Goals are to be set primarily at the district level, based on the work plans of the local communities prepared with a CNA approach (Nanda, 2004, p.12).

The National Population Policy (NPP) 2000 has been another step in the paradigm shift that started with the “target free” approach. The NPP 2000 affirms the commitment of the government to voluntary and informed choice and the consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services. The NPP 2000 has distinguished between immediate, medium-term and long-term policy objectives.

The immediate objectives are to address unmet need for contraception, develop health care infrastructure and train health personnel, and provide integrated service delivery for basic reproductive and child health care. The medium-term policy objective is to attain the replacement level of fertility of 2.1 by the year 2010. The long-term objective is to have a stable population by 2045.

Many critics point to the failures of the Indian population control program. The program has been fairly successful so far considering the fact that the birth rate has gone down from 41 per thousand in the 1960s to 27 per thousand in 1990s. The increase in population has been a result of the death rate declining at a much faster rate than the birth rate. The total fertility rate has gone down from 5.9 in the 1950s to 2.85 in 1998-99 (NHFS II).

### Comparison of Indonesia and India

Analysts believe that many factors stand behind the success of the Indonesian program. One of the most critical is the development of a network of village family planning groups to promote community acceptance for birth control. Research carried out between 1981 and 1984 showed that eligible couples were often unwilling to join the program if they thought that practicing family planning was not favored by the community or was shameful (Warwick, 1986). Countering this attitude was important, especially in a society dominated by Islamic practices. The program had several features that addressed the problems of perception. BKKBN sought the support of religious leaders, established acceptors’ groups, made community leaders the chief implementers in the villages and held public meetings about contraception. Such initiatives helped in making contraceptive practices a less sensitive subject for discussion.

The use of the *banjar* system in Bali province is a classic example of such a strategy. *Banjar* is a long-standing community organization at the sub-village level. Almost all families in Bali province belong to it. The basic function of the *banjar* is to involve the community in all kinds of social welfare functions. *Banjar* meetings are a regular phenomenon held every 35 days and attended by all male heads. The BKKBN officials approached their heads and succeeded in placing the family planning on the agenda of these meetings. The heads of households were required to report publicly on their household’s family planning status in these meetings (Parsons, 1984). This kind of strategy gave the program a very high degree of social acceptance.

The success of the program through *banjar* meetings gave a clear direction to the policy-makers. The emphasis shifted from individuals to community as the key variable. This feature has been one of the main reasons for success of the program. Making community the predominant force to mould individual fertility behavior was one of the main strategies. Although individual fertility behavior was the ultimate objective, the community was used to function as the intermediate mechanism for gaining individual acceptance (Parsons, 1984).

A parallel can be drawn between the *banjar* system of Indonesia and the social structure of the major tribes like Bhil and Gond in India. Though Indian tribes do not have meetings as regular as the *banjar*, tribal heads do hold considerable authority. Until the 1990s, however, the Indian program did not involve tribal heads, remaining a program run predominantly by government officials.

In Indonesia, village family planning groups also helped in creating a strong government-society link. These groups formed in response to increasing problems of maintaining supplies of pills, which were becoming more popular than the IUD. The authorities had to look for a structure that could maintain constant re-supplies to the users. These groups became a major resource in doing that. The program implementer associated with each group, often the wife of the village head or some village level official, would bring supplies from the mother clinic. The pills were then distributed through various mechanisms, the monthly meeting being the most common. In some parts of Indonesia, to encourage women to attend the monthly meetings regularly, a monthly lottery system was used (Parsons, 1984). By contrast, in India the program implementer in India has been the health worker who is on the government payroll. Most health workers do not belong to the villages they serve. Thus they are always seen as an outsider advocating family planning practices, and hence the degree of social acceptance is low. The poor reach of the field implementers also meant that the link between government and society was very weak.

One of the major reasons for successful expansion of village family planning groups in Indonesia was the BKKBN's ability to devise innovations to make these groups more attractive to village women, giving them incentives to stay within the system. Availability of micro-credit to the groups was one such innovation. The BKKBN provided funds with low interest rates to the groups for micro-credit purposes. Many groups established rules of eligibility, requiring family planning use for a specific period of time before they could have access to these low interest loans. This worked like an incentive to use the family planning methods. This intervention also helped in strengthening the government-society link.

A significant feature of the program was active association of religious leaders with the program - another feature that helped not only in increasing social acceptance but also in strengthening the government-society link. At the beginning of the program, most religious leaders were hostile as they thought that the program was promoting sterilization and abortion, violating Islamic traditions. The government made the prudent decision before the program started to consult religious leaders and to omit the two methods of fertility control most opposed by Muslims: abortion and sterilization. Active support from the Department of Religious Affairs, training and orientation of many religious leaders, and continuous personal contacts were some of the factors that contributed to the attitudinal changes of the religious leaders. Once the attitudes toward the program became more positive,

they were asked to help promote family planning. Warwick sees this shift among religious leaders from a stance of hostility to one of active support, seen in many parts of Indonesia, as a major success in the implementation of the program (Warwick, 1986). The Indian program, by contrast has paid little attention to this factor. While the majority of the Indian population is Hindu and the religious leaders of this community have no reservations concerning family planning, almost 11 percent of the population belongs to the Muslim community whose religious leaders have similar reservations to leaders in Indonesia. The Indian program has done little to involve religious leaders from this community.

**Table 1**  
*Total Fertility Rates in India and Indonesia*

Year	India	Indonesia
1950-55	5.97	5.49
1955-60	5.92	5.67
1960-65	5.81	5.42
1965-70	5.69	5.57
1970-75	5.43	5.20
1975-80	4.83	4.73
1980-85	4.48	4.11
1985-90	4.15	3.50
1990-95	3.80	3.00
1995-00	3.45	2.60

Source - Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2001 Revision, <http://esa.un.org/unpp>

**Table 2**  
*Population Growth Rates in India and Indonesia*

Year	India	Indonesia
1950-55	2.00	1.67
1955-60	2.26	2.08
1960-65	2.26	2.11
1965-70	2.28	2.37
1970-75	2.24	2.27
1975-80	2.08	2.21
1980-85	2.08	2.04
1985-90	2.04	1.83
1990-95	1.91	1.59
1995-00	1.76	1.40

Source - Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2001 Revision, <http://esa.un.org/unpp>

Another critical factor in making the program widely acceptable and establishing the wide network was the decision of the BKKBN to co-opt the PKK, the nation's most powerful women's organization and an institution

that straddled state and society. The PKK's ties to the Ministry for Home Affairs helped the BKKBN in gaining political priority for its program. Moreover, by doing so the BKKBN gained a powerful presence in the villages, thus strengthening the government-society link. An army of volunteer village family planning workers controlled by these PKK leaders became available to the BKKBN for disseminating the program. The fact that these volunteers had been mostly locals has been a strong support point that could not have been achieved so easily by other means. The PKK was ideally suited for the task of family planning promotion, since it had a strong village presence and since its mission, to improve social welfare at the village level for families, was congruent with BKKBN objectives (Shiffman, 2002). The lack of an organization with such a national umbrella in India means a tougher challenge for Indian policy-makers in creating a strong government-society link.

The core strategy for recruiting clients in Indonesia has been a combination of individual persuasion and community influence (Warwick, 1986). The general practice adopted by the BKKBN was to approach a potential contraceptive user through one of its field motivators. If the client accepted contraception after visits by motivators, no other direct influences were applied. The community norms may have played an indirect role even in such acceptance. If the person was unresponsive to persuasion or accepted but later dropped out of the program, the village head, other administrators, their wives, or members of acceptors' groups would approach that individual and talk about family planning methods. At times, local religious leader would also drop by to explain to the individual that fertility control was not against the religion but on the contrary a religious obligation. Those not responding were persuaded by even larger numbers of program implementers. The poorer sections of society, at times, felt pressure because of higher susceptibility.

One of the critical factors of the Indonesian fertility control program is the strong female-centric program component. Birth control methods in Indonesia are centered on largely female methods of contraception. This is highlighted by the steady decline in reported use of the male methods of condoms, vasectomy and withdrawal, from a combined total of 3.1 percent of couples in 1987 to 1.9 percent ten years later. The bureaucracy showed little desire to promote male methods and community leaders have been found to be very conservative in promoting male methods. The family planning program itself tried to avoid promotion of male methods (Hull, 2002).

With respect to freedom of choice, the BKKBN has claimed that most of its clients use family planning services out of personal motivation. However, critics claim that program implementation strategies used in certain areas of Indonesia were coercive. There are examples, especially in East Java in the 1970s, of application of heavy-handed social and administrative pressures. As Warwick describes it:

In the presence of civilian, military, and police leaders,

women were taken to a house in which IUDs were being inserted. They were asked to go in one door and put under very strong pressure to accept an IUD before they could leave by another door (Warwick, 1986, p. 470).

Such kind of pressures may prove to be counter-productive as has been seen in the Indian sterilization drive during the mid 1970s. The drive threw back the Indian program by almost two decades (Sen, 2003).

Warwick in 1986 strongly suggested that imposition rather than free choice was at work on individuals in Indonesia:

The free choice of individuals is endorsed so long as it is in harmony with the national consensus. Such consensus does not come from popular consultation, for otherwise it would not have to be *propagated to all social strata*. Rather it is the result of a national decision embodied in government population policies that are transmitted by field workers to communities and from them to individual users (Warwick, 1986, p. 481).

Warwick expressed raised a doubt about the degree to which individuals internalized the motivation to practice family planning. However, Hull has shown that birth control in Indonesia has become a majority behavior. According to him, family planning has become a universally accepted practice among all political, religious and social groups (Hull, 2002).

### Learning for India

The problems for the Indian program have slightly different dimensions. In a country with a democratic and participatory system, there are limits to the degree to which a government can adopt a strategy that infringes upon the rights of citizens. Moreover, the kind of community-level pressure tactics employed in Indonesia may not be suitable in the Indian scenario. In addition, a study by Visaria and Visaria segments the growth of population in the coming years to three factors: 61 percent due to population momentum; 18.6 percent due to unwanted fertility; and only 21 percent due to wanted fertility (Sen, 2003). Thus the effect of a young age structure on population momentum is far more important than the impact of high desired fertility, although the latter can not be ignored. Obviously, the Indian program has to work on issues other than contraception.

The unwanted fertility can be tackled by improving access and quality of family planning services and safe abortion and by empowering women so that they can gain control over their fertility. The impact due to population momentum can be influenced by raising the age at marriage for girls through education.

The federal system of governance in India is also different from the unitary political system in Indonesia. Health is a state subject in India and hence the national government has less capacity to force its agenda on the states than did the Indonesian government (although this has changed recently in Indonesia as power has been

decentralized to district levels). However, in India, much funding of the population programs in the states comes from the national government, and hence the national government can play a major role in defining these policies and goals.

The lessons from the Indonesian experience depend on the line Indian policy-makers will choose for population control. The core of the Indonesian policy has been the promotion of contraceptive use, a strategy that is only a part of the Indian National Population Program. However, certain features of the Indonesian program can fit quite well in the Indian context.

### **Social Acceptance**

Using village heads and their wives as field implementers holds great potential in India. The education-extension approach of the Indian program advocating women's education and empowerment and late marriage for girls can percolate down more smoothly if the program can involve prominent personalities in the villages and convince them of the benefits of the program. So far, community involvement in the population program has been very low. Lack of an organization like the PKK in Indonesia is a weakness in India. However, the panchayat system introduced in the 1950s can provide an alternative, and women representatives or wives of the panchayat heads can be used as field implementers in a way similar to the Indonesian program. The NPP 2000 recognizes the need of involving panchayats in the program. However, it sees them as a vehicle "to promote a gender sensitive, multi-sectoral agenda for population stabilization that will "think, plan and act locally, and support nationally" (NPP, 2000, p. 5). What is also needed is that they act as field implementers in the villages. Their influence over the masses will help the program in getting the messages through.

The Indian policy document talks about creating public support through demonstration of strong support to the small family norm by political, community, business, professional and religious leaders, media and film stars, sports personalities, and opinion makers (NPP, 2000). This strategy has yet to be implemented on a large scale - something Indonesia has been able to carry out since the 1970s.

The Indonesian program used the *banjar* system to its advantage. India also needs to use the social structures and systems prevalent in many parts of the country to make family planning a socially and individually accepted behavior. It is agreed that revealing women and men's contraceptive practices publicly exerts considerable pressures on individuals that may not be acceptable in all parts of the country. However, the strategy can be applied in selective sectors where demand-side problems are significant. In particular, the social structure in tribal areas can be helpful in propagating the program where the words of tribal heads in the villages carry considerable weight.

Social and public acceptance of fertility control measures in Indonesia was facilitated by public talks on contraceptive measures, and village heads or their wives discussing their own contraceptive practices in public. This strategy made these practices not only acceptable but also provided forums to individuals to discuss the pros and cons of the practices. In contrast, still in most of the societies in India, contraceptive practices are not discussed openly, thus making it difficult for extension workers to bring the idea to every eligible individual. What is needed in India is open public discussion regarding contraceptive practices in order not only to make them socially acceptable but also to prevent damage to the program due to rumors or misinformation.

The involvement of religious leaders is another strategy that can be very helpful in India. Many Indian people believe in spiritual practices, and spiritual leaders hold authority. The way the Indonesian program involved religious leaders who had strong initial reservations against several contraceptive practices is a lesson that Indian policy-makers can emulate in their program.

### **Community Involvement**

The success of the Indonesian program is due also to the large network of village family planning groups which extends to the hamlet level. India also needs to take this program to the village and hamlet level and establish an extensive rural network as a means of transferring information. Whatever strategy India wants to adopt - fertility control or freedom of choice along with women's empowerment - India does need a network that can carry the message down to the local level. The present network of one field worker for five to eight thousand people is inadequate to handle the needs of the program. Panchayat Raj institutions existing in all states can become a powerful resource in this regard as they can provide a strong network to the program. Village Health Committees formed in some states can be another mechanism for developing a rural network.

Similarly, in recent years, several social structures have been created all over the country. Several states have formed women's self-help groups which engage in activities like thrift savings and self-employment. These groups, if associated with the program, can strengthen the government-society link. They can be used in propagating the various strategies envisaged in the NPP document. Various NGOs working in different parts of the country can also help in strengthening this link as well as in increasing community participation in the program.

The political organizations have so far not associated themselves actively in the program. There has been little effort in engaging them in the program. Considering the democratic setup in the country, these organizations also need to be involved actively in the propagation of the program. This will help in increasing community participation. Similarly, the Indian social structure is based on a caste system. Many of these castes have their own organizations which meet frequently and discuss

the problems of their community. Involving them in the program will help in strengthening the government-society link.

### Conclusion

The Indonesian family planning program has been very successful in controlling population growth. The program has concentrated more on the promotion of contraceptive use than on equity or freedom of choice. Those who feel strongly about the individual's right to reproductive choice may not approve of these tactics, but the fact remains that the country has been able to attain its objectives through the chosen path. Many other countries are still struggling with population problems, India being one of them.

The result of population control in Indonesia is bound to bear fruit in the coming years as the country moves on the path of development. However, the total fertility rate is still above the replacement rate of 2.1 and it has to make serious efforts to reach that level. The present strategy has been successful so far, but the challenges ahead are daunting. One challenge for the BKKBN will be to extract the same kind of support from the unstable political leadership. The privatization of health facilities is another factor that program leaders must consider. To date, there has been support from the private sector to the program, but continuance may pose some problems to the BKKBN. The move to self-sufficiency where a section of the users are paying for the contraceptives will be a litmus test for the program. This will indicate whether the program has really been demand driven and contraceptive use sustainable. Another barrier to future implementation is a decentralization law that has brought local BKKBN offices under the control of district government rather than the national government. This will hamper the power of the organization to implement national policy. However, the biggest challenge for Indonesian policy makers in the coming years will be in addressing population growth due to momentum. So far the BKKBN has stressed contraceptive promotion only. It must refine its policies in order to take care of the momentum.

India, on the other hand, is trying to follow a mixed path. Women's education and empowerment and improvement of reproductive and sexual health facilities is one component; promoting contraceptive use is another. Though Indonesia and India have different approaches to the population problem, generating social acceptance and creating strong government-society links can help in both countries. If applied conscientiously, these strategies will lead to better program implementation in India. Above all else, India's leaders must make the program truly national by converting it into a mass movement.

### References

- Badan Pusat Statistik (BPS). (1998). *Statistical yearbook of Indonesia*. Jakarta: Badan Pusat Statistik, Government of Indonesia.
- Hull, T.H., Hull, V.J., & Singarimbun, M. (1977). Indonesia's family planning story: success and challenge. *Population Bulletin*, 6, 1-52.

- Hull, T.H. (2002). *Caught in transit: questions about the future of Indonesian fertility*, United Nations Population Division publication. Retrieved July 12<sup>th</sup>, 2004, from [www.un.org/esa/population/publications/completingfertility/RevisedHULLpaper](http://www.un.org/esa/population/publications/completingfertility/RevisedHULLpaper).
- Maharatna, A. (2002). India's family planning programme: an unpleasant essay. *Economic and Political Weekly*, March 9, 971-981.
- Ministry of Health and Family Welfare. (2000). *National Population Policy 2000*. New Delhi: Government of India.
- Nanda, A R. (2004). *Obsolescence and anachronism of population control: from demography to demology*, George B. Simmons Memorial Oration, XXVI Annual Conference of The Indian Association for the Study of Population on Population, Health and Environment at Annamalai University, Tamil Nadu.
- National Family Health Survey 1998-99 (NFHS II). (1999). *India- key findings*. Mumbai, India: International Institute for Population Studies.
- Parsons J. (1984). What makes the Indonesian family planning programme tick? *Populi*, 11, 4-19.
- Sen, G. (2003). Population: a new paradigm for old and new concerns. In Sengupta, R., & Singh, A. (Eds.), *Challenge of sustainable development: the Indian Dynamics*. Calcutta: Indian Institute of Management.
- Shiffman, J. (2002). The construction of community participation: village family planning groups and the Indonesian state. *Social Science & Medicine*, 54, 1199-1214.
- Shiffman, J. (2004). Political management in the Indonesian family planning program. *International Family Planning Perspectives*, 30, 27-33.
- Srinivasan, K. (1998). Population policies and programmes since independence. *Demography India*, 27, 1-22.
- Suyono, H., Pandi, S.H., Astawa, I.B., Moeljono, & Reese, T.H. (1976). *Village family planning, the Indonesian model: institutionalizing contraceptive practice, Technical report series, Monograph no. 13*. Jakarta: National Family Planning Coordinating Board.
- United Nations Population Division (UNDP). Data online for all countries. Retrieved October 22<sup>nd</sup>, 2003, from <http://esa.un.org/unpp/index.asp?panel=2>.
- Warwick, D.P. (1986). The Indonesian family planning program: government influence and client choice. *Population and Development Review*, 12, 453-490.
- Weidemann, A. (1999). *The Indonesian family planning program and the International Conference on Development and Population*, Programme on Population and Development Dept of Sociology, Lund University, September 1999 Report no. 26. Retrieved October 19<sup>th</sup>, 2003, from <http://www.soc.lu.se/prop/weidemann.pdf>.
- Visaria, P. (2000). *Population policy in India: evolution, performance and challenges*, Dr. K.S. Sanjivi lecture at the Voluntary Health Services, Chennai, India, August 2000.

### End Notes

- <sup>1</sup> A unitary NRR means that a cohort of mothers is replaced by an equal number of daughters at the end of their reproduction period, after accounting for the effect of mortality.

