THE CONSTRUCTION OF COMMUNITY PARTICIPATION:
VILLAGE FAMILY PLANNING GROUPS AND THE INDONESIAN STATE

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We arranged it in phases...It was not necessary for people to be aware that it was being constructed, however. In India it is there but it is not orderly. We did not want it to be like that. We wanted community participation, but in organized form.

-- Former Deputy Chairperson of the Indonesian National Family Planning Coordinating Board (BKKBN)¹

Introduction

In the world of family planning programs, Indonesia's is recognized as a model case. It is widely understood to have contributed to one of the largest rises in contraceptive prevalence rates and declines in fertility in the developing world over the past three decades. In a poor country with a population that is close to ninety percent Islamic, the average number of babies per women declined from nearly 6 when the program began in 1969 to 2.78 by the mid 1990s (CBS et al. 1998). The percentage of currently married women using modern contraception rose over the same time period from a very low figure to 54.7 percent (CBS et al. 1998). Few predominantly Islamic societies in the world have seen such significant fertility-related change, even those that have experienced much greater socioeconomic transformation than has Indonesia. Most observers agree that the family planning program has been a major factor behind these shifts.

In evaluating why the program has worked, analysts have given much credit to a network of village family planning groups that has blanketed the archipelago (Warwick 1986, Suyono et al. 1976, Parsons 1984, Curtin et al. 1992). These groups, composed primarily of female volunteers, made contraception available to women in even the most remote parts of the country, served as sources of information on family planning and side effects, and acted as agents of family planning motivation and method continuance. At the height of their existence, there were over 1,000,000 such groups across Indonesia's provinces (KMNK/BKKBN 1996a), one for every 32 couples of reproductive age, an astonishing level of social penetration by a family planning network. It is unlikely the
state program could have achieved such effectiveness in the absence of these wide-reaching social institutions.

Officials in the BKKBN, the government agency that has managed the Indonesian family planning program, have called this archipelago-wide network an example of effective community participation on a national scale (see NFPCB 1987, and Hamijoyo and Chauls - undated). They have acknowledged BKKBN involvement in sparking this participation, but stress its voluntary and self-sustaining quality. Other analysts have echoed this descriptor. Discussing the origin of this network, for instance, former chairman of the BKKBN Haryono Suyono and his colleagues portray this network as community inspired, shaped and led (Suyono, Hendrata and Rohde 1993, 486 - italics added):

For a small stipend, some community members had been willing to distribute the monthly supply of contraceptives to each participating household. This rapidly led to a volunteer force throughout Java and Bali. Indigenous community organizations grasped the opportunity to provide a useful, desired community service and established community-based family planning clubs.

But is such a characterization accurate? Is this network an example of genuine community participation - of a spontaneous movement spreading on its own momentum through the creativity of tens of thousands of village volunteers? Or is this network better characterized as a state-orchestrated initiative, directed from above, and an example of 'community participation' only in a superficial sense of the term?

This question of interpretation of the nature of the network taps into an issue that has inspired considerable discussion in the public health literature - namely the meaning of 'community participation.' Scholars have debated a number of issues in this regard, including whose definitions of 'community' matter and how particular interpretations of 'community' achieve ascendency (Jewkes and Murcott 1996, 1998), the role of state ideological imperatives and objectives in promoting 'community participation' (Ugalde 1985; Zakus 1998), and whether a common understanding of 'community participation' can be generated at all (Rifkin 1986). Zakus and Lysack (1998) have reviewed the
extensive literature on the subject and offered an operational definition. They write (p. 2, italics added):

Community…participation in health…may be defined as the process by which members of the community…(a) develop the capability to assume greater responsibility for assessing their health needs and problems; (b) plan and then act to implement their solutions; (c) create and manage organizations in support of these efforts; and (d) evaluate the effects and bring about necessary adjustments in goals and programmes on an ongoing basis. Community participation is therefore a strategy that provides people with a sense that they can solve their problems through careful reflection and collective action.

This definition offers an understanding of community participation as a process of active involvement on the part of local individuals and groups in the assessment of health needs, in planning solutions, in creating the structures for and implementing these solutions, and in assessing outcomes. Above all else, Zakus and Lysack understand community participation as the meaningful and substantive sharing of health programmatic decision-making at the formulation, implementation and evaluation phases.

Yet even if a program appears to have generated such active involvement, what interpretation do we give to the nature of such participation if it was directed from above, conceptualized and orchestrated from the beginning by the state? What do we make of such activity if it unfolded predominantly according to government plan? What credence do we give to participant expression of voluntarism if the state knew from inception the contours and conditions of their inclusion? Would we, then, call such a program an example of genuine community participation? Or might it be better be described as a carefully orchestrated exercise in state co-optation?

In this article, I investigate the history of the development of this network in order to examine these questions. I seek to analyze the nature of the groups that comprised the network, to shed light on the question of the character and quality of participation and to investigate BKKBN claims concerning the existence of community participation. Far from offering a simple characterization of the essence of these groups, I argue that they
are odd and complex hybrids, entities that straddle state and society and that belong fully to neither. They retain many features of state institutions: they are indeed products of systematic state efforts to mobilize society in service of a national fertility control project. However, they are also socially embedded community entities, composed primarily of volunteers, whose rapid spread across the country would have been impossible unless genuinely felt social needs were being met. While the network cannot be characterized as a passive tool of the state, neither does it deserve designation as an example of meaningful 'community participation.' The state had too large a hand in its creation, form, development and utilization.

States, societies and family planning programs

The case of the Indonesian family planning group network offers interesting empirical material for a research agenda that has only begun to develop in the family planning literature. This agenda involves the adoption of an approach from the discipline of political science - the state-society framework - in order better to understand the nature and level of effectiveness of family planning programs in developing countries. The state-society framework is one of the newest approaches in political science, created to analyze developing world politics. A reaction to prior approaches that were overly aggrandizing and determinist in thrust, the state-society framework considers how states and societies are intertwined and mutually constitutive. Neither is taken to be derivative of the other. Rather, state institutions are viewed as shaping social institutions, and vice-versa. State and social organizations are seen as being in competition to set social rules. States seek four capacities in this regard: to penetrate society, to extract resources from society, to allocate those resources in particular ways and to regulate social behavior. However, they do so on contested terrain, encountering resistance from social bodies in the process of seeking to become the dominant rule-making institution. According to
Migdal (1988), states have been more effective at penetration and resource extraction than they have at resource allocation and the regulation of social behavior.

The value of the approach for family planning analysis is that it goes beyond the existing organizational and social-demographic approaches that have dominated family planning program analysis, and directs attention to the way in which family planning programs are embedded institutions of an explicitly political nature. They are parts of both states and societies, transformative of and transformed by each. Many family planning programs are quite clearly state projects, efforts - to use state-society terminology - of government institutions to regulate social behavior. Yet they do so with varying degrees of cooperation and resistance from social institutions. When their efforts meet social needs, for instance by providing for existing demand for contraception and fertility control, state organizations will find the terrain easy to traverse. On the other hand when they are seeking to change social behavior in unwanted ways - for instance attempting to reduce fertility beyond a level acceptable to individuals - they will find the terrain difficult to cross. Beyond this, in the process of carrying out family planning programs, the state will find its project transformed by the nature of the social cooperation and resistance it encounters; similarly social institutions and behaviors will themselves take on new forms and functions during program implementation.

Susan Greenhalgh (1990, 1992, 1993, 1994) is the only scholar who has explicitly employed a state-society approach in family planning analysis. Reacting to studies that simplistically portrayed states as unified, monolithic entities shaping societies and fertility practices at will through population policy, she has adopted state-society constructs in the analysis of the Chinese and other programs. For instance, she has shown how Chinese Communist Party cadres, far from being absolute wielders of power at the local level, have had to negotiate with villagers in order to implement the one-child policy. Village women have been active agents of resistance and change, removing IUDs as party cadres leave the scene, concealing unauthorized pregnancies from birth planning
workers, hiding from teams of cadres making the rounds to mobilize pregnant women to undergo abortion, and forcing local party officials to accept local practices of having two children per family (Greenhalgh 1992). Yet Chinese leaders maintain many levers to shape fertility behavior, including the ability to fine and punish villagers, to pressure individuals through mass organizations, and to push cadres to achieve targets via higher salaries (Greenhalgh, Zhu and Li 1993). Beyond this, state-directed shifts in the organization of society such as the emergence of the urban unit (danwei) system in the 1950s and the rural household responsibility system in the late 1970s led to changes in child-rearing incentives and in fertility patterns (Greenhalgh 1990, Greenhalgh 1992). Through her studies of China and elsewhere, Greenhalgh has consciously and usefully employed state-society constructs to reveal the complex interplay between state and social forces in shaping family planning programs and fertility behavior, providing a model for how other scholars might do the same in the future.  

In this article I continue the agenda Greenhalgh initiated and employ state-society constructs to analyze the case of the Indonesian village family planning groups. I argue that using a state-society framework is the best means of untangling the nature of this unusual network that developed across the Indonesian archipelago over three decades. The network is, essentially, a product of a state organization utilizing the power of an authoritarian political apparatus to co-opt state and social institutions in order to meet a social need and to shape behavior at the village level. The deeper points I wish to raise are that family planning programs ought to be viewed as institutions of a political nature embedded in state and society, and that the state-society framework is the most useful lens for uncovering their political nature and the character of their interactions with their environments.  

I begin the article with a discussion of the original strategies employed at the village level in society by the state family planning agency. I then discuss the emergence and development of the village family planning group system. Finally, I draw out the
state-society hybrid nature of these groups, and their meaning for state-society analysis as it relates to our understanding of family planning programs.

**State, Society and the Indonesian Village Family Planning Groups**

**Early state strategies for social engagement: The clinic and fieldworker approaches**

The Indonesian state was not aggressive in its initial attempts to penetrate society to promote family planning. When the government set up a family planning program in the late 1960s, it adopted a passive, non-intrusive clinic-based approach to contraceptive provision, a strategy that private family planning groups, including the Indonesian Planned Parenthood Association, had been using for over a decade. The idea was that contraceptive service capacity would be established in health clinics, family planning personnel would work in these clinics, and women and men would travel to these locales 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. 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 (Rogers 1971, 13).

An August 1971 study quickly revealed the limitations of this approach. It showed that the number of clinics had jumped sharply in 1970 and 1971 but that each was handling very few acceptors per month (Rogers 1971, ix). The target set by the Ministry of Health for 1970-1971 was only 8 acceptors per clinic per month, which prompted the authors of the study to point out that the nation would never reach its demographic goals with such low objectives (Rogers 1971, 19). At the same time the government was carrying out this clinic approach, another slightly more proactive strategy, community outreach through fieldworkers, was being developed. The
philosophy behind the fieldworker approach was that motivation at the household level was necessary to encourage contraceptive use, and that door-to-door outreach by fieldworkers would expand the arms of the clinic considerably.  

The fieldworker approach achieved considerable results in the early years of the program. The number of yearly new contraceptive users from 1969 to 1975 grew thirty-fold to nearly 1.8 million annually. However, there was one trend that began to worry BKKBN officials. Increasingly, new contraceptors were selecting the pill rather than the IUD. Nationally in 1969, twice as many new users adopted the IUD as adopted the pill. By 1975 the pill was the overwhelming choice, with nearly seven out of ten new users choosing that form of contraception, and just over one out of ten adopting the IUD. This trend was occurring not just nationally but in all provinces where the program was being carried out, except for Bali.

This shift created a problem for the state family planning organization (Parsons 1984). As long as contraceptive users were selecting the IUD, a fieldworker strategy that reached out to bring women to clinics could be effective. In the clinics the device could be inserted, and there was no issue of resupply. Such was not the case with the pill, which required ongoing resupply and constant reminders to continue to contracept. With women scattered in villages across the country, many with difficult access to clinics and wavering motivation for family planning, there was a danger that large numbers would discontinue use. Moreover, the fieldworkers had enough work on their hands recruiting new users and escorting them to clinics. They could hardly begin to monitor old users and ensure their continued use of contraception. This situation posed a threat to the state fertility control project. BKKBN officials came to believe a new institution was necessary, one that could serve as a source of pill and condom resupply, as a means of social pressure to ensure that old users did not give up their practice of family planning, and more fundamentally, as a state instrument to penetrate local governments, social organizations and ultimately households to institutionalize the family planning program.
Deepening state penetration of society: The emergence of the village family planning group strategy

It was under these circumstances that the village family planning group was born, an innovation of the Indonesian family planning program developed to solve the resupply and use monitoring problems. Village family planning groups began as supply mechanisms for pills and condoms, tools the BKKBN used to reach into the villages. Over time they grew to cover much of the country and became far more elaborate mechanisms of state control and social penetration.

National dialogue within the BKKBN that led to the emergence of the village family planning group concept began in 1974 (Suyono et al. 1976, 13). At that time the central office started discussions with BKKBN provincial offices on means of maintaining program momentum. The BKKBN central office did not dictate to the six provinces on Java and Bali how to move beyond the clinic but rather encouraged each provincial office to find its own path, in accordance with the cultural nuances of the region (Suyono et al. 1976, 13). It asked provinces to find a way to make resupply easier, to link outlets to a ‘mother clinic,’ and to have contraceptives flow from the clinics to the outlets via the fieldworkers. This would enable the program to stay within the clinic statistical system and ensure supervision of the clinic over the resupply centers.

The state's engagement of provincial bureaucracies and social institutions

The flexibility the central office gave to provinces resulted in different mechanisms of engaging village institutions in each. In some provinces the state organization created new social institutions; in others it worked through existing structures. In each it managed to co-opt local government institutions or social leaders in support of the program, and in some to gain the active participation of higher levels of the provincial government.
In the province of West Java, the BKKBN worked through informal village leaders, as the fieldworker would bring monthly supplies from the clinic to a resupply depot located in the home of an acceptor who had social authority (Suyono et al. 1976). In Central Java, the system differed slightly in that the BKKBN managed to engage an official member of the local governing structure, a member of the village head’s staff, as distributor of re-supplies (Suyono et al. 1976, 14; Adioetomo 1994), a person whom the BKKBN also enlisted to monitor the contraceptive practices of villagers. By 1975 the BKKBN managed to generate the involvement of the provincial government in the implementation of the program, as the governor of Central Java decreed that this local official be integrated with village governing bodies (Suyono et al. 1976, 14). In Central Java as in West Java, sub-village family planning groups sprung up at the hamlet level, enabling the BKKBN to penetrate village society to an even deeper level. A system was employed in which a leader was sent to obtain supplies from the village family planning group (Suyono et al. 1976, 14). It was through these mechanisms that the BKKBN successfully enlisted the PKK, a powerful national woman’s organization, which took responsibility for coordinating these institutions (Adioetomo 1994, 145). The BKKBN managed also to have the provincial governor assign responsibility directly to local government heads to guide family planning group activities. In Central Java, then, the BKKBN was particularly successful in penetrating the provincial bureaucracy to gain active support for the family planning program.

The East Java system resembled that in Central Java, in that the BKKBN used a member of the village chief’s staff to serve as distributor of contraceptive supplies. In that province as well, the BKKBN managed to enlist the governor’s involvement, who himself ordered the establishment of a village family planning group system in September 1974. One innovation that emerged in the province was a lottery system which served as a magnate for new users (Suyono et al. 1976, 14), a mechanism eventually adopted on a national basis. Women, when receiving pill re-supplies, paid 35
rupiah, ten of which were kept for record keeping and 25 added to a lottery fund. One person each month won a prize, with a new winner each month until each person had had a chance to win. New users were attracted to this system, hoping to become the winner of the lottery. The East Java innovation set a precedent for a new dimension to the family planning groups that later would be adopted nationally: making them the basis for activities beyond family planning such as income generation and nutrition promotion, that would heighten their attraction to family planning users, serve to institutionalize these structures, and facilitate continuity of contraceptive use.

Bali, a predominantly Hindu island, was different from the provinces on Java in that the BKKBN worked through an already existing social institution, one that served as a mechanism of social control and informal local governance, to promote family planning (Parsons 1984, 8). The banjar was a long-standing community organization at the sub-village level that served a variety of social welfare functions and to which practically every family in the province belonged. Going through the banjar heads, the BKKBN provincial office managed to co-opt these organizations for family planning purposes, and place family planning on the agenda of banjar meetings, which were held every 35 days and attended by all male heads of households (Parsons 1984, 8). Through this mechanism the BKKBN was able to put in place a system of community pressure to use contraception, in which heads of households were required to report publicly on their household’s family planning practices (Parsons 1984, 7), including their wives’ pregnancy status, whether contraception was being used, if so what method and for how long (Parsons 1984, 7). Balinese women, unlike those in the provinces on Java, predominantly used the IUD. As a result, the initial focus of this system was less on resupply than on the recruitment of new users and the maintenance of old ones. A prominent means of social control that the BKKBN used in Bali was the mapping of users (Suyono et al. 1976, 15). Their family planning status was noted publicly, color coded by contraceptive method, and displayed prominently in the public banjar meeting
place. This device was adopted by the BKKBN and used on a national basis (Parsons 1984, 8), giving this state organization the capacity to monitor fertility practices down to the household level. In adopting these innovations the state family planning agency was employing considerable creativity in finding ways to gain social acceptance for its national fertility control project.

A routine BKKBN report from 1981 on the Bali banjar system indicates the degree to which the organization managed to penetrate these institutions for monitoring and program implementation purposes (BKKBN Propinsi Bali 1981). All 3,747 of Bali’s village family planning groups were recorded as having submitted family planning reports for this period. Based on data coming through the banjars, the Bali provincial office of the BKKBN was able to ascertain that 77.31% of the total number of eligible couples were active contraceptive users in the month of March 1981 and that 3059 couples stopped using contraception in the three month period of January-March 1981. Of the 3,747 banjars 18 received a mark of ‘poor,’ meaning that 35% or lower of the banjars’ eligible couples were contracepting.

**Expansion of state penetration and of the network**

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. Between the years 1974 and 1979, Bali experienced a 94% increase in the number of active contraceptive users, East Java a 100% increase, West Java a 123% increase and Central Java a 258% increase (BKKBN 1986, 135).

BKKBN officials initially encouraged regional variation in village family planning group structure. However, in a series of three national meetings in 1975 and 1976 the organization issued a set of guidelines to bring a degree of uniformity to the way
they functioned and to enhance its capacity to penetrate village society and monitor household family planning practices. During these meetings the BKKBN also officially adopted the village family planning group concept as national policy (BKKBN 1976, 3-6), a recognition that the strategy appeared to be working. At the third and final meeting BKKBN officials agreed that the primary purpose of building a village family planning group network was to create, “strong socio-cultural mechanisms so that family planning will become a need felt by the people themselves.” An objective was announced of establishing at least one family planning group in each village on Java and Bali, as well as building family planning groups at the sub-village level (Suyono et al. 1976, 7).

A significant outcome of these three foundational meetings was the creation of a uniform village family planning group recording and reporting system that gave the state organization an unusual capacity to monitor the individual contraceptive practices of villagers across the country. There were five forms and cards that village family planning group administrators were ordered to use to carry out and report on their work (BKKBN 1976). These included a card given to contraceptive acceptors each time they visited the clinic for family planning purposes, a register of eligible couples and acceptors in a village, a monthly report on village family planning group activities and recruitment of new acceptors, and a record of people who had previously used family planning but who had stopped contracepting. The village family planning group administrator was to be in charge of completing and submitting these forms, copies of which were to be sent to BKKBN offices and village chiefs. The fifth report was to be created by BKKBN district level offices, based on village family planning group reports, on contraceptive use in the areas under their jurisdiction. Copies were to be sent to the provincial BKKBN office as well as the national BKKBN headquarters. BKKBN statistics from the 1990s indicated that these were not idle commands and that its mechanisms for monitoring individual family planning behavior were working. Between the years 1989 and 1994 the
percentage of village family planning groups that provided monthly reports was consistently above 90% (BKKBN 1994, 94).

Through the 1980s and 1990s, the state’s expansion into the family planning affairs of its citizens deepened as the village family planning groups evolved in organizational complexity and spread throughout Indonesia’s 27 provinces. Many developed into groups of female members practicing contraception. The BKKBN assigned the village family planning groups more and more responsibility and by 1980 the organization expected them not merely to monitor contraceptive use and help with resupply, but also to recruit new users, help with side effects and assist in community development activities such as nutrition, income generation and maternal and child health (BKKBN 1980, I). The BKKBN acknowledged that they grew to, “exert a subtle but firm form of peer pressure on the non-contracepting part of the community, and internally discourage discontinuation of contraception” (NFPCB 1987, 11). Initially most groups existed only at the village level, but gradually they came to penetrate society at three geographic levels: village family planning groups at the village level, sub-village family planning groups at the hamlet level and acceptor groups at the neighborhood level.

In 1990, BKKBN leaders decided at their annual national work meeting to codify the complexity of this institutional evolution and pay special attention to the quality of village family planning groups, above and beyond quantity (BKKBN 1990, iii). A four-tiered system was devised, and BKKBN fieldworkers were required to report on each of the groups under their jurisdiction. The BKKBN specified seven duties groups ought to be performing: 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.\textsuperscript{14} Manuals were issued by the BKKBN central office for lower level officials
giving detailed instructions on the evaluation and recording of the quality of groups (See
BKKBN 1995b). The codification of this system was an indicator of the extent to which
the BKKBN had managed to move these groups from simple distributors of contraceptive
methods to mechanisms for the promotion of state objectives in the realm of fertility
control, agents of BKKBN social penetration and new user recruitment.

**Breadth and depth of the network's scope**

Data on group quantity and quality indicate the degree to which the BKKBN
managed to blanket the country with these groups. Tables 1 and 2 provide evidence
concerning the extent of coverage.

**Table 1: Spread of village family planning groups across Indonesian archipelago (density refers to
number of groups per couples of reproductive age)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of village groups</th>
<th>Number of sub-village groups</th>
<th>Number of neighborhood groups</th>
<th>Total number of groups</th>
<th>Density of groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1975</td>
<td>11,837</td>
<td>2,200</td>
<td>--</td>
<td>14,037</td>
<td>1/1370</td>
</tr>
<tr>
<td>1984</td>
<td>57,440</td>
<td>126,751</td>
<td>--</td>
<td>184,191</td>
<td>1/133</td>
</tr>
<tr>
<td>1996</td>
<td>63,457</td>
<td>318,876</td>
<td>719,791</td>
<td>1,102,124</td>
<td>1/32</td>
</tr>
</tbody>
</table>

Source: BKKBN\textsuperscript{15}

Across time there was a dramatic increase in the number of groups and in their
density with respect to couples of reproductive age. In 1975 there was only one group for
every 1370 couples of reproductive age. By 1996, the figure had risen to one group for
every 32 couples of reproductive age in Indonesia, more than one million groups amidst a
population of couples of reproductive age of around 35 million. This represents an
astonishing level of penetration of society by such institutions. Also, the data indicate
that in the 1970s the system only penetrated to the village level via village family
planning groups, but that gradually it reached to the hamlet level via sub-village family planning groups, and finally in the 1980s and 1990s to the neighborhood level via acceptor groups.

It is important to look not just at the quantity of groups, but also at their quality. A group that has just two or three members, meets irregularly and performs few outreach activities is likely to have far less impact on family planning outcomes and represents a lesser degree of state penetration of society than does one that has 30 members, meets weekly and is actively involved in recruiting non-users and in organizing other community activities. Using data gathered by the BKKBN since it began to record group quality in the 1990s, table 2 shows the number of groups and the percentage functioning at a high level of efficacy for the years 1992 to 1996.

Table 2: Level of institutionalization of village family planning groups

<table>
<thead>
<tr>
<th>Year</th>
<th>Beginning groups (percent of total)</th>
<th>Advanced groups (percent of total)</th>
<th>Total number of groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1992</td>
<td>21.8</td>
<td>79.2</td>
<td>861,651</td>
</tr>
<tr>
<td>1993</td>
<td>16.4</td>
<td>83.6</td>
<td>969,330</td>
</tr>
<tr>
<td>1994 (Jan)</td>
<td>16.6</td>
<td>83.4</td>
<td>1,050,602</td>
</tr>
<tr>
<td>1994 (Jul)</td>
<td>15.9</td>
<td>84.1</td>
<td>1,043,410</td>
</tr>
<tr>
<td>1995 (Jan)</td>
<td>11.4</td>
<td>88.6</td>
<td>1,100,401</td>
</tr>
<tr>
<td>1996 (Jan)</td>
<td>8.5</td>
<td>91.5</td>
<td>1,102,124</td>
</tr>
</tbody>
</table>

Source: BKKBN

Aside from a rise in the total number of groups over time, these statistics show an increase in the percentage of groups in the higher categories, and point to the existence of a state-organized national network functioning at a high level of effectiveness. More than ninety percent (meaning the top three quality categories) have a strong management system, meet regularly with family planning officials, offer birth control services, gather, record and report to higher level officials a demographic and fertility profile of their communities, and engage in family planning motivational activities. In other words as
of 1996, this BKKBN-generated network was functioning as a strong agent of the state for social orchestration in the realm of family planning.

**Factors that facilitated state penetration of village society for family planning**

Seven factors were critical to the BKKBN's effectiveness in orchestrating the expansion of this massive system. First was the fact that the BKKBN co-opted the PKK, the nation’s most powerful women’s organization and an institution that straddled state and society, in order to recruit members and develop the groups. The organization's power derived from the fact that the wives of Ministry of Home Affairs officials, the ministry that controlled the governors and provincial bureaucracies, were automatically its leaders. The national chairwoman of the PKK was the wife of the minister of home affairs. The provincial PKK leaders, who reported to the national chairwoman, were the wives of the governors. This leadership structure extended all the way to the villages, where local PKK heads were the village chiefs’ wives. Moreover, much of its funding was channeled through the ministry.

By engaging the PKK the BKKBN gained political priority for its program through the PKK leaders’ ties to the Ministry for Home Affairs. In addition, by doing so the BKKBN gained a powerful presence in the villages. It acquired the services of an army of volunteer village family planning workers controlled by these PKK leaders, a local presence that not even the largest, most powerful, most financially-endowed ministry could muster by itself, let alone a small bureaucracy like the BKKBN. 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. Moreover, the PKK’s members were primarily married women who themselves might be interested in family planning, and the organization’s leader was a national political figure with capacity to mobilize this large
Within the PKK, a Jakarta-based leading group was established with responsibility for family planning and reporting directly to the national PKK chairwoman. By the year 1989, this functional group managed 304,160 volunteers working in the area of planning motivation (PKK 1989), meaning that for every BKKBN fieldworker, there were almost 17 PKK volunteers. By engaging the PKK, it was as if the BKKBN lengthened its arms tenfold, enabling it to reach into village society even more deeply.20

A second reason the BKKBN managed to expand the network of family planning groups was that the agency devised a number of innovations that made these groups more attractive to village women, giving them incentives to stay within the system. The most important was conceived in 1979. That was the provision by the BKKBN of funds for income generation purposes (NFPCB 1987, 11). Most villagers had no access to micro-credit, and this program became an important source of recruitment for acceptors. 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 (NFPCB 1987, 11). These groups engaged in cottage industries primarily, but also used funds for purchase of animals and the establishment of a variety of shops (NFPCB 1987, 12). The BKKBN reported the existence of 92,217 such groups as of 1993 (BKKBN 1994, 99) – although it is unclear from these statistics whether these figures are conflated with all acceptor groups.

A third factor was the BKKBN's success in getting placed on a list of official criteria used to evaluate the performance of governors and district chiefs the growth in number of village family planning groups. The Minister for Home Affairs decreed that eight policy sectors were to be given priority in the country. These came to be known as 'the eight successes.' Population was one of the eight, and the number of village family planning groups was a measure of performance in this sector. Governors and their subordinates were given yearly awards based on the eight successes. This was a subtle
but important mechanism by which the BKKBN was able to help institutionalize priority for family planning within this critical bureaucracy.

Fourth, the BKKBN consciously revamped the job responsibilities of its fieldworkers as the network grew. In the early years of the program they were responsible primarily for new contraceptive user recruitment. Gradually these functions moved into the hands of village family planning group members themselves, and the fieldworkers became managers of systems of village family planning groups, with little direct user motivation responsibility. The fieldworker was thereby freed up to take on a more sophisticated role as local political and social organizer at the village level, coordinating with village heads, managing groups, monitoring their effectiveness and supervising the family planning reporting system so that higher-level officials could monitor progress in the field. This transformation in practice was officially incorporated into BKKBN policy guidelines, as the fieldworkers became the organizations’ front-line political and social orchestrators. As part of their training fieldworkers were explicitly ordered to approach formal leaders, as this excerpt from a training manual indicates:

especially [go after] the village chief…so that they take an active operational role in family planning…[and provide] political and operational commitment…[also] the village administrator (Pamong Desa), the heads of neighborhoods (Ketua RW), the chief law enforcement officers (Babinsa, Babinmaspol), the head of the Village Resilience Committee (Ketua LKMD), civil servants, and Armed Forces leaders.

A tool for implementing this social orchestration role and for supervising the network of groups were regular coordination meetings at the village level, meetings that the BKKBN leadership required its fieldworkers to hold once per month (BKKBN 1995a). At these meetings fieldworkers could monitor each group's performance, facilitate their planning for the upcoming month, and sustain village-level political commitment for the program. These meetings were not a matter of theory only. BKKBN service statistics show that they occurred regularly, in most villages across the country. Table 3, for instance, indicates that in the first half of the 1990s each fieldworker held on average more than 20 such meetings a year.
Table 3: Family planning coordination meetings held by state fieldworkers at the village level

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of fieldworkers (state employees of BKKBN)</th>
<th>Number of village-level coordination meetings held during the Year</th>
<th>Number of coordination meetings per fieldworker during the year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989/90</td>
<td>17,210</td>
<td>468,266</td>
<td>27</td>
</tr>
<tr>
<td>1990/91</td>
<td>18,441</td>
<td>439,002</td>
<td>24</td>
</tr>
<tr>
<td>1991/92</td>
<td>19,953</td>
<td>443,884</td>
<td>22</td>
</tr>
<tr>
<td>1992/93</td>
<td>24,029</td>
<td>490,324</td>
<td>20</td>
</tr>
<tr>
<td>1993/94</td>
<td>26,682</td>
<td>537,878</td>
<td>20</td>
</tr>
</tbody>
</table>

Source: BKKBN 1994

Fifth, the BKKBN creatively negotiated its way through the Indonesian bureaucracy, taking advantage of the inter-sectoral nature of the program and generating the support and implementation assistance of a number of sister organizations. These included most notably, the Ministry of Health, the Ministry for Home Affairs, the Armed Forces and the Ministry of Education. In doing so, the BKKBN also managed to gain critical implementation assistance from a number of women's organizations connected to the bureaucracy that were instrumental at the local level. These included Dharma Pertiwi, a national organization for wives of military officials, and Dharma Wanita, a similar organization for wives of government bureaucrats, both of which contributed volunteers for family planning promotion at the village level.

A sixth reason the BKKBN managed to set up this network, and perhaps the most important factor of all, was that the agency was working within an authoritarian political system that afforded it enormous space to maneuver and undertake new initiatives, without having to take into account popular voice or seek formal approval. Until Indonesia moved to a more democratic system in the late 1990s, parliament and civil society had much less power than did most Indonesian bureaucratic actors. While the BKKBN did need to present annual plans to the country's parliament, that body offered no significant check on its power. Also, there were few ways for any popular resistance
that may have existed to the program to find significant voice in the formal political structure. This is not to say that the bureaucracy could act at will, but it is to say that the BKKBN, as a government agency, faced far fewer constraints to action than it would have had it been embedded in a system with more democratic institutions.

Seventh, and related to the point above, the BKKBN had the sustained support of President Suharto within this authoritarian political structure. Suharto was committed to the program and regularly voiced his support publicly. The BKKBN capitalized on this support by using it to ensure that governors and other political and social actors diverted resources toward the program, and avoided setting up barriers for family planning. Ultimately Suharto's support was the oil that provided the BKKBN maneuverability through the authoritarian political system. It should be noted, however, that contrary to much of what has been written on the Indonesian family planning program, Suharto's support was as much a dependent as an independent variable. That support did not emerge in a vacuum: it had much to do with how the BKKBN leadership engaged the president in a sustained way, keeping him informed of program initiatives and successes so as to ensure his ongoing attention to the program.

Social influences on the state program

In my examination of the program, I have challenged the contention that the network was an example of pure community participation by emphasizing the ways in which the state shaped the village family planning network from above. However, I do not mean to suggest that state objectives and actions were the sole factors shaping the network. The state-society framework that I employ emphasizes the mutually constitutive nature of state and society, not unidirectional causality, and we can delineate several critical dimensions of influence going in the reverse direction.
First, the very decision by the BKKBN to set up the network was made in response to a social trend: the increasing selection by new family planning acceptors of the pill over the IUD. BKKBN leaders had hoped in the early 1970s to run the program through a system of fieldworkers and clinics, promoting long-term methods of contraception such as the IUD that required minimal monitoring. But village residents, with the exception of those in Bali, shunned the IUD in favor of the pill, forcing the state family planning institution to devise alternative implementation strategies that required a greater emphasis on community outreach and resupply mechanisms. In other words, the composition of social preferences led to a re-orientation in state strategy.

Second, the initial forms of village family planning groups were as much socially determined as they were shaped by the state. In Bali the long-standing banjar community institutions formed the locale in which the family planning program was implemented. Banjar practices shaped the way in which the program was run in the province, including the level of social pressure on non-contracepting households to adopt family planning. The state merely appropriated existant social institutions for its purposes. In West Java, East Java and Central Java the state did have a role in creating the initial groups, but even in these provinces there was considerable social influence on their nature and activities. For instance, the lottery system arose in East Java as a means to attract new users, and was adopted throughout the country. And the means by which contraceptives were delivered to villages varied from province to province: in West Java informal village leaders were key; in Central Java a member of the village head's staff; in Bali the banjar leaders.

Third, the very success of the program was contingent upon the existence of pre-existing social demand for means of regulating fertility. While the program may have been responsible for creating some demand, it is highly unlikely that it was the sole or even the primary cause. Development during the Suharto years brought with it socioeconomic and political changes external to the program that created the conditions
for demand for fertility regulation, conditions that were not existent during the Sukarno era. Female literacy and education rates rose dramatically under Suharto, political stability was restored, infant mortality levels declined and household incomes increased. One might argue that even the program itself was a product of a shifting external socioeconomic and political environment. As McNicoll and Singarimbun point out (1986) have pointed out, an effective family planning program would have been difficult during the pro-natalist Sukarno years, when the country was politically unstable and socioeconomic development had yet to take off.

Fourth, the very role of the BKKBN's ground-level bureaucrats - the fieldworkers - evolved in response to social changes. As mentioned above, the fieldworkers were initially the frontline workers of the program, visiting women in their homes, delivering contraceptives, and accompanying them to clinics. As the network took off the fieldworkers were removed from the frontline and became social orchestrators, managers of local networks of family planning groups, and responding to the needs of these networks. In other words, changes at the local level surrounding the program's effectiveness shifted the way the state family planning bureaucracy functioned.

Finally, the program was shaped from without by hybrid state-society groups such as the PKK. This national women's group, with a large social component, provided a significant portion of the volunteer army that staffed the network. The groups were led by tens of thousands of volunteers, many in the PKK, and composed of tens of millions of members of society, most of whom joined on a voluntary basis.

An interesting line for future research concerns the socio-political and economic impact of the network on village society in Indonesia. One would presume that given its rapid growth, its size and its power, the network would have had considerable influence on the nature of village-level power dynamics, political structures, social institutions and economic development initiatives, effects that would have gone well beyond the original family planning objectives for which the network was established. Yet little research has
been conducted on this subject. How did these networks change household dynamics and
gender relations at the village level? How were power relationships within village
governments transformed with the existence of these groups, and with the power afforded
to the PKK that came from influence over this critical social development program? Did
the formation of groups independently spur social initiatives in other policy areas, such as
health, education and care for the vulnerable? What impact did the provision of small-
scale loans to contraceptors, initiated inside the program, have on economic development
within villages, and on the control of resources? Overall, did the creation of this network
spark social dynamism and political transformation at the village level that otherwise
would not have occurred? These are the questions that a state-society frame compels us
to ask, and that are deserving of additional attention by scholars.

**Conclusion: States, Societies and Family Planning Programs**

Many social factors shaped the Indonesian village family planning network. However, there is far too much evidence of state involvement in the construction of the
network to designate it, as the BKKBN has, an example of successful community
participation. This was, in many ways, a state-orchestrated effort. Its creation was a
BKKBN idea, as was its institutionalization at the provincial level, and its expansion
across the archipelago. The uniform recording and reporting system was designed and
promoted by the BKKBN. The fieldworkers - the BKKBN's ground level bureaucrats -
guided the formation of the groups at the base level of society. Pushed by the BKKBN,
governors were pressured to promote the expansion as well through the 'eight successes'
development program. Above all else, the BKKBN molded these groups into their
village-level eyes and ears, servants of the state fertility control project and monitors of
household contraceptive practice.
This is not to discount the significant social influences on the program - the character of social demand for contraceptive choices, socioeconomic shifts that generated demand for fertility regulation, the variety of social institutions that emerged at the provincial and local levels, the role of volunteers, and the influence of the PKK and Islamic leaders. However, much of the network's development and effectiveness lay in the state family planning agency's creative negotiation of the authoritarian political terrain in which the program was embedded.\textsuperscript{24}

The case of the Indonesian family planning groups highlights the utility of a state-society lens in analyzing family planning programs. By viewing the BKKBN as the agent of the state fertility control project, maneuvering through political and social institutions to establish the network and reshape social behavior, we gain an understanding of the explicitly political nature of family planning implementation. We also see how the program sits embedded in both state and society, shaped by each. The authoritarian political structure molded BKKBN strategy, pushing the agency to maneuver through the Indonesian bureaucracy and numerous social institutions to gain material, financial and political resources to support the program. Yet it could not traverse this terrain at will: it had to adapt its strategy constantly to conform to social needs and the particularities of local contexts.

The state-society framework offers much promise for future family planning program analysis. Too often the explicitly political nature of programmatic interactions with state and social actors are overlooked, as is the degree to which programs are a product of and transformative of their social environments. The field of family planning program analysis would profit from looking at developments in the state-society literature as a future guide for understanding both the nature of programs, and the factors that shape their effectiveness.
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Notes

1 Personal interview, July 16, 1996


3 The most notable works that have developed and employed the state-society approach are by Joel Migdal (1987,1988, 1994a, 1994b) and Atul Kohli and Vivienne Shue (1994). All of these criticize prior political development paradigms. Modernization theory, the dominant political development paradigm of the 1950s and 1960s, conceptualized development as a linear operation in which traditional societies gradually come to resemble modern nations through uniform patterns of change (see Almond 1960 for an early articulation). Dependency theory arose in the 1960s in criticism of the optimism of modernization theory. Its advocates observed that most developing world societies were not undergoing the transformation that modernization theorists had assumed they would. Many countries remained mired in poverty and political turmoil, and were not following paths that resembled those of the advanced industrial nations. Unlike modernization theorists, to explain political change scholars in the dependency tradition focused not on the individual nation-state as the unit of analysis, but on the world system in its totality. They divided this system into core and periphery (or variants thereof), placing the advanced industrial states in the former and less developed states in the latter category. They argued that the structure of the international capitalist system confined poor
countries to permanent subordination in service of the interests of the advanced industrial nations. Only revolution could transform this situation of dominance (for classic articulations of dependency theory see Frank (1967), and Valenzuela and Valenzuela (1978)). It was in the 1980s and 1990s that new paradigms of political development emerged, ones that began to ascribe agency to the state. Both the statist and state-society approaches developed as a result of dissatisfaction with the socioeconomic determinist thrusts of previous political development paradigms. Statist theory, which received its strongest articulation in a 1985 volume by Evans, Reuschemeyer and Skocpol, criticized both the modernization and dependency approaches for reducing the state to a dependent variable and for being excessively focused on social processes. Its proponents sought to bring the state squarely into analyses of transformation, arguing that the state itself had autonomous interests not fully derivable from social groups or classes, and functioned as an actor shaping social development. The state-society approach went beyond this to look at state and social interactions and their mutual transformations, critiquing statist approaches for focusing excessively on the political determinants of socioeconomic change.

4 Other works on family planning, while not employing state-society terminology, use similar frames of reference. For instance, Donald Warwick (1982) has argued that population programs are organically related to a country's social and political environment, and that program administrators who ignore this fact risk having their programs cast out as foreign bodies. He uses the metaphor of 'transaction' to understand
family planning program implementation, a construct that focuses on interactions between state and social institutions. With this metaphor he emphasizes deliberate action on the part of state agents to achieve results, conscious dealing between implementers and program environments, and negotiation among parties with conflicting interests. In an earlier work, Simmons, Simmons, Misra and Ashraf (1975) called for an open-systems perspective in family planning program analysis, urging us to pay attention to the external factors that impinge on family planning programs, including the other organizations with which the program must interact, cultural constraints, and the sociopolitical and economic environments.

5 Ruth Simmons has been a pioneer in pushing for analysis of family planning and population programs as institutions, and I follow from her work and those of her colleagues in formulating these ideas. See Simmons, Ness and Simmons (1983), Simmons and Simmons (1987), and Simmons, Simmons, Misra and Ashraf (1975).

6 The 1967 figure was 4.6 acceptors per clinic, and by 1970 the figure was only at 5.2 (Rogers 1971, 19). The BKKBN was set up in 1970, but prior to this year there were private family planning efforts, as well as a semi-governmental body, the LKBN, from which the BKKBN emerged. It was these organizations that were initially involved in clinic development. The city of Jakarta also had a program that involved the government.

7 In 1967 and 1968 fieldworkers had been used in Jakarta on a small-scale basis (Rogers 1971, 11). A total of forty were employed in the capital (Rogers 1971, 12) during the year 1967. By 1970, there were 154 fieldworkers working on the island of Java and by
August 1971, 1075 across the six provinces on Java and Bali (Rogers 1971, 12). By the mid-1980s there were more than 15,000 fieldworkers across the country.

8 The Indonesian term for the village family planning group is Pembantu Pembina Keluarga Berencana Desa (PPKBD). Although the English literature on the subject has used the term ‘village contraceptive distribution center,’ it translates literally as ‘assistant in building family planning in the village.’ In reality it refers to much more than a distribution point or a person, as the following discussion shows, so I employ a term with broader reference.

9 There have been a number of studies that have discussed aspects of the village contraceptive distribution center system. See, for instance, Suyono et al. (1976), Parsons (1984), Adioetomo (1994), Warwick (1986) and Paul (1982).

10 The program began in 1970 in these six provinces, then through the 1970s expanded to the other twenty-one.

11 In this province as early as 1973 individuals contracepting had brought up the idea of a resupply network as they wanted an easier way to obtain contraceptives (Suyono et al. 1976, 13). The BKKBN designed a demonstration project, and from this the system emerged. Following a test project the system spread throughout West Java. In addition, family planning groups formed at a lower geographic level – the kampung (Suyono et al. 1976, 14) - many of which became involved in other activities such as sewing and nutrition.
“... terciptanya mekanisme sosio kulturil yang kuat sehingga KB dirasakan sebagai kebutuhan masyarakat itu sendiri” (BKKBN 1976, 7).

Seven duties of village family planning groups (Source: BKKBN 1995b)

<table>
<thead>
<tr>
<th>Duty</th>
<th>Summary Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Management</td>
<td>(Kepengurusan) The group has a clear leader, or system of collective leadership.</td>
</tr>
<tr>
<td>2. Awareness-raising, Motivation and Counseling</td>
<td>(Penyuluhan, Motivasi dan Konseling) The group leader and/or participants engage in activities to encourage community members to postpone marriage until an appropriate age, to plan their births, and to promote the welfare of family members via participation in various local organizations such as mother groups for under-five year olds.</td>
</tr>
<tr>
<td>3. Service Provision and Referral</td>
<td>(Pelayanan Ulang dan Rujukan) The group provides a pill and condom distribution channel for family planning users, and referral service for medical help when side effects connected with birth control arise.</td>
</tr>
<tr>
<td>4. Regular Meetings</td>
<td>(Pertemuan Rutin) The group meets periodically, and these meetings involve family planning officials.</td>
</tr>
<tr>
<td>5. Data Collection and Recording</td>
<td>(Pendataan dan Pencatatan) The group performs routine recording functions, including participation in a yearly national data gathering effort on all families. Beyond this, the group uses the data for the benefit of the local community.</td>
</tr>
<tr>
<td>6. Activities in the Prosperous Family Program</td>
<td>(Kegiatan Keluarga Sejahtera) The group engages in Prosperous Family Program activities in accordance with guidelines. [The Prosperous Family Program is an extension of BKKBN activities that began in the 1990s and that goes beyond family planning. It includes a micro-credit program and various community health development activities].</td>
</tr>
<tr>
<td>7. Efforts to Become Self-sufficient</td>
<td>(Upaya Kemendirian) The group has used own resources to provide contraception and/or economic support to less prosperous families in the community.</td>
</tr>
</tbody>
</table>


It seems unlikely penetration would ever move significantly beyond one group per 32 couples, however, since the government, beginning in the 1980s, started to encourage
private sourcing of contraceptive methods to encourage self-sufficiency and to reduce reliance on government and community sources, including the village family planning groups. Trends in sources of methods indicate the initiative has had results: between 1994 and 1997 the percentage of users acquiring contraception from private medical sources rose dramatically from 28 to 42 percent (CBS 1998, 81).

17 Beginning refers to groups in the first BKKBN- formulated quality category discussed in the previous section. Advanced refers to groups in the second, third and fourth quality categories - meaning that they can perform at least five of the seven functions the BKKBN expects groups to perform, and that they are functioning at a high level of effectiveness. Statistics refer to total number of village-level, sub-village level and neighborhood level groups. 1992 and 1993 statistics from KMNK/BKKBN 1994b. Totals in each category are rounded to nearest 10 as only percentages were given. 1994 statistics from KMNK/BKKBN 1995. 1995 and 1996 statistics from KMNK/BKKBN 1996a. The latter brochure also contains statistics for the month of July 1995, not included above. These are oddly incongruous with the data from the other four time periods reported above. They show a huge rise in the course of just six months in the number of groups nationally, from 1,100,401 to a total of 1,830,000, and then a sudden decline in an equally short period of time back to the trend, with a total of 1,102,124. It is unlikely this rise and fall has anything to do with the reality of the number of groups nationally. A more plausible explanation is reporting or recording irregularities.

18 As with other BKKBN service statistics, these data on quality must be assessed with caution. Fieldworkers and their supervisors are both the organizers of the groups and the
reporters of the data, and are evaluated in part on how well they make these groups work and how many they organize. There is a principal-agent problem, and the rise in absolute numbers and upward trend in the quality of groups may reflect the desire of fieldworkers to look good to their superiors as much as actual improvements in the field. They may also reflect modifications across time in the reporting system, or actions by fieldworkers to hype the indicators (such as counting minimal outreach activity as evidence the group is performing a family planning awareness-raising function) rather than concrete measures that genuinely improve the quality of groups. There are no sources of data besides BKKBN service statistics that measure quality on a national basis that could be used to provide independent confirmation of the level of organizational sophistication of these groups. What can be said, though, is that senior BKKBN managers are genuinely interested in how their base-level institutions are functioning, and their intention in gathering this information is primarily for internal management and planning purposes, not external reporting on organizational performance. For this reason, these data are likely more valid than other kinds of organization-gathered information, such as provincial contraceptive use rates, which more regularly capture the attention of international donor organizations and are more commonly used for evaluation of lower level officials. It is not unreasonable to assume from these statistics, therefore, that at an aggregate level this network of groups has a reasonably high level of organization sophistication, and that these data do not represent a large distortion of what is happening in the field.
Interview with official from Ministry for Home Affairs, Directorate-General for Rural Development.

The politically ambiguous nature of the PKK was a feature of a number of other so-called 'social organizations' in the Indonesian polity. Few politically oriented Indonesian groups during the Suharto era were allowed to function independently of the state, and most were required to receive official state sanction through registration. One might best portray state penetration of social institutions in terms of a spectrum. Some organizations were fully-embedded inside the state (including the BKKBN), others straddled state and society (such as the PKK), and yet others operated primarily within society but inside strong, state-delineated parameters (for instance, the national Islamic groups Muhammadiyah and Nahdlatul Ulama, each of which had millions of members and engaged in social development activities, but were explicitly barred by the state from political organizational work). For more information on the character of state-society relations in Indonesia under Suharto, see Antlov (1995), Liddle (1996), MacIntyre (1991), Warren (1990) and Wibisono (1989).

See KMNK/BKKBN 1995a.

On this point see especially Gertler and Molyneaux (1992).

Yet another significant social influence was that of the country's Islamic leaders at both the national and local levels. BKKBN leaders were aware that these leaders could pose a significant obstacle to the program if they were not consulted and managed carefully. Unlike programs elsewhere in Asia, sterilization has never been an emphasis of the
Indonesian family planning program. Abortion has been explicitly ruled out. Even the IUD was introduced into the program carefully, only after BKKBN leaders consulted with national Islamic leaders and allayed their concerns that this contraceptive device might lead to abortion, and assured clerics that IUDs would only be inserted by female doctors, or in the presence of husbands.

24 There were four dimensions to this negotiation strategy. First, the BKKBN managed to engage key actors in the state bureaucracy, gaining the support of provincial governments as it sought to expand the program. Second, the agency effectively harnessed social energy and demand for fertility control to create new groups where these did not exist. Third, where social institutions already were present, such as in Bali, the BKKBN co-opted these to support its objectives. And fourth, the agency engaged a number of powerful social actors, particularly the PKK, as allies in its project.