

**I. PROJECT IDENTIFICATION**

**1. PROJECT TITLE**  
**Family Planning Assistance - Services**

**2. PROJECT NO. (M.O. 1000.2)**  
**497-15-580-188.0**

**3. RECIPIENT (specify):**  
 **COUNTRY** Indonesia  
 **REGIONAL** \_\_\_\_\_  **INTERREGIONAL** \_\_\_\_\_

**4. LIFE OF PROJECT**  
**BEGIN FY** 1968  
**ENDS FY** 1980

**5. SUBMISSION**  
 **ORIGINAL**  
 **REV. NO.** 3 **DATE** 3/15/75

**APPENDIX ATTACHED**  
 **Yes**  **NO**

**CONTR./PASA NO.** \_\_\_\_\_

**II. FUNDING (\$000) AND MAN MONTHS (MM) REQUIREMENTS**

A. FUNDING BY FISCAL YEAR	B. TOTAL \$	C. PERSONNEL		D. PARTICIPANTS		E. COMMODITIES \$	F. OTHER COSTS \$	G. PASA/CONTR.		H. LOCAL EXCHANGE CURRENCY RATE: (U.S. OWNED)		
		(1) \$	(2) MM	(1) \$	(2) MM			(1) \$	(2) MM	(1) U.S. GRANT LOAN	(2) COOP COUNTRY	
1. PRIOR THRU ACTUAL FY	14,267	374	NA	749	NA	12,728	262	154	NA			
2. OPRN FY 75	840	--	--	85	95	580	150	25	6			17,266
3. BUDGET FY 76 *	301	--	--	61	53	65	150	25	6			7,700
4. BUDGET +1 FY 77	290	--	--	50	58	65	150	25	6			14,500
5. BUDGET +2 FY												20,000
6. BUDGET +3 FY												
7. ALL SUBQ. FY												
8. GRAND TOTAL		*										

Currency Rate: US 1 = Rp. 1414.5

**9. OTHER DONOR CONTRIBUTIONS**

(A) NAME OF DONOR	(B) KIND OF GOODS/SERVICES	(C) AMOUNT
See details in Part V.A.	See Part V.A.	\$11,500

**III. ORIGINATING OFFICE CLEARANCE**

<b>1. DRAFTER</b> J. Jarrett Clinton, M.D.	<b>TITLE</b> Chief, Population & Health Division	<b>DATE</b> 3/4/1975
<b>2. CLEARANCE OFFICER</b> Richard M. Cashin	<b>TITLE</b> Director, USAID/Indonesia	<b>DATE</b> 3/15/75

**IV. PROJECT AUTHORIZATION**

**1. CONDITIONS OF APPROVAL**

\* Note: FY 1976 includes 5 quarters (7/1/75 - 10/1/76) unless noted otherwise.

**2. CLEARANCES**

BUR/OFF.	SIGNATURE	DATE	BUR/OFF.	SIGNATURE	DATE

**3. APPROVAL AAs OR OFFICE DIRECTORS**

SIGNATURE	DATE

**4. APPROVAL A/AID (See M.O. 1025.1 VI C)**

SIGNATURE	DATE

ADMINISTRATOR, AGENCY FOR INTERNATIONAL DEVELOPMENT

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## I. INTRODUCTION

This project is responsive to the needs of Indonesia's rural poor. By providing easier access to fertility control mechanisms, this project will improve the social and economic well-being of rural poor families. To date the majority of Indonesian national family planning program acceptors are the wives of rural farmers, fishermen and manual laborers. Many of the acceptors are illiterate; most are minimally educated. Furthermore, the availability of modern contraception allows women to escape the bonds of constant pregnancy and childbearing and enhance their social and educational status.

Numerous factors affect the Indonesian family decision to reduce the total family size through the use of contraceptives. Once that important decision has been made, however, there must be readily available an adequate supply of reliable, appropriate and effective contraceptive techniques. Notwithstanding efforts to develop once-a-month or once-a-year contraceptive devices, the oral contraceptive, IUD and condom remain the safest, most available and effective contraceptives for the present and most probably for the life of this project.

In the January 1974 DAP Population Sector Review of USAID/Indonesia, seven critical program issues were identified. Two of the seven were as follows:

- "Wider access of all acceptable types of contraceptives to the people. Greater use of private sector and non-clinical distribution schemes.
- Long-term procurement of contraceptives for public programs and subsidized private schemes."

This activity responds to those critical program issues by improving accessibility and the delivery efficiency of contraceptives supplied through the national family planning program. USAID and the GOI agree that the BKKB should be preparing itself for eventual self-financing of contraceptive supplies. As these preparations proceed, USAID will encourage the BKKB increasingly to assume responsibility for financing their contraceptive needs with USAID complementing GOI inputs as necessary to introduce new technology and insure adequacy of supply.

## II. GOAL

### A. Statement of Goal

The project goal is to include fertility reduction measures as an integral part of development policies and programs leading to a 50% reduction in the crude birth rate by the year 2000. (The CBR in 1973 was 40-46/1000.) While the BKKB is examining shorter-term fertility targets, no decisions have been made at this time. Beyond the offering of services, serious consideration will be given by the GOI to creating the desire for a small family size through granting family incentives, tax structure changes and improving old-age insurance.

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USAID will continue efforts to measure the impact of the national program on fertility. Studies leading to measures of fertility have been initiated and will be repeated in selected provinces in 1976.

### B. Measures of Goal Achievement

Progress toward goal achievement will require analysis of both short and long-term program objectives. Short-term considerations will be:

1. Evaluation of the national population/family planning program's demographic impact.
2. Measurement and monitoring of mortality experience and fertility measures such as age-specific birth rates, total fertility rates, gross reproduction rates and net reproduction rates.
3. Reviewing available indices of contraceptive coverage and use prevalence.

Long-run considerations will be:

1. Fertility and mortality trends and their impact on population growth.
2. Reassessment of fertility goals to insure compatibility with Indonesian socio-economic development goals.
3. Evaluation of fertility impact of family formation, socio-economic and other intermediate variables.
4. GOI success in creating Indonesian desire for a small family norm.

### C. Means of Verification

Data for such evaluations and the measures of verification in achieving objectives will be generated through surveys, mini-census, extensive analyses of existing data and review of research and development projects. Such efforts will be coordinated by the National Family Planning Coordinating Board (BKKBN) and conducted by such research units as the Demographic Institute, Central Bureau of Statistics, Social and Economic Research Institute, Faculty of Public Health, Department of Health and other central and regional private/non-private organizations.

### D. Assumptions of Goal Achievement

Successful achievement of this goal assumes that the GOI will continue its interest and high priority in reducing Indonesian fertility as rapidly as possible. This will be demonstrated through continued policy decisions and budgetary support to the population/family planning sector.

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**III. PROJECT PURPOSES**

**A. Statement of Project Purposes**

The purpose of this project is to increase the prevalence of use of all legal types of contraceptive methods.

**B. Conditions Expected at the End of the Project**

The requirement to continue the accessibility of contraceptive services will continue for many years. In the context of this project, however, attainment of the project purposes will be measured by the degree of new family planning acceptors, prevalence of contraceptive use, contraceptive continuation rates, the degree to which contraceptives at reasonable prices are provided in the private sector and the overall cost per new acceptor or per birth averted required to attain these project purposes.

Based on the GOI National Family Planning Coordinating Board's program projections, there should be the following magnitude of new family planning acceptors through the government supported clinics:

	<u>GOI FY 74/75</u>	<u>75/76</u>	<u>76/77</u>
Java and Bali New Acceptors**	1,400,000	1,500,000	1,600,000
Prevalence of Use*	16-20%	20-24%	24-28%
Outer Islands New Acceptors**	50,000	100,000	150,000
Prevalence of Use*	<u>+0.5%</u>	<u>+1.0%</u>	<u>+1.5%</u>

\*USAID/POP estimate of percent of married women age 15-44 contracepting.

\*\*An increase in these targets may occur if early years' progress exceeds the original targets. Quantitative targets for private sector distributions have not yet been determined.

Contraceptive continuation rates should approximate 60% for the first 12 months after initial acceptance and 50% for the first 24 months. The present (Feb. 75) prevalence of contraceptive use of approximately 16% of fertile women in Indonesia should grow by approximately .7 to 1.0 million new current contraceptors per year.

USAID estimates of prevalence of use on Java/Bali by contraceptive type for US FY 1974 through 1980 are presented in Annex A.

While the estimated GOI FY 1973/74 benefit-cost ratio of fertility reduction is about 5 to 1\*, it is nevertheless prudent to maximize

\*Reference: The Indonesian National Family Planning Program: A Cost-Effectiveness Analysis 1971/72-1973/74, Sudarmadi and Reese. Forthcoming Technical Report in BKPM Technical Report Series.

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the cost-efficiency of the national family planning program. Again, the National Family Planning Coordinating Board has not established definite cost efficiency targets. Based on recent Indonesian analyses and world experience, a three-year average cost efficiency of approximately \$15 per current acceptor seems reasonable and feasible.

Although the cost per acceptor is increasing slightly, the cost per birth averted (currently \$33) is expected to decline. The estimated GOI FY 1973/74 savings per birth averted is estimated conservatively at \$139.

The benefit cost ratio and savings per birth averted are based on the combined GOI/Donor expenditures for GOI FY 1973/74 and the benefits derived from the estimated cumulative births averted in that year. Benefits are conservatively estimated as the expenditures required to feed and clothe the cohort of births averted over their lifetime. This stream of benefits is discounted back to 1973/74 and its present value compared to the 1973/74 costs of the family planning program. Details of these calculations are contained in the reference cited on Page 4.

#### C. Means of Verification

New acceptor and contraceptive use indicators can be verified through analyses of program data derived from the family planning service statistics systems, sample contraceptive use survey and contraceptive continuation rate surveys being implemented now and in the future. The degree of non-clinical contraceptive distribution can be confirmed through the above, by distribution records, and through retail outlet surveys.

Cost efficiency analyses have been conducted and will continue to be taken periodically. The data are available from BKKBN financial records, annual expenditures and aggregated family planning/population foreign assistance data. (See reference Page 4.)

#### D. Important Assumptions

The primary and critical assumption for this project purpose is that there will be a growing demand for contraceptive use. While an increase in the accessibility, quality and variety of family planning products and services can in itself increase demand for contraceptive services, this alone may not be sufficient for the long run. The GOI has implemented a broad scale information/motivation program which includes mass media, family planning field-workers, a reenergized health education program (USAID financed Project 188.1), traditional media and population education for both in and out-of-school. These programs are receiving GOI support and donor assistance from the IDA/UNFPA, Ford Foundation, International Planned Parenthood Federation, World Education, Inc. and the Pathfinder Fund. Many of these agencies receive AID/W funds.

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Family planning demand research, encompassing a broad spectrum from applied social science research to explicit evaluation of information programs has only begun. Donor assistance to these efforts is provided by IDA/UNFPA, Population Council, USAID and others. USAID will accelerate support to this area through the Research, Evaluation and Development subproject (188.3).

#### IV. OUTPUTS

##### A. Statement of Project Outputs

The specific output of this project is contraceptive accessibility created through the development and continuation of both public and private sector contraceptive products and services distribution schemes.

##### B. Output Indicators

There will be the following number of family planning clinics, capable of providing oral contraceptives, IUDs, condoms to new and continuing acceptors:

	<u>Cumulative</u>	
	<u>Java &amp; Bali</u>	<u>Outer Islands</u>
GOI FY 74/75	2,500	340
75/76	2,700	375
76/77	2,800	415

Unspecified at this time is the number of clinics and medical facilities which will provide, in addition to the above, male and female sterilization services. By 1977 it is estimated by USAID that no less than 300 sterilization centers or centers capable of receiving mobile sterilization teams will be in operation. A degree of uncertainty exists because, due to heavy conservative Moslem pressure, the GOI does not yet officially endorse sterilization as a means of contraception.

By 1977 extra-clinical distribution of oral contraceptives, commercial, quasi-commercial and extra-clinical distribution of condoms will be established throughout the entire Java and Bali program. The extra-clinical oral contraceptive distribution will primarily focus on facilitating re-supply in every village (desa). Commercial oral contraceptive distribution will be pursued to the degree allowed by GOI health regulations. Condom distribution via indigenous drug outlets, consumer product firms, village leaders, mail order and non-clinical workers will be implemented. In FY 75 an Indonesian national foundation was established and began operations to promote and administer government support to private contraceptive distribution schemes. Also in FY 75 a nationwide condom distribution scheme utilizing an indigenous drug supply company was initiated. BY FY 76 operations in at least three provinces (in Java) of village resupply depots for oral contraceptives will have begun.

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Three more provinces will be added to this program in FY 77. In addition, during this project, trials will be made of three to six other potential schemes for possible later nationwide implementation.

### C. Means of Verification

That these outputs have occurred can be confirmed through review of the computerized clinic registration forms and the official quarterly and annual reports.

Commercial and quasi-commercial contraceptive distribution schemes can be evaluated through distribution records, retail outlet surveys and through the periodic reports of Indonesian private companies and foundations engaged in non-clinical contraceptive distribution schemes.

### D. Assumption

These magnitudes of outputs, even with considerable USAID and other foreign assistance cannot be achieved unless the GOI continues their policies of establishing and financing family planning clinics and approving non-clinical distribution schemes both within the public and private sectors. Further, these outputs cannot achieve long-term success unless the schemes prove attractive either from a profit or social service standpoint to traditional and modern marketing groups.

## V. INPUTS

### A. Statement of Project Inputs

GOI support to the national family planning program is budgeted and channeled through the National Family Planning Coordinating Board (BKKB).

USAID estimates that the total BKKB budget will increase no less than approximately 25% per year from a base of Rp. 3.2 billion (equivalent to \$7.7 million) in GOI FY 74/75 (nearest equivalent to US FY 75).

USAID is one of more than twenty donors to the national family planning program and if this project is approved at recommended levels, should continue to make the largest annual financial obligations during the next several years.

Other major donors include the current combined IDA/UNFPA package (approximately \$3-5 million per year), International Planned Parenthood Federation (approximately \$1.0 million per year), Ford Foundation (\$300-500 thousand per year), Pathfinder Fund (\$300-500 per year), Population Council (approximately \$150 thousand per year). Several other donors provide collectively between \$5-50 thousand per year.

Total foreign assistance and total BKKBN budget plus a 10% allocation for non-BKKBN funded staff and buildings is estimated as follows (USAID estimates only):

	US FY 1975 (\$ million)%	US FY 1976 <sup>Ⓢ</sup> (\$ million)%	US FY 1977 (\$ million)%
GOI	7.7/35%	14.5/54%	± 20.0/63%
USAID*	0.8/ 4%	0.3/ 1%	0.3/ 1%
AID/W**	6.7/31%	6.2/23%	6.0/19%
Other Donors	6.5/30%	6.0/22%	5.5/17%
Total	21.7/100%	27.0/100%	31.8/100%

\*Excludes Project 497-15-580-188.1, 188.2 and 188.3 inputs (collectively requiring \$0.8 million in FY 75, \$0.7 million in FY 76 and \$0.5 million in FY 77) approved in separate PROPs.

\*\*Centrally funded oral contraceptives provided through Project 632-11 580-982.

Ⓢ--For comparison purposes, calculated at four quarters only.

From FY 1975 through FY 1977, it is estimated that the GOI project inputs will increase from 35% to 63% of total while the total AID (USAID and AID/W) project inputs will shrink from 35% to 20% of total. Clearly, the GOI will meet the obligation of providing no less than 25% of this project's financing. An annual approved budget statement for a given fiscal year will be obtained at the beginning of each GOI FY (April 1).

The financing burden for oral contraceptives will be gradually assumed by the GOI (or other donors) as approximated and illustrated below:

Year of Obligation	Total Millions			AID/W Contribution Millions			GOI Contribution Millions		
	Cycles	\$	%	Cycles	\$	%	Cycles	\$	%
FY 75	34.0	6.80	100%	33.3	6.7	98%	0.7	0.14	2%
FY 76*	42.1	8.38	100%	38.7	7.7	92%	3.4	0.68	8%
FY 77	39.9	7.98	100%	30.0	6.0	75%	9.9	1.99	25%

\*FY 1976 includes 5 quarters (7/1/75 - 10/1/76)

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Oral contraceptive requirements estimates are fully outlined in the Table IX. A. FBS format in Annex B.

Plans call for the SOI to procure Indonesian produced condoms beginning in FY 1976. Present stock in-country or on order and undelivered is sufficient to meet local consumption requirements until at least FY 1978 and local production capacity will be scaled to meet demand. Thus, no AID financed condoms will be required for FY 1976 and beyond.

### B. Budget

#### USAID Project Inputs (\$ 000's)

	<u>Total</u>	<u>FY 1976</u>	<u>FY 1977</u>
A. TDY (contract)	50	25	25
B. Medical Equipment	130	65	65
C. Participant Training (111 mm)	111	61	50
D. Local Currency Development Projects	300	150	150
Contraceptive Distribution	(200)	(100)	(100)
Management Development	<u>(100)</u>	<u>( 50)</u>	<u>( 50)</u>
<b>Total</b>	<b>591</b>	<b>301</b>	<b>290</b>

Short-term consultants will be used to assist and advise in the development of alternative delivery systems. Medical equipment, as necessary, will be used primarily to support the gradually emerging sterilization programs. Participant training, primarily US training, will focus on senior leaders in high level program management positions. A considerable portion of the funds are for necessary extensions of on-going training. The local currency development projects focus primarily on the development or management of alternative or supplemental delivery systems for oral contraceptives and condoms.

#### AID/W Project Inputs (000,000's)

(Funded through Project 632-11-580-982)

	<u>Total</u>		<u>FY 1976*</u>		<u>FY 1977</u>	
	<u>Cycles</u>	<u>\$</u>	<u>Cycles</u>	<u>\$</u>	<u>Cycles</u>	<u>\$</u>
Oral Contraceptives	68.7	13.7	38.7	7.7	30.0	6.0

\*FY 1976 includes 5 quarters (7/1/75 - 10/1/76)

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The relationship (linkage) between these oral contraceptive requirements and the project's purpose (prevalence of use) is detailed quantitatively in Annex A. The calculation of the requirements estimates, using the FBS Table IX. A. format, is explained in Annex B.

### C. Means of Verification

AID documents such as PROPs, Project Agreements, PIO/s and PARS will provide means of verification of USAID inputs.

GOI and other donor inputs can be verified through plans, budgets, budget expenditures and program reports.

### D. Assumption

An important assumption in the utilization of these inputs is that all donor agencies will contribute toward effecting a high degree of cooperation between donors and the relevant GOI organizations. This coordination applies to the utilization of human and material resources provided by the various agencies.

USAID direct hire staff, complemented as necessary by TDY personnel, will work with the BKKBW, and through the BKKBW with other GOI agencies, institutions and private foundations and organizations to plan, implement and evaluate the inputs described in Section V. of this PROP.

Specific assistance provided through this subproject will be described and obligated through annual Project Agreements between the GOI National Family Planning Coordinating Board and USAID.

Though AID/Washington will procure and finance the oral contraceptives and condom supplies, the annual Project Agreement will describe and justify these requirements.

## VI. Role of Women

By offering an alternative to frequent childbearing, this project should free women for greater participation in education, employment and the development process. Additionally, the commitment to use contraceptives in the Indonesian context is a decision mutually agreed upon by husband and wife. This mutual discussion reinforces the woman's right to participate in family development decisions.

Annex AEstimated Prevalence of Use by Contraceptive Type for Java-Bali US FY 1974-1980

	1974	1975	1976**	1977	1978	1979	1980
Total Married Women age 15-44 on Java-Bali at end of FY (millions)*	13.6	13.9	14.3	14.7	15.1	15.5	15.9
OC Prevalence of Use at end of FY (millions)	1.0	1.4	1.8	2.2	2.6	3.0	3.3
OC Users as % of Married Women age 15-44	7.3%	10.0%	12.6%	15.0%	17.2%	19.3%	20.7%
IUD Prevalence of Use at end of FY (millions)	.7	.9	1.1	1.3	1.5	1.7	1.9
IUD Users as % of Married Women age 15-44	5.1%	6.5%	7.7%	8.8%	9.9%	10.9%	11.9%
Condom Prevalence of Use at end of FY (millions)	.1	.2	.3	.4	.5	.6	.7
Condom Users as % of Married Women age 15-44	.7%	1.4%	2.0%	2.7%	3.3%	3.8%	4.4%
Cumulative OC, IUD, Condom Prevalence at end of FY (millions)	1.8	2.5	3.2	3.9	4.6	5.3	5.9
Cumulative OC, IUD, Condom Users as % of Married Women age 15-44	13.1%	18.0%	22.4%	26.5%	30.5%	34.2%	37.1%
OCs (millions) required to support above prevalence (assumes 13 monthly cycles/cy)	13	18	23	29	34	39	43
Cost of OCs at \$.20/cycle \$ (000,000)	\$2.6	\$3.6	\$4.6	\$5.8	\$6.8	\$7.8	\$8.6

\* Approximated from GOI Bureau of Statistics projections.

\*\* For comparison purposes, FY 1976 treated as four quarters only.

**APPENDIX B****OC Requirements Estimates FY 1975 - 77, Table IX A****FBS Format**

(000's cycles)

<b>A. <u>Usage CY 74-77</u></b>	<b><u>82,447</u></b>		
1974	12,450		
1975	17,810		
1976	23,332		
1977	28,855		
<b>B. <u>12/31/73 Unused</u></b>	<b><u>49,187</u></b>		
Central Warehouse	2,436		
Distribution System	9,637		
On Order and Undelivered as of 12/31/73	36,414		
Host Country Conts. of approx.	700	● \$0.20 = \$	140,000
(A-B) = <u>FY 1975 Oblig.</u>	33,260	● \$0.20 = \$	6,652,000
<b>C. <u>CY 1978 Usage</u></b>	<b><u>34,378</u></b>		
Host Country Contribution of approx. 10%	3,438	● \$0.20 = \$	687,600
<b>D. <u>FY 1976 Oblig.*</u></b>	<b>38,675</b>	● \$0.20 = \$	7,735,000
<b>E. <u>CY 1979 Usage</u></b>	<b>39,901</b>		
Host Country Contribution of approx. 25%	9,901	● \$0.20 = \$	1,980,200
<b>F. <u>FY 1977 Oblig.</u></b>	<b>30,000</b>	● \$0.20 = \$	6,000,000

\*cal. lated as 1.25 x 30,940,000 due to five quarters in US  
FY 1976.