AID 1020-25 (10-76) 4970188 (15) REPORT U-445

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PROJECT APPRAISAL REPORT (PAR) PD-AAD-748-G1

1. PROJECT NO.	2. PAR FOR PERIOD	3. COUNTRY	4. PAR SERIAL NO.
497-15-580-188.0	7/1/75 TO 11/9/76	Indonesia	77-1

5. PROJECT TITLE

Family Planning Assistance - Services

6. PROJECT DURATION: Began FY 68 Ends FY 77	7. DATE LATEST PROP	8. DATE LATEST PIP	9. DATE PRIOR PAR
	3/15/75	None	9/3/75 9p.

10. U.S. FUNDING	a. Cumulative Obligation Thru Prior FY: $ (000) 1/ 28,589	b. Current FY Estimated Budget: $ (000) 2,000	c. Estimated Budget to completion After Current FY: $ 2/ -0-

11. KEY ACTION AGENTS (Contractor, Participating Agency or Voluntary Agency)

a. NAME	b. CONTRACT, PASA OR VOL. AG. NO.
1. USAID direct-hire Population and Health Staff	
2. The Indonesian National Family Planning Coordinating Board (BKKBN)	

I. NEW ACTIONS PROPOSED AND REQUESTED AS A RESULT OF THIS EVALUATION

A. ACTION (X) USAID	AID/W	HOST	B. LIST OF ACTIONS	C. PROPOSED ACTION COMPLETION DATE
X		X	Prepare PP for OC Loan and FP Development Services Grant projects for FY 1978-82	May 1977

1/ Represents total project inputs FY 68 through FY 76 and TQ, although current PROP covers only FY 75-77; includes $12,770,500 USAID obligations and $15,818,000 for contraceptives obligated under AID/W projects but Mission programmed in this project (188.0).

2/ Although project ends FY 1977, PRPs request continuation FY 1978-82 via OC Loan ($56,000,000) and FP Development Services Grant ($17,000,000).

D. REPLANNING REQUIRES REVISED OR NEW: [X] PP PROP [ ] PIP [ ] PRO AG [ ] PIO/T [ ] PIO/C [ ] PIO/P

E. DATE OF MISSION REVIEW 11/4/76

PROJECT MANAGER: TYPED NAME, SIGNED INITIALS AND DATE	MISSION DIRECTOR: TYPED NAME, SIGNED INITIALS AND DATE
William H. Johnson 10/29/76	Thomas C. Nibleck 11/8/76

Evaluation Officer: RFZimmerman

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II. PERFORMANCE OF KEY INPUTS AND ACTION AGENTS

A. INPUT OR ACTION AGENT / CONTRACTOR, PARTICIPATING AGENCY OR VOLUNTARY AGENCY	B. PERFORMANCE AGAINST PLAN: UNSATISFACTORY 1	2	SATISFACTORY 3	4	5	OUT STANDING 6	7	C. IMPORTANCE FOR ACHIEVING PROJECT PURPOSE (X): LOW 1	2	MEDIUM 3	4	HIGH 5
1. USAID/PH direct-hire staff						X						X
2. Miscellaneous short-term contractors			X						X			
3.												

Comment on key factors determining rating

As recommended in PAR 76-1, USAID/PH has discussed and developed with BKKBN the strategy and requirements for family planning services assistance FY 1978 and beyond. Two FY 1978-82 PRPs ($56 million OC Loan and $17 million FP Development Services Grant)outline the strategy and requirements. In addition USAID/BKKBN have continued to explore possible mechanisms for improved overall program management. Improvements have been made in logistics and decentralization has spurred innovation. Plans for improvements in planning, supervision, and local cost project management are underway.

4. PARTICIPANT TRAINING	1	2	3	4	5	6	7	1	2	3	4	5
				X						X		

Comment on key factors determining rating Participant training completions and skills utilization have been highly satisfactory, but scarcity of qualified candidates with requisite English skills continues to compromise full realization of planned inputs/outputs. Lack of travel funds has also limited nominations. Other donors are now assisting with travel costs and USAID waivers can be sought as required. Plans call for increased emphasis on in-country training through local institutions especially for outer island personnel.

5. COMMODITIES	1	2	3	4	5	6	7	1	2	3	4	5
						X						X

Comment on key factors determing rating GOI continues to receive and distribute large volumes of commodities (about 35 million cycles of OCs since last PAR) through 2 ports to 16 provincial and 221 regency warehouses, 3300 clinics and about 25,000 village resupply centers. Numerous reviews by IIS, AG, GAO, IGA and management consultants have all concluded that the logistics system is basically sound.

6. COOPERATING COUNTRY		1	2	3	4	5	6	7	1	2	3	4	5
	a. PERSONNEL					X							X
	b. OTHER						X						X

Comment on key factors determining rating Top divisional and provincial personnel show evidence of continued growth,especially on Java/Bali. Outer Islands provincial personnel appear often to be available only part time for family planning. Rapid and well managed growth of village distribution on Java/Bali has continued program progress. Outer Islands program has achieved the same results in 2 years that took 3 years to achieve on Java/Bali (60 acceptors per 1000 MWRA). However, mid-level management needs additional strengthening and Outer Island personnel need more supervisory assistance, training and experience.

7. OTHER DONORS	1	2	3	4	5	6	7	1	2	3	4	5
			X							X		

(See Next Page for Comments on Other Donors)

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II. 7. Continued: Comment on key factors determining rating of Other Donors: As stated in PAR 76-1, continued absence of resident UNFPA representative impedes utilization of UNFPA resources. IBRD performance seems to be improving somewhat as they learn from past mistakes. The lack of coordination with IPPF compounds our difficulty in understanding future IPPF assistance plans. Pathfinder Fund has unilateraly and unwisely closed its resident office. Other donors, many of whom receive AID/W funds, continue to satisfactorily contribute.

III. KEY OUTPUT INDICATORS AND TARGETS

A. QUANTITATIVE INDICATORS FOR MAJOR OUTPUTS By GOI FY		TARGETS (Percentage/Rate/Amount) CUMULATIVE PRIOR FY	CURRENT FY 76/77 TO DATE	CURRENT FY 76/77 TO END	FY 77/78	FY 78/79	END OF PROJECT
Family Planning Clinic Centers opened and operating (cumulative)	PLANNED	2808	-	3100	3215	3400	-
	ACTUAL PERFORMANCE	3343	3507				
	REPLANNED			3500	3600	3700	0-
New Acceptors (000s cumulative)	PLANNED	6000	-0-	7775	9750	-	
	ACTUAL PERFORMANCE	6625	7536				
	REPLANNED			-	-	-	-
Java/Bali extra-clinical and commercial village OC and condom distribution centers (cumulative)	PLANNED	-	-	-	approx. 30,000	-	-
	ACTUAL PERFORMANCE	25,000	27,00				
	REPLANNED			-	-	-	-
Estimated full or part-time centers offering voluntary surgical contraception (VSC) (cumulative)	PLANNED	-	-	-	300	-	-
	ACTUAL PERFORMANCE	unknown	-				
	REPLANNED			VSC not yet officially included in GOI program.			

B. QUALITATIVE INDICATORS FOR MAJOR OUTPUTS	
1. Appropriate annual increases in GOI development budget for family planning.	COMMENT: Since 1968/69 GOI has paid for an estimated 39% of program costs with USAID and other donors combined contributing 31% and 30%. GOI budget has significantly increased each year from $75,000 in 68/69 to $15,600,000 in 76/77.
2. Cost-effectiveness of program	COMMENT: Estimated cost effectiveness of 68-77 inputs are: cost per acceptor = $13.08, costs per CYP = $11.25, cost per birth averted = $41.47.
3. Socio-political support for program.	COMMENT: President Suharto continues to meet quarterly with provincial governors to review FP progress. Ministry of Interior officials at provincial, regency and sub-district levels share responsibility with BKKBN for program progress.

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IV. PROJECT PURPOSE

A. 1. Statement of purpose as currently envisaged. 2. Same as in PROP? ☐ YES ☒ NO

To generate increased prevalence at use of all legal types of contraceptive methods.

B. 1. Conditions which will exist when above purpose is achieved.

24-28% of married women age 15-44 practicing contraception by end FY 77

Indicators by US FY

End of US FY — Contraceptive Prevalence *

	OC	Condom	IUD
1974	7.3%	0.7%	5.1%
1975	10.0%	1.4%	6.5%
1976	12.6%	2.0%	7.7%
1977	15.0%	2.7%	8.8%

*as % of married women age 15-44 (Java/Bali only)

2. Evidence to date of progress toward these conditions.

During FY 76 it is estimated that contraceptive prevalence on Java-Bali only (as a percentage of married women age 15-44) increased from 18.0% to 21.3% as follows:

	Start FY 76	End FY 76
Pill	10.1%	13.2%
Condom	1.4%	0.99%
IUD	6.5%	6.9%
Injections	N/A	0.1%
Others	N/A	0.2%
Total	18.0%	21.3%

V. PROGRAMMING GOAL

A. Statement of Programming Goal

Decrease natural rate of increase at population by reducing fertility (i.e. 50% reduction of CBR estimated at 40/46 per 1000 by year 2000)

B. Will the achievement of the project purpose make a significant contribution to the programming goal, given the magnitude of the national problem? Cite evidence.

Increased contraceptive use prevalence should result in reduced fertility. Preliminary evidence available from the 1973 Fertility/Mortality Survey, program impact estimates by Dr. John Laing, a smaple vital registration survey, BKKBN data, USAID estimates tend to support the thesis that fertility is falling in Java and may be falling rapidly in East Java and Bali. Data from the 1976 Intercensal Population Survey should be available in early 1977 to confirm or reject the evidence that fertility is falling.

ANNEX 1 Continued Relevance of Current Project Purpose

1. Are there alternative approaches to achieving the project's goal of lower fertility?

This project lowers fertility by increasing the use of contraception and thereby lowering the risk of conception. As explained below, there are many real and hypothesized alternative approaches to lowering fertility, however the only feasible interventions in most settings are reducing mortality (to begin the demographic transition) and increasing the use of contraception (to speed the completion of the demographic transition). Since mortality in Indonesia has already fallen and is continuing to fall, all available AID population funds should be spent on increasing the use of contraception. Socially, politically and technologically, contraception is the only feasible alternative for AID inputs.

The theory of demographic transition has been widely accepted and frequently applied to explain the vital revolution from high to relatively low fertility and mortality. This theory proposes that: 1) technological advances and social and economic modernization will reduce mortality and fertility; 2) a lead-lag relationship will appear between the mortality and fertility declines; 3) the methods for lowering mortality can be relatively rapidly and efficiently introduced and implemented, whereas the reduction of fertility depends upon more complex normative changes and occurs more slowly; 4) since mortality declines more rapidly than fertility, accelerated population growth accompanies the vital revolution.

Experience to date indicates that the more dynamic but less understood of the factors in the vital revolution is fertility. Fertility is accepted as the variable more independent of societal manipulation. However, both mortality and fertility are important variables in the biosocial system responsible for demographic trends.

Fertility can affect mortality directly via maternal mortality and indirectly via the social and economic system of the society. A decline in fertility should, ceteris paribus, lower maternal mortality and free capital for alternative investment. Economic improvements from alternative capital investments may act to lower mortality.

However, the complex of variables affecting fertility can do so only indirectly via the "intermediate fertility variables." These variables, as set forth by Davis and Blake, are: 1) intercourse variables, including age of entry into sexual unions,

extent of permanent celibacy, amount of reproductive period spent after or between sexual unions, voluntary and involuntary abstinence and coital frequency; 2) Contraceptive variables, including involuntary fecundity or infecundity, extent of contraceptive use, and voluntary fecundity or infecundity; 3) Gestation variables, namely, voluntary and involuntary foetal mortality. Values for the "intermediate variables" determine the level of fertility. But the "intermediate variables" are influenced by norms about family size, norms about "intermediate variables," and the mortality rate. These factors are in turn influenced by the social and economic structure which is in turn affected by the environment. The environment also directly influences mortality. And all factors in this complex system are influenced by fertility. *

From this complex biosocial model, it can be seen that many variables directly or indirectly influence mortality and fertility. In addition, interdependence exists between many of the factors relating mortality and fertility. The factors that can affect mortality (e.g., technology, health and sanitation practices, nutrition, education, work conditions, employment, transportation and communications, housing, clothing, recreation, environment, consumption and savings, social security, etc.) can also indirectly affect fertility. And the factors that can affect fertility (e.g., "intermediate variables," social norms about family size, social norms about "intermediate variables," economic, social, political and religious organization, net migration and environmental factors) can also indirectly affect mortality. Obviously, the balance of all these factors is never exactly the same in the experience of any two countries. So care must be taken in making inferences from existing research findings. In addition, the social psychological variables that may better explain fertility have not yet been discovered. Because of the interdependence of the factors influencing vital systems' trends, the limited generalizability of research findings and the social psychological unknowns surrounding fertility behavior, hypotheses relating declines in mortality and fertility are inherently speculative and incomplete.

However, the most plausible hypotheses derived from experience to date are that: 1) mortality declines because of improved social and economic conditions and/or implementation of modern public health procedures; 2) because of declining mortality, families recognize that children have a better life chance and that they need to produce fewer children to satiate their desire for the values children provide; 3) basic changes in the functions of the family and kinship systems (e.g., change in economic units from familial to industrial, necessary increases in education, separa-

*Kingsley Davis and Judith Blake, "Social Structure and Fertility: An Analytical Framework," in Nam, Population and Society, pp. 196-211.

tion of workplace and residence, specialization, less familial indentification and reference, reduction in the economic contributions of children, increased "rationality" i.e. behave to maximize utility and secularism) lead to perceived increases in the costs of children, reductions in the number of children desired and norms favoring smaller families which ultimately bring about fertility decline; 4) family planning programs to encourage the use of contraception can speed the transition to lower fertility and mortality.

2. What is the current priority of the project with the GOI?

- see page A-7, Annex III

- GOI Development Budget for Family Planning:

GOI FY	($000)
1968/69	75
1969/70	300
1970/71	1,323
1971/72	2,300
1972/73	5,134
1973/74	5,885
1974/75	8,400
1975/76	12,500
1976/77	15,600

3. What is the GOI view of USAID role? Do USAID and GOI share common perception of project purpose?

- response by Dr. Haryono Suyono (if available)

- yes

4. Are there adverse side effects to this project?

a) Economic? No
b) Ecological? No
c) Social/political? Speculative
d) Health? No - see following discussion

Obviously oral contraception carries with it the risk of morbidity. Morbidity evidenced by so called side effects, appears in about 10% of pill users and can be classed into three categories: Those annoying and sometimes uncomfortable but seldom dangerous to health; those carrying significant health risks (not life threatening, but may lead to permanent damage); those life threatening as follows:

Fairly Minor

Nausea, weight gain, headaches, spotting, decreased menstrual flow, missed periods, vaginal infection or discharge, depression, acne, chloasma, etc. Many of these minor side effects can be minimized by switching to a pill with a different estrogen/progestin mix. Choices of other OCs will be maintained in the program with BKKBN purchases and the assistance of other donors.

Not Life Threatening but Significant

Gallbladder disease, hypertension, jaundice, diabetes.

Life Threatening

Blood Clots (thromboembolism).

The major concern with the use of oral contraceptives is a measurable increase in morbidity and mortality due to the thromboembolic disease. Nonetheless, such a risk is neglible when compared to maternal morbidity and mortality that would result from not using contraception. In economically developed countries the mortality associated with pregnancy and childbirth can be compared to mortality associated with use of OCs as follows: 1/

Mortality

Age Group	Pregnancy and Childbirth*	Oral Contraception*
15-19	10.8	1.3
20-24	8.5	1.3
25-29	12.1	1.3
30-34	25.1	4.8
35-39	41.0	6.9
40-44	69.1	24.5

* Ratio per 100,000 live births, U.S., 1973
** Rate per 100,000 users per year, data from U.S., England and Wales.

The above illustrates that, even in economically developed countries, women of reproductive age are less likely to die if they use OCs than from complications of the reproductive process. In Indonesia where maternal mortality is 4 to 6 times higher than in the U.S.

the hazard to life from unwanted pregancy is at least tens of times greater than from the use of oral contraceptives - even if one assumes the risk of thromboembolism to be the same as in the U.S. and Britain. There is some data to suggest that the risk of thromboembolism among fertile women with different ethnic composition and diet, living in developing countries near the equator, who are leaner, more active and do not smoke cigarettes, the incidence of thromboembolic phenomena is probably much lower and may be negligible. 2/

5. Do the benefits justify the cost?

- see Annex III, page 7

1968 to 77

Cost per acceptor = $13.08

Cost per CYP = $11.25

Cost per birth averted = $41.47

It is clear that the societal benefits of each birth averted will vastly exceed the cost.

6 Are there unexpected benefits?

A village development dynamic has appeared in conjunction with the introduction of village family planning. Family planning groups are branching out into nutrition, cooking, sewing, handicrafts and other cottage industry activities.

1/ Christopher Tietze et al, "Mortality Associated with Control of Fertility," Family Planning Perspectives, January/February 1976

2/ Ravenholt, R.T., Speidel and Perry, "nonclinical Distribution of Oral Contraceptives," presented at Tenth Annual Meeting of American Association of Planned Parenthood Physician, Detroit, 1972.