

PO-ANN-048
ISN-30931

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

PROJECT PAPER

INDONESIA

FAMILY PLANNING DEVELOPMENT AND SERVICES II

497-0327

JUNE 1983

USAID/INDONESIA

UNCLASSIFIED

Project Paper
497-0327: Family Planning Development
and Services II

Table of Contents

	<u>Page</u>
I. Project Data Sheet	
II. Project Authorization	
III. Project Background, Rationale, and Description	1
A. Background	1
B. Rationale	6
C. Project Summary	7
D. Project Issues	9
E. Project Components	10
1. Village Family Planning	13
2. Urban Family Planning	19
3. Voluntary Sterilization Services	25
4. Training	31
5. Modern Management Technology	38
6. Research and Development	41
IV. Financial Plan and Analysis	45
V. Implementation Plan	54A
A. Implementation Plan Chart	54A
B. Implementation Plan Narrative	54

VI. Monitoring Plan	59
VII. Conditions and Covenants	60
VIII. Evaluation Arrangements	62
IX. Annexes	A- 1
A. PID Approval Message (State 319620 dated 15 November 1982)	A- 1
B. Log Frame Matrix	A- 4
C. Statutory Checklist	A- 5
D. B/G Request for Assistance	A-14
E. FAA, Section 611(e) Certification (not applicable)	A-16
F. Project Analyses	A-17
1. Technical Analysis	A-17
a. Village Family Planning	A-17
b. Urban Family Planning	A-24
c. Voluntary Sterilization Services	A-31
d. Training	A-35
e. Modern Management Technology	A-44
f. Research and Development	A-45
2. Economic Analysis	A-46
3. Social Soundness Analysis	A-50
4. Administrative Analysis	A-53
6. Contraceptive Supply	A-58

AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT DATA SHEET		1. TRANSACTION CODE A A = Add C = Change D = Delete	Amendment Number _____	DOCUMENT CODE 3
2. COUNTRY/ENTITY Indonesia		3. PROJECT NUMBER 497-0327		
4. BUREAU/OFFICE ASIA		5. PROJECT TITLE (maximum 40 characters) Family Planning Development and Services II		
6. PROJECT ASSISTANCE COMPLETION DATE (PACD) MM DD YY 1 2 3 1 8 9		7. ESTIMATED DATE OF OBLIGATION (Under "B." below, enter 1, 2, 3, or 4) A. Initial FY <u>83</u> B. Quarter <u>3</u> C. Final FY <u>85</u>		

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY <u>83</u>			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	3,317	5,183	8,500			19,500
(Grant)	(1,137)	(1,863)	(3,000)	(2,496)	(5,004)	(7,500)
(Loan)	(2,180)	(3,320)	(5,500)	(3,274)	(8,726)	(12,000)
Other U.S.	1.					
	2.					
Host Country	NA	NA	20,905	NA	NA	66,866
Other Donor(s)	NA	NA	7,500	NA	NA	24,000
TOTALS	NA	NA	36,905	NA	NA	110,366

9. SCHEDULE OF AID FUNDING (\$000)

1. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) PN	400B	430	430			7,500	9,500	7,500	9,500
(2) HE	400B	-	510			-	2,500	-	2,500
(3)									
(4)									
TOTALS						7,500	12,000	7,500	12,000

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)						11. SECONDARY PURPOSE CODE	
440	410	450	420	460		500	
12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)							
A. Code	INTR	PART	TNG	DEL	PVON		
B. Amount	19,500	17,300	6,000	15,000	1,000		

13. PROJECT PURPOSE (maximum 480 characters)

To increase the use in Indonesia of all legal types of contraceptives methods from 43% of all married women of reproductive age in December 1982 to 58% in March 1987.

14. SCHEDULED EVALUATIONS				15. SOURCE/ORIGIN OF GOODS AND SERVICES			
Interim	MM YY	MM YY	Final	MM YY	<input checked="" type="checkbox"/> 000 <input checked="" type="checkbox"/> 941 <input checked="" type="checkbox"/> Local <input type="checkbox"/> Other (Specify) _____		
	0 6 8 4	0 6 8 6		0 3 8 7			

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment)

17. APPROVED BY	Signature William P. Fuller <i>William P. Fuller</i>	18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION MM DD YY
	Title Director USAID/Indonesia	
	Date Signed MM DD YY 0 6 0 8 8 3	

ACTION MEMORANDUM FOR THE DIRECTOR

June 2, 1983

FROM : Jonathan L. Sperling, PRO 

SUBJECT : Project Authorization

Action: Your approval is requested for a grant of \$7,500,000 and a loan of \$12,000,000 from Section 104 Population Planning and Health of the Foreign Assistance Act of 1961 as amended, appropriation to Indonesia, for the Family Planning Development and Services II Project, Project No. 497-0327. It is planned that a total of \$3,000,000 grant and \$5,500,000 loan will be obligated in FY 1983.

Discussion: The Project Paper attached incorporates the changes you requested during the last Executive Committee meeting. Specifically the method of describing the process of identifying specific sub-project activities has been included, greater detail has been provided on the need for long-term strategic financial planning in the research component, greater detail has been provided in the training component for administrative training, required conditions precedent for sterilization activities have been included, aggregate budget totals have been placed on the front of the paper, and a number of editing changes have been made.

Waivers: None

Justification to the Congress: FY 83 Technical Notification to the Congress (see JAKARTA 01941 and JAKARTA 02990 for TN and STATE 097017 on notification of expiration of CN).

Clearances Obtained: The Project Identification Document was approved in AID/W on November 3, 1982. Mission Director has the authority to approve this project. The Project Paper has been reviewed and cleared by POP/RLA, PRO and FIN. The supporting grant and loan agreements have been drafted by RLA and cleared by PRO, POP and FIN.

Recommendation: That you sign the attached Project Authorization and Project Data Sheet indicating your approval of the Project Paper.

PROJECT AUTHORIZATION

INDONESIA

Family Planning Development
and Services II
Project No. 497-0327

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Family Planning Development and Services II project for Indonesia, the "Cooperating Country", involving planned obligations of not to exceed \$12,000,000 in loan funds and \$7,500,000 in grant funds over a three year period from date of authorization subject of the availability of funds in accordance with the A.I.D. OYB/allotment process, to help in financing foreign exchange and local currency costs for the project. The planned life of the project is six years and six months from the date of initial obligation.
2. The project consists of assisting the Government of Indonesia in its efforts to increase the prevalence of contraceptive use to 58% of all married women of reproductive age (ages 15-44), through support for the following programs: village and urban family planning, voluntary sterilization services, training, modern management technologies, and research and development. Funds provided to support these activities will be used for a variety of interventions, including, but not limited to, technical assistance, commodities, renovation and equipment of facilities, training, development and expansion of public and private family planning networks experimentation with fee-for-service techniques and marketing of contraceptives, development of computer and word-processing capabilities, and seminars and workshops.
3. The Project Agreements which may be negotiated and executed by the officers to whom such authority is delegated in accordance with A.I.D. regulations and Delegations of Authority shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as A.I.D. may deem appropriate.
4. a. Interest Rate and Terms of Repayment
The Cooperating Country shall repay the Loan to A.I.D. in U.S. Dollars within forty (40) years from the date of first disbursement of the Loan, including a grace period of not to exceed ten (10) years. The Cooperating Country shall pay to A.I.D. in U.S. Dollars interest from the date of first disbursement of the Loan at the rate of (a) two percent (2%) per annum during the first ten (10) years, and (b) three percent (3%) per annum thereafter, on the outstanding disbursed balance of the Loan and on any due and unpaid interest accrued thereon.

b. Source and Origin of Commodities, Nationality of Services
Commodities financed by A.I.D. under the project shall have their source and origin in the Cooperating Country or, if loan-funded, in countries included in A.I.D. Geographic Code 941, or, if grant-funded, in the United States, except as A.I.D. may otherwise agree in writing. Except for ocean shipping, suppliers of commodities or services shall have the Cooperating Country or, if loan-funded, countries included in Code 941, or if grant-funded, the United States, as their place of nationality, except as A.I.D. may otherwise agree in writing. Ocean shipping financed by A.I.D. under the project shall, except as A.I.D. may otherwise agree in writing, be financed only on flag vessels or the United States, if grant-funded, or Indonesia, and Code 941 countries if loan-funded.

c. Special Covenants

The Cooperating Country shall covenant:

(1) that all individuals participating in family planning programs (whether involving distribution of contraceptives or sterilization, or both), supported in whole or in part by funds provided hereunder, do so on the basis of an informed consent voluntarily given with knowledge of the benefits, risks, principal effects and available alternatives; and assure that all individuals practice methods of family planning consistent with his or her moral, philosophical, or religious beliefs.

(2) not to use any part of the funds provided hereunder for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions.

(3) not to use any part of the funds provided hereunder to pay for the performance of involuntary sterilization or to coerce or provide any financial incentive to any person to practice sterilization.

(4) that any agreements between the Cooperating Country and any public or private sector institution which concern voluntary sterilization activities will apply the above special covenants to such institution.

Signature: William P. Fuller
William P. Fuller
Mission Director

Date: 8/6/83

Clearances: POP: CJohnson: [Signature]
PRO: JSperling: [Signature]
FIN: RClark: [Signature]
LA: LChiles: [Signature]

Drafted: LA: LChiles: 06/03/83, mai

III. Project Background, Rationale, and Description

A. Background

The Government of Indonesia is concerned with the size, rate of growth, composition, and distribution of the population. Indonesia is the world's fifth most populous nation, with more than 153 million people. During the 1970's the population grew at an average annual rate of 2.3%. According to the 1980 population census, 41% of the population was under the age of 15 years, creating a high dependency ratio. Nearly two-thirds of the population live on the islands of Java-Madura-Bali, which comprise less than seven per cent of the land area. Java is one of the most densely populated areas in the world, with 1,815 persons per square mile.

The Government of Indonesia officially recognized its population problems in 1967 when President Suharto signed the World Leaders Declarations on Population. However, family planning information and services were provided mainly through private organizations until 1970, when the National Family Planning Coordinating Board (BKKBN) was established. The Board reports directly to the President.

The family planning program has grown rapidly since 1970. During the first phase of the program, 1970-74, family planning services were offered in health clinics in Java-Bali. The second phase began in 1974 with extension of services through a village family planning program in Java-Bali and the expansion of services through health clinics in ten large provinces on the outer islands. The village family planning system now has been introduced into all 27 provinces, although large areas are not yet adequately served. The village family planning program aims to make family planning information and contraceptive services available at the village or sub-village level utilizing paid fieldworkers and village volunteers.

The national family planning program in Indonesia probably has been more successful than in any other large developing country except China. Success of the family planning program can be measured by a declining birth rate, steadily increasing prevalence of contraceptive use, a reduced child/woman ratio, and growing numbers of outlets for family planning information and contraceptive services.

Less tangible, but equally important, are the continuing dynamic political support and personal leadership of the President of Indonesia and the active, creative staff of the National Family Planning Coordinating Board (BKKBN). Throughout Indonesia and among all political, religious, and cultural groups there is consensus that rapid population growth must be halted, soon, and a powerful commitment by all groups to make family planning information and contraceptives readily available and easily accessible to all Indonesian couples.

The BKKBN is a well-run organization with imaginative, dynamic, competent leaders. Population/family planning policies are clear, and the organizational infrastructure is expanding rapidly throughout the country. BKKBN philosophy is to establish village organizations to be responsible for providing family planning information and services. And the philosophy has been translated into action with the formation of thousands of village contraceptive depots and acceptors groups.

Indonesia is the first developing country to have moved from total dependence on donor grant funds for contraceptives, to accepting loans for contraceptives procurement, to assuming the financial commitment for procurement of contraceptives, and to developing domestic production capability for its future contraceptives requirements.

AID grants and loans helped create one of the world's largest markets for contraceptives. The Government of Indonesia is now seeking foreign private sector involvement to maintain and improve product quality, expand production, and transfer the latest technologies for backward integration of local production. U.S. companies are actively pursuing the opportunities created with AID assistance.

In the past, AID assistance concentrated on helping to build a basic family planning organization and on providing massive quantities of contraceptives for rapid expansion of village family planning services. Today, basic elements of a sound national family planning program are in place and working. Family planning performance results over the past twelve years are impressive:

- the crude birth rate dropped from 44-46 births to 30-32 births per 1,000 population;
- the population growth rate fell from 2.7% to less than 2%;
- current users of contraceptives in the official program increased from 181,000 in 1970 to 9.9 million by December 1982; and
- prevalence of contraceptive use in the official program grew from 1% in 1970 to 42.6% of married women of reproductive age by December 1982. USAID estimates that an additional 5%-6% utilize the private sector for contraceptive requirements.

These performance results were based on the development of a successful family planning program, within which:

- family planning outlets increased from a few hundred clinics in 1970 to over 5,600 hospitals, clinics, and health centers and, with the direct assistance of USAID, over 130,000 active village family planning posts, sub-village depots, and family planning acceptor groups by December 1982;
- distribution of oral contraceptives grew from less than one million monthly cycles in 1970 to 64.4 million cycles in calendar year 1981;

- tens of thousands of persons were trained to assist in the family planning program, including physicians, nurses, midwives, field workers, village volunteers, educators, and village leaders;
- political support for the family planning program comes from government leaders at all levels, beginning with the President of Indonesia, who has frequently demonstrated his deep personal commitment to the program;
- the GOI's share of the total family planning budget increased from 29% of a \$4.6 million budget in 1970/71 to 72% of a \$120 million budget in 1982/3, a measurable consequence of the GOI's political commitment to expanding family planning services;
- a nationwide reporting and feedback system is in place and is utilized for managing, supervising, and planning;
- a nationwide logistics system functions well; contraceptive and other commodities reach the village and sub-village levels on a regular basis;
- a domestic oral contraceptives manufacturing capability now is producing 40% of oral contraceptives used this year, with a planned expansion to meet all major contraceptive requirements by 1986;
- the BKKBN has taken the lead to collaborate with the Ministries of Health, Social Affairs, Local Government, Religion, and Agriculture in coordinating the provision of simple nutrition and health services at the village level through the infrastructure of the village family planning program.

USAID has been, and still is, the major foreign donor for population and family planning. The concept of village family planning was tested with AID research and development funds. AID's agreement to provide massive supplies of contraceptives, first on a grant and then on a loan basis, made national expansion of village family planning a reality. AID provided flexible funding to allow BKKBN to experiment with new ways of extending family planning information and contraceptive services to meet special provincial or regional cultural and social needs. More than 100 persons have received master's or PhD-level training in the U.S.; and they now occupy many key leadership positions in the BKKBN, research organizations, and demographic and public health school faculties. Technical experts have provided assistance in training and manpower development, logistics, oral contraceptive production and quality control, data analysis, and management, just to name a few.

The national family planning program has attained already a good momentum. But GOI and BKKBN leaders are well aware that achievement of future targets is an immense undertaking that may require a reorientation of strategy and programs. The BKKBN's new Panca Karya, or Five Operational guidelines, strategy for the 1980's gives priority to:

- Women under age 30, or with less than two children, who should plan a maximum of two children. First births should be delayed to age 20 by postponing marriage and birth planning.
- Women over age 30, and those with three or more children, who should plan no more children and should be offered means of fertility regulation.
- Encouraging teenagers to postpone marriage and, when married, to postpone the first pregnancy.
- Adding nutrition surveillance and education, basic health services, income-generating opportunities, and other community improvement activities in areas with higher rates of contraceptive use to help institutionalize the concept of family planning.
- Strengthening the process of program institutionalization in a mental and spiritual way so as to provide psychological support to the population/family planning program.

These five strategies work together to promote the national theme of a "small, happy, and prosperous family norm" where a two-child family is ideal.

Until recently, the BKKBN divided the 27 provinces into three groups which reflected their chronological entry into the family planning program: Java-Bali; Outer Islands I (ten large provinces); and Outer Island II (the remaining 11 least densely population provinces). The BKKBN has shifted to a more mature division of provinces by rates of contraceptive prevalence:

- Phase I - less than 15%,
- Phase II - 15% to 34%,
- Phase III - 35% to 54%,
- Phase IV - 55% to 74%, and
- Phase V - over 75%.

Program strategies, budgets, manpower requirements, and other program elements are developed separately for provinces in each phase, and shift as a province moves from one phase to the next.

With this in mind, future AID assistance which is described in this Project Paper, is being shifted to reflect opportunities to resolve remaining problem areas as Indonesia moves toward national implementation

of a mature family planning program. Remaining areas include:

- Increasing rates of contraceptive use in low-performing areas, particularly in urban areas through the introduction of new contraceptive technologies, especially voluntary sterilization;
- Increasing institutional capability through training and technical assistance for management, supervision, and administration; and accelerating decentralization of program planning, implementation, administration and evaluation;
- utilizing the private sector to provide family planning services on a fee-for-service basis to reduce government involvement and budget;
- leading BKKBN into new areas or approaches utilizing flexible funds for demonstration projects or first year costs, after which the budget is provided by BKKBN.

USAID's long experience with the Indonesian national family planning program, its qualified staff of technical experts, and the knowledge of personalities, procedures, and programs, in the family planning field give the U.S. Government a unique comparative advantage over other donors with regard to assisting the Indonesian program. Building on this base, the project seeks to assist the FKKBN overcome remaining program weaknesses and to extend family planning information and services throughout selected areas of the country. By continuing support, USAID has an opportunity to help Indonesia become the first large developing country to bring the birth rate down to the level in developed countries.

B. Rationale

The Government of Indonesia (GOI) supports rapid fertility reduction as a crucial element of its national plans for economic and social development. The Second, Third, and Fourth Five-year Development Plans highlight the GOI's concerns about the size, rate of growth, composition, and distribution of the population. Powerful and continuing political support from the President, his new Cabinet, and all major political groups and substantial GOI financial and administrative support for the national family planning program underscore the GOI's commitment to rapid reduction of the birth rate. The national family planning program is viewed by the GOI as the most effective means of reducing fertility and also as an effective means of organizing villagers to undertake village-level activities aimed at improving health, nutrition, and economic conditions.

The Country Development Strategy Statement for Indonesia approved by AID/W in February 1983 highlights the need for strong AID support for the Indonesian national family planning program possibly through the end of the decade. USAID's objectives are to help strengthen institutional capacity and capability, transfer modern management techniques and technologies, and assist in introducing the most effective means of fertility control.

This project description is consistent with guidance contained in AID/W's Population Assistance Policy Paper and with the Population Strategy Paper prepared by the AID/W Population Sector Council. The proposed project builds upon fifteen years of USAID assistance to the GOI in the population-family planning sector (Projects 188, 270, and 271). This project focuses on the expansion and improvement of family planning services and on strengthening management, training, and research capabilities. Through Project 497-0305, Village Family Planning/Mother-Child Welfare, USAID supports GOI efforts to integrate family planning services with health, nutrition, and income-generating activities at the village level.

The proposed project forms part of the Indonesian national family planning program, to which the GOI currently contributes over 70% of all resources; USAID, around 20%; other donors, around 10%.

Thus, the goal and purpose are those of the GOI's national family planning program. Outputs and inputs are more narrowly defined in terms of specific USAID and BKKBN contributions for six project components.

The demographic goal of the GOI is to reduce the crude birth rate to 22 births per 1,000 population by October 1990. This represents a 50% reduction over the twenty year period, 1971-1990. By December 1982, the estimated crude birth rate was 31-32 births per 1,000 population.

The purpose of this project is to help the GOI increase the prevalence of contraceptive use through the national family planning

program to 58% of all married women of reproductive age (ages 15-44 years) by March 1987. Contraceptive prevalence was estimated at 43% nationally by the end of December 1982, with great provincial variation. Three provinces reported prevalence rates over 60%; eight provinces, rates under 15%.

C. Project Summary

USAID proposes a three year (FY 1983-85) project which will provide \$19,500,000 to the Indonesian National Family Planning Coordinating Board (BKKBN) for activities in six inter-related project components. The USAID contribution includes \$7,500,000 in grant funds and \$12,000,000 in loan funds. The six components are:

1. Expansion of village family planning services in 13 priority provinces (\$899,000 grant; \$ 4,155,000 loan);
2. Development of urban family planning programs in the 10 largest cities, with special emphasis on utilization of the private sector and cost-recovery activities (\$3,000,000 loan);
3. Extension of voluntary sterilization services in 12 priority provinces (\$3,582,000 grant);
4. Management and institutional improvement through training (\$250,000 grant; \$4,845,000 loan);
5. Management and institutional improvement through the introduction of modern management technologies (\$849,000 grant) and,
6. Research and development support to measure program progress, test new ways of delivering information and services, and strengthen monitoring and supervision of program operations (\$1,900,000 grant).

The BKKBN will contribute approximately \$66,866,000 as support for the joint activities.

SUMMARY OF USAID AND BKKBN INPUTS
BY SIX PROJECT COMPONENTS

(US\$000)

PROJECT COMPONENT	USAID	BKKBN	TOTAL
1. Village Family Planning	5.054	38.692	43.746
2. Urban Family Planning	3.000	14.173	17.173
3. Voluntary Sterilization	3.582	11.716	15.298
4. Training	5.095	684	5.779
5. Modern Management Technology	869	104	973
6. Research and Development	1.900	1.497	3.397
TOTAL	19.500	66.866	86.366

Project implementation will be concentrated in three Indonesian fiscal years. Most of the USAID-supported activities will begin April 1984 and continue through March 1987. However, each component has its own implementation schedule; and some activities will begin during the Indonesian fiscal year April 1983 - March 1984. Other activities, such as academic degree training, will continue through the decade.

Project beneficiaries are the 23 million married women of reproductive age (MWRA) who will have access to family planning information and contraceptives in order for them to determine voluntarily the number and spacing of the children they want. Village women are directly involved in the formation of activities of village or hamlet acceptors groups which provide peer support and serve as vehicles for collective action to improve the health and welfare of families.

D. Project issues

The issues raised by AID/Washington in the Project Implementation Document approval cable regarding this project (State 319620 dated November 15, 1982) are addressed in this Project Paper on the pages indicated:

Project Paper (Where addressed)

Issues:	<u>Page/s</u>
1. Cost Recovery	19-20, 47-48, 62, A-27, A-46 to A-49, A-55
2. Private Sector	19-20, 62, A-24 to A-27, A-46 to A-49
3. Voluntary Sterilization	25-26, 60, 61, 63, A-31 to A-34
4. Village Family Planning Services	3-5, 13-14, 60, A-17 to A-23
5. Counterpart Contribution	6, 7, 8, 47, 53
6. AID/Washington Central Funding	A-32, A-45
7. Construction	25, 40, A-31
8. Contraceptive Supply	A-58 to A-62
9. Evaluation	10-12, 60, 62-63
10. Other Concerns	
- Cost Estimates	45-48
- Contracting	31, 38, 48
- Social Structures	A-17 to A-21, A-24 to A-27, A-50 to A-52
- Public Health Schools	31-32, A-36, A-40, A-42 to A-43

E. Project Components

Since the inception of Indonesia's family planning program USAID's Office of Population has responded to the BKKBN's requests for assistance with alacrity and close cooperation. Whether the request, in the form of a proposal, was to assist various activities in a certain province, test out a new and innovative approach to family planning delivery, or to conduct a discrete piece of research, USAID's response has always been through fast, flexible funding and a unique labor-intensive, collegial relationship with BKKBN colleagues at both central and provincial levels.

In 1979 an in-depth study to weigh the key determinants of political will, administrative capacity, and sociocultural determinants for fertility and contraceptive readiness was conducted for the Indonesian family planning program. The study, titled "AID's Role in Indonesian Family Planning: A Case Study with General Lessons for Foreign Assistance," was conceived by the Population Division of AID/Washington's Asia Bureau at a time when the Indonesian program had been in existence for eleven years and U.S. assistance to it had totaled \$43.2 million in grants and \$14.3 million in loans. This study points up several important aspects of the BKKBN/USAID relationship which continue to be essential to the on-going planning, administration, monitoring and evaluation of the program throughout the 1980s. The most important of these aspects is what this study calls "the mechanism;" that is: "A mechanism, based on local-cost programming and project implementation letters (PILs), was developed by the mission population office to move resources quickly to provincial and rural activities where there is high probability that the resources will be used effectively. The ability of the Office to provide funding for local initiatives within weeks (rather than months or years) has been highly instrumental in stimulating commitment. It is this mechanism, together with the successful management-oriented data system developed by the BKKBN and the A.I.D. Mission, that has permitted effective decentralization. If only one element were to be singled out as most important in explaining the effectiveness of A.I.D. support to this particular program, it would certainly be the use of this funding mechanism." (page 2)

Briefly, the mechanism operates as follows for five of the six components in this Project Paper. The training component follows its own procedures as specified in that section.

Public or private institutions, such as provincial BKKBNs, universities, research organizations, and private sector organizations, submit project proposals to the BKKBN with a copy to USAID's Office of Population. Initially each proposal is informally discussed and prioritized for action by the relevant bureau(s) of the BKKBN and the USAID Project Officer. Prior to agreement on a sub-project, representatives from the Central BKKBN, USAID, and the province or agency involved typically visit the project site and collaboratively agree upon various activities and a detailed budget as submitted in the project

proposal. To assist the joint team in evaluation and judgement of activities, the BKKBN's monthly service statistics, a part of the data system, is utilized to review progress to date. In addition, other regular reporting and sampling systems of the BKKBN provide additional information for monitoring program performance. The idea, and necessity, of the site visit is to jointly review the proposal within its own context and sociocultural milieu, review program progress and potential, and reach agreement in principle that the organization is capable of carrying out the proposed activities and the proposal is ready for funding. At this stage the team works on strengthening the proposal for final submission to the BKKBN and USAID. Once the proposal is in final form one last review between the BKKBN and USAID is conducted at the Central BKKBN. After agreement by the BKKBN's relevant operational bureau(s) and the support bureaus of Planning and Finance and USAID that the proposal is socially sound and cost-effective, the proposal is formally submitted to USAID for funding. Upon receipt of the formal request, USAID prepares a Project Implementation Letter (PIL) which typically includes a brief description of activities to be carried out under the specified time frame, standard AID reporting and accounting procedures, a detailed budget, an overall allocation of funds for the funding period, and a detailed planned cash disbursement schedule for the first quarter of activities. A brief evaluation of project progress is done quarterly through activity and financial reports submitted by the institution, as well as informal discussion between the BKKBN and USAID, prior to the next release of funds. Each release of funds is bound by the fiscal procedures and receipting requirements as well as USAID quarterly activity and financial reporting requirements. And, if at the successful conclusion of a project, a follow-on sub-project is proposed, the BKKBN and USAID representatives make an assessment of provincial or agency capabilities and previous success in implementing joint projects.

Other important aspects this study points up are flexibility, decentralization and local participation. The fast, flexible funding procedure developed by the mission reflects its own decentralization of the BKKBN program. This lodges both authority to act and credit for performance in the provincial offices or other institutions. The double support for decentralized programming mobilizes great amounts of human resources by stimulating local initiative and participation through demonstrating that such initiative can bring quick and effective central support.

The Indonesian family planning program and AID's fast, flexible support to it have been unusually effective in eliciting initiative and participation of provincial and village leaders. BKKBN effectively delegates authority for program management to provincial staff, administrators, religious, and other formal and informal leaders. The extensive field travel of USAID population staff together with Indonesians and the staff's ability to commit funds and then move them quickly to the provinces are key ingredients in generating local initiative. This gives local leaders the confidence that their ideas can be quickly translated into action and being able to see quick results encourages local leaders to be more active. This has apparently also

helped many of them to resist the lures of the capital and to remain instead in the provinces where their talents are so needed.

The value of this process cannot be overestimated. It provides for intensive interaction with BKKBN officials, in headquarters and provinces, through which USAID staff gain a clear understanding of the needs of the program. This permits them to selectively support its strongest parts. It permits funding to be highly flexible, adjusting activities to the specific field needs, and it fosters a high degree of local initiative.

What has been true up through 1979 is even more important today and for the future. Since 1980 the BKKBN and USAID have worked closely in strengthening, stream-lining, and standardizing this process. In 1981, after further experimentation with the mechanism, an Indonesian language procedures manual titled "Pedoman Prosedur Kerja Bantuan USAID" was published for use by all public and private institutions receiving USAID-funding through the BKKBN. This manual details standardized procedures for proposal submission; planning; activity and financial management and accountability; and evaluation. As is pointed out in the "Financial Plan and Analysis" section of this Project Paper, these procedures will apply for both Grant and Loan funds in order to retain fast, flexible funding under this Project.

The 1979 study synthesizes the lessons learned as follows:

"A.I.D. support to Indonesian family planning is regarded as one of the U.S.'s most successful foreign assistance efforts. Many lessons can be extracted and should be transferable to programs elsewhere. Most broadly they derive from putting basic development principles into practice. In particular they concern the mechanism for fast, accurate funding. It is the use of this procedure by a technically competent, culturally sensitive goal-oriented staff that most distinguishes A.I.D. support to the program. Legal and administrative provisions for the procedure are standard in the A.I.D system. Its effective use depends, however, upon having a resident staff and upon that staff being given adequate support and authority to act." (page 2)

Each of the six components are described below. For each component there is a brief synopsis of activities, in some cases a table, a USAID budget and a BKKBN budget, and an individual implementation plan.

1. Village Family Planning:

With the success of the village family planning (VFP) activity to date, there is an excellent opportunity to build on this success by both continuing to spread its geographical reach into even more remote and difficult areas and to deepen its impact where the institutional framework is now available. Increasing the rates of contraceptive prevalence in low-performing areas is vital to the success of the entire family planning effort. USAID's continued support for expansion of the village contraceptive posts and acceptor groups -- the key to effective rural family planning -- will encourage the BKKBN to move even more aggressively into areas which are difficult to reach and where social conditions call for innovative approaches.

Specifically, USAID proposes to assist the BKKBN to increase the number of fully-functioning village and sub-village family planning posts. Even more important, the quality of information and services must be strengthened. USAID will provide \$5,054,000, including \$899,000 of grant funds and \$4,155,000 of loan funds, to expand services in low-performing areas which have potential for growth. Special focus will be on thirteen priority provinces selected by both the BKKBN and USAID for special attention through REPELITA IV. The majority of villages and sub-villages will be provided with high quality information and services in the provinces of West Java, Central Java, East Java, North Sumatra, West Sumatra, Lampung, South Sulawesi, and Nusa Tenggara Barat. For the more advanced provinces of Central and East Java, which are well beyond routine types of village family planning assistance, different criteria will be used. For the administratively and topographically more difficult provinces of South Sumatra, Nusa Tenggara Timur, Aceh, Riau, and West Kalimantan the expected village and sub-village coverage in each province will be 50% of the total. Illustratively, the thirteen provinces include approximately 51,000 of Indonesia's 65,500 villages.

The program will include: strengthening or expanding the number of village or sub-village service points; education and training; pilot testing of new techniques or approaches; information and motivation services; strengthening management, logistics, and reporting capabilities and techniques; equipment and supplies; essential operating costs; supervision and consultation support.

The fast, flexible funding mechanism which relies upon decentralization and local participation, which was detailed in the "Project Components" section, was developed after years of village family planning experience. Now, as in the past, this means that an annual plan will be developed for each province tailored to the specific needs of that province to include the inputs most appropriate, and agreed to by BKKBN and USAID via a Project Implementation Letter.

As of December 1982, there were 1,673 sub-districts in Phases I, II, and III of contraceptive prevalence. USAID will concentrate its village family planning assistance on these sub-districts, or other sub-districts in these same three phases as the

situation demands. These thirteen provinces, as the table below dramatically shows, contain 78% of all non-contracepting married women of reproductive age in Indonesia.

Each province has its own socio-cultural, religious, demographic, and geographic characteristics. Although BKKBN has permitted some flexibility to respond to varying provincial needs, greater responsiveness to local needs is essential to expand services in areas with lower levels of infrastructure, a lack of effective means of transportation and communications, differing attitudes toward the roles of women and children, smaller and more distant villages, fewer field staff, and weaker governmental apparatus.

USAID practice is to provide support in a village or sub-village for one or two years, until the BKKBN can provide budget for routine program costs. Then USAID funds are utilized for other activities or in other geographic areas still in need of additional service facilities or still in the first three prevalence phases (0-54%).

GOI/BKKBN inputs are estimated at \$38,692,000; they represent the estimated BKKBN budgets for the thirteen provinces over a three year period. BKKBN funds from both administrative and development budgets cover the main operating expenses for the family planning program. These budgets provide for staff salaries, facilities, contraceptives, operating and supervisory costs, materials and supplies, training courses and workshops, and information services.

BKKBN inputs are sufficient to meet minimum new and current user targets. USAID funds will enable BKKBN to meet higher targets each year.

Note: For further information see
Table Q in the Annex Section for VFP

TABLE A.
VILLAGE FAMILY PLANNING
(In thousands)

<u>Province</u>	<u>Married women of reproductive age</u> (1)	<u>Current contraceptive users</u> (2)	<u>60% of MWRA</u> (3)	<u>Target group</u> (4) = (3)-(2)	<u>Current users as % of PWRA</u> (5)
I. 13 BKKBN/USAID Provinces					
1. West Java	4,342	1,608	2,605	997)	37.0
2. Central Java	3,952	1,995	2,371	376)	34.6%
3. East Java	4,510	2,967	2,706	-261)	65.8
4. North Sumatra	1,350	453	810	357)	33.6
5. West Sumatra	359	169	215	46)	31.4
6. South Sumatra	729	206	437	231)	28.3
7. Lampung	789	244	473	229)	32.4%
8. South Sulawesi	947	416	568	152)	43.9
9. NTB	431	181	259	78)	42.0
10. NTT	371	30	223	193)	8.1
11. Aceh	416	94	250	156)	22.7
12. Riau	319	37	191	154)	10.8%
13. West Kalimantan	390	117	234	117)	30.1
Sub-Total	18,905	8,517	11,342	3,086)	77.6%
II. Remaining 13 Provinces: (excluding DKI Jakarta)	3,040	990	1,822	879)	22.2%
Total	21,945	9,507	13,164	3,965	

Source: BKKBN Monthly Service Statistics Report, December 1982

TABLE B
USAID INPUTS BY FISCAL YEAR AND BY
COMPONENT ELEMENT: VILLAGE FAMILY PLANNING
13 PROVINCES

*(SEE: TABLE Q)

(US\$000)

	1983	1984	1985	1986	1987	Total
Married Women of Reproductive Age (MMRA in millions)	*19.1 (+2%)	19.5 (+2.3%)	19.4 (+2.5%)	20.4 (+2.7%)	21.0	
Contraceptive Prevalence Rate (CPR in per cent)	44	48	52	56	60	
Current Users (CU in millions)	*8.4	9.4	10.3	11.4	12.6	
0 ± \$0.15/CU (\$ millions)	--	154	1.500	1.600	1.800	5.054

Grand Total: 5.054 million over 3-year life of project.

*Figures based on BKKBN's "Summary Ranking: MMRA and CU," December 1982
 (Table Q)

TABLE C
GOI/BKKBN INPUTS
VILLAGE FAMILY PLANNING
13 PROVINCES
(US\$000)

<u>Line item support</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
A. <u>Information & Motivation</u>				
1. Information (IE&C)	77	77	85	239
2. Implementing Unit Operational Costs	96	96	106	298
B. <u>Contraceptive Services</u>				
1. Clinic Operations	636	636	700	1.972
2. Implementing Unit Operational Costs	102	102	112	316
C. <u>Fieldwork Coordination</u>				
1. Family Planning Services	4.603	4.603	5.063	14.269
2. Field Operational Costs	1.286	1.286	1.415	3.987
D. <u>Staff Salaries</u> (13 provinces)	5.573	5.573	6.130	17.276
E. <u>Central BKKBN's</u> Bureau for Fieldwork Coordination	108	108	119	335
TOTAL	12.481	12.481	13.730	38.692

Implementation Plan Narrative

Village Family Planning

<u>Time</u>	<u>Number of Months</u>	<u>Tasks</u>	<u>Responsible Agent</u>
1. 5-6/83	1	Draft, negotiate, and sign Project Agreement \$162,000 of FY-83 grant funds and \$1,500,000 of FY-83 loan funds.	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
2. 6-7/83	1	BKKBN meets all general conditions precedent; USAID acknowledges them.	BKKBN/USAID
3. 7/83- 3/84	8	Joint project formulation of VFP activities in 13 provinces; start drafting, negotiating, and sign PILs FY-83 funds for local cost support.	BKKBN/USAID
4. 3/84- 3/85	12	Draft, negotiate, and sign Project Agreement \$633,000 of FY-84 grant funds and \$1,155,000 of FY-84 loan funds.	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
		Ongoing assessment of FY-83 USAID-funded VFP activities.	BKKBN/USAID
		Draft, negotiate, sign PILs FY-84 funds for VFP expansion.	BKKBN/USAID
5. 3/85- 3/86	12	Draft, negotiate, and sign Project Agreement \$104,000 of FY-85 grant funds and \$1,500,000 of FY-85 loan funds.	BKKBN/BAPPENAS/ DEPLU/AMEMBASSY/ USAID
		Ongoing assessment of FY-84 funded VFP activities.	BKKBN/USAID
		Draft, negotiate, sign PILs FY-85 funds for VFP expansion.	BKKBN/USAID
6. 3/86- 3/87	12	Complete FY-85 funded VFP activities. Evaluate impact to date of all Project-funded VFP inputs.	BKKBN/external evaluation team/ USAID

2. Urban Family Planning:

Progress in urban areas has not kept pace with the outstanding progress in the rural areas. It is now clear that a new, innovative, and imaginative approaches to urban family planning are essential if a major impact is to be obtained quickly. USAID proposes to support a BKKBN program to address the urban problem differently in the future. Private activities of a wide variety will be given strong support in addition to strengthening and expanding government services tailored to the urban environment.

USAID will provide \$3,000,000 of loan funds, to expand information and services in the ten largest cities in Indonesia where family planning performance and contraceptive prevalence rates have been below the national average. The ten cities are Jakarta, Surabaya, Bandung, Medan, Semarang, Palembang, Ujung Pandang, Malang, Padang, and Surakarta (Solo). Improving family planning services in Jakarta is top priority because of the size of the city and its long-standing low performance. Since it is the largest and initial urban effort, Jakarta will get a larger proportion of AID funds than other cities.

Following up on a successful pilot project, USAID will promote the use of private clinics and physicians and midwives in poor and lower middle class working and residential areas. The pilot clinics are recovering 50% or more of expenses from fees-for-service within the first eighteen months of operation.

The program will include the development and expansion of both public and private clinic and service provider networks; training of physicians and midwives; new channels for the sale of contraceptives; expanded information and education campaigns; technical assistance for management and market research; equipment and supplies as needed; pilot tests of new techniques and approaches; and experiments with fee-for-service techniques. By 1990 the BKKBN hopes to have between 25-35% of current users shifted over to some fee-for-service mechanism. This means that some 4,000,000 acceptors from the projected 19,000,000 target for 1990 would receive services from non-government sources.

The same basic project proposal and funding mechanism detailed in the "Project Components" section will be used for this urban family planning component. The BKKBN and USAID are currently working on a more comprehensive urban strategy which will be implemented over time. At the same time, with USAID funding under Project 0270, a private sector organization, in collaboration with the BKKBN and USAID, is currently undertaking a series of city assessments designed to determine private sector potential in five of the largest cities. These assessments, plus several workshops on urban family planning, will provide answers for an overall strategy and point the direction for the future.

However, while the broader strategy is being advised, an annual plan will be developed for each city tailored to the specific requirements of that city to include the inputs most appropriate, and agreed to by BKKBN and USAID via a Project Implementation Letter.

The GOI/BKKBN inputs are estimated at \$14,173,000 they represent the estimated BKKBN budgets for the ten largest cities over a three year period. BKKBN funds from both administrative and development budgets cover the main operating expenses for the family planning program. These budgets provide for staff salaries, facilities, program contraceptives, operating and supervisory costs, materials and supplies, training courses and workshops, and information services.

These kinds of activities will be delivered via the dual public sector/private sector approach currently being implemented by the BKKBN starting in Jakarta. This approach calls for the utilization of currently active, as well as the inclusion of potential, service points and providers in the provision of quality contraceptive information and services.

Note: For further information see
Table S in the Annex Section for VFP

TABLE D
URBAN FAMILY PLANNING
(In thousands)

<u>CITY</u>	<u>Married women of reproductive age</u> (1)	<u>Current contraceptive users</u> (2)	<u>60% of MMRA</u> (3)	<u>Target group</u> (4) = (3) - (2)	<u>Current users as % of MMRA</u> (5)
<u>I. 10 BKKBN/USAID CITIES:</u>					
1. Jakarta DKI	1.062	372	637	265	34.2
2. Surabaya	323	131	194	63	40.5
3. Bandung	219	93	131	38	42.6
4. Medan	248	87	149	62	35.1
5. Semarang	173	61	104	43	35.2
6. Palembang	126	27	76	49	22.0
7. Ujung Pandang	117	24	70	46	20.5
8. Malang	80	42	48	6	53.1
9. Padang	80	22	48	26	27.0
10. Surakarta	71	39	43	4	54.5
	2.499	898	1.500	602	
<u>II. OTHER 22 CITIES/TOWNS:</u> (average)					
	595	268	357	89	
<u>TOTAL:</u>					
	3.094	1.166	1.857	691	

Source: BKKBN Monthly Service Statistics Report, December 1982

TABLE E
USAID INPUTS BY FISCAL YEAR AND BY
COMPONENT ELEMENT: URBAN FAMILY PLANNING

*(SEE: SECTION A, TABLE S)

(US\$000)

	1983	1984	1985	1986	1987	Total
Married Women of Reproductive Age (MwRA in millions)	*2.5	2.6	2.7	2.8	3.0	
Contraceptive Prevalence Rate (CPR in per cent)	36% (+6%)	42% (+6%)	48% (+6%)	54	60%	
Current Users (CU in millions)	*0.9	1.1	1.3	1.5	1.8	
① \$0.35/CU (\$ millions)	--	-- 1	455	525	630	1.610
2. Clinic Prototype Development	--	--	140	--	--	140
3. Media Campaigns	--	200	200	100		500
4. Pilot Projects	--	150	150	150	150	600
5. Technical Assistance	--	--	050	050	050	150
Sub-Total	--	350	540	300	200	1.390
GRAND-TOTAL						3.000

Grand Total: 3.000 million over 3-year life of project.

*Figures based on BKKBN's "Summary Ranking: MwRA and CU," December 1982 (table S)

TABLE F
GOI/BKKBN INPUTS
URBAN FAMILY PLANNING
10 CITIES
(US\$000)

<u>Line item support</u> 1/	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
A. 10 Cities (Jakarta, Surabaya, Bandung, Medan, Semarang, Palembang, Ujung Pandang, Malang, Padang, Surakarta)	4.282	4.710	5.181	= 14,173

1/Note: The above estimated costs consist of: (a) 10% of the total annual GOI budget for the provinces; (b) GOI FY 1982/83 budget for urban family planning; and (c) staff salaries for the 10 urban BKKBNs.

Implementation Plan Narrative

Urban Family Planning

<u>Time</u>	<u>Number of Months</u>	<u>Tasks</u>	<u>Responsible Agent</u>
1. 5-6/83	1	Draft, negotiate, sign Project Agreement \$1,500,000 of FY-83 loan funds.	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
2. 6-7/83	1	BKKBN meets all general conditions precedent; USAID acknowledges them.	BKKBN/USAID
3. 7/83- 3/84	8	Determine numbers and locations of new urban service points in public sector, of private sector clinic improvement activities, and of private doctors and midwives to be trained. Start drafting, negotiating, and subobligating FY-83 funds for these programs.	BKKBN/YKB/selected other institutions/USAID
4. 3/84- 3/85	12	Ongoing assessment of FY-83 USAID-funded urban FP expansion.	BKKBN/YKB/USAID
		Draft, negotiate, sign PILs for remaining FY-83 funds for urban FP expansion.	BKKBN/YKB/USAID
5. 3/85- 3/86	12	Draft, negotiate, sign Project Agreement \$1,500,000 of FY-85 loan funds.	BKKBN/BAPPENAS/ DEPLU/AMEMBASSY/ USAID
		Ongoing assessment of FY-83 funded urban FP activities.	BKKBN/YKB/ USAID
		Draft, negotiate, sign PILs for FY-85 funds for urban FP expansions.	BKKBN/YKB/USAID
6. 3/86- 3/87	12	Complete FY-85 funded urban FP activities. Evaluate impact to date of all Project-funded urban FP inputs.	BKKBN/YKB/external evaluation team/ USAID

3. Voluntary Sterilization Services:

In order to establish comprehensive family planning centers in hospitals and clinics, voluntary sterilization services need to be available along with other health and family planning services. Available voluntary sterilization services are inadequate to meet current demand and grossly inadequate to meet anticipated future demand. Voluntary sterilization is the major missing link in the national family planning program; and the need for voluntary sterilization will grow as larger numbers of families complete their desired family size but still need contraceptive protection for many years.

While over 1300 physicians and supporting staff have been trained and certified to perform voluntary sterilizations, the current availability of these services is sharply restricted by the shortage of appropriate facilities.

The BKKBN, in collaboration with the Ministry of Health and the private Association for Secure Contraception (PKMI), plans to extend voluntary sterilization services to provincial and regency (kabupaten) level hospitals and to sub-district (kecamatan) clinics in areas of high contraceptive prevalence, where demand for more permanent methods of family planning is growing steadily.

Of the six components funded under this Project, voluntary sterilization is the newest area for direct USAID funding through the use of bilateral assistance. Up to now all assistance for voluntary sterilization in Indonesia, except for certain commodities, has been centrally funded from AID/W through various U.S. contractors/grantees to Indonesian institutions providing voluntary sterilization services. While the same basic project proposal and funding mechanism as detailed in the "Project Components" section will be utilized, the anticipated first step to be funded under this Project is a "needs assessment" of the hospitals and clinics in Jakarta and the three large Java provinces as shown on Table G. Since the major role of the BKKBN is coordination of the overall family planning program and that of the Department of Health implementation of health services, including voluntary sterilization services, it is probable that the Indonesian Association for Secure Contraception (PKMI) will conduct the needs assessment. Such an assessment will provide important planning information on number of male and female operations performed per hospital/clinic as well as each service points' specific needs in terms of renovation, equipment, and training; such information is currently incomplete.

Hospitals and clinics will be upgraded in regencies and sub-districts in Jakarta, the three largest Java provinces, and eight priority Outer Island provinces.

Selection of sub-districts will be based upon the level of contraceptive prevalence, potential demand for voluntary sterilization, and degree of support from provincial and sub-district level officials and informal leaders.

All facilities, both hospitals and clinics, will provide information and a full range of contraceptives to insure that each family planning acceptor can make an informed choice (the AID/W approved "informed Consent Form" is found in the Annex Section on Voluntary Sterilization of the Project Paper.)

Comprehensive family planning centers including voluntary sterilization facilities will be established in approximately 173 hospitals and 346 clinics over a three year period, with USAID support. USAID will provide \$3,582,000 in grant funds toward renovating and equipping these facilities. Training of physicians and paramedical personnel and technical assistance will be provided when appropriate.

GOI/BKKBN inputs are estimated at \$11,716,000, including payments for physicians and staff, medicines and supplies, and operating costs of newly-created facilities over a three year period.

All AID funds used for voluntary sterilization services under this project are in full compliance with Policy Determination No. 3 (PD-3). For further details refer to Technical Analysis IX F.I.c. for voluntary sterilization.

TABLE 6

USAID INPUTS BY FISCAL YEAR AND BY COMPONENT ELEMENT:

VOLUNTARY STERILIZATION

(US \$000)

	Year 1	Year 2	Year 3	TOTAL
I. EQUIPMENT				
a. Minilap Kits - 1,000	175	--	--	175
b. Vasectomy Kits - 500	104	--	--	104
c. Falope Rings - 400,000	--	200	--	200
II. RENOVATION/FURNISHINGS:				
A. Government provincial and regency hospital's 153 x @ \$6,000				
1. Year 1 -- 83 x 6,000	498	--	--	498
- East Java 31				
- Central Java 30				
- West Java 12				
- DKI Jakarta 10				
2. Year 2 -- 70 x 6,000	--	420	--	420
- North Sumatra 11				
- West Sumatra 12				
- Lampung 4				
- South Sumatra 6				
- West Nusa Tenggara 5				
- South Sulawesi 21				
- North Sulawesi 4				
- West Kalimantan 7				
B. Government sub-district Health Centers (clinics) 306 x @ \$2,500 (2 units per hospital)				
1. Year 1 Group -- 166 x 2,500 (Jakarta/Java)	415	--	--	415
2. Year 2 Group -- 140 x 2,500 (8 provinces)	--	350	--	350

TABLE G (cont'd)

USAID INPUTS BY FISCAL YEAR AND BY COMPONENT ELEMENT:

VOLUNTARY STERILIZATION

(US \$000)

	Year 1	Year 2	Year 3	TOTAL
C. Implementing Unit Hospitals: @ \$6,000 20 x @ \$6,000				
1. Year 1 -- 4 x 6,000	24	--	--	24
2. Year 2 -- 8 x 6,000	--	48	--	48
3. Year 3 -- 8 x 6,000	--	--	48	48
D. Implementing Unit Health Centers: (clinics): 40 Centers @ \$2,500				
1. Year 1 -- 8 x 2,500	20	--	--	20
2. Year 2 -- 16 x 2,500	--	40	--	40
3. Year 3 -- 16 x 2,500	--	--	40	40
III. <u>PROGRAM IMPLEMENTATION:</u>				
A. Repair and Maintenance Center (RAM) Contract with PKMI	150	150	150	450
B. Training, Certification, Reporting, and Technical Assistance Contract with PKMI	250	250	250	750
T O T A L S:	1.636	1.458	488	3.582

GRAND TOTAL: 3.582 million over 3-year life of project

Note: These costs are based on multi-country experience of the International Project Association for Voluntary Sterilization (IPAVS) and in-country experience of the Indonesian Association for Secure Contraception (PKMI).

TABLE H
GQI/BKKBN INPUTS
VOLUNTARY STERILIZATION
12 PROVINCES
(US\$000)

<u>Line item support</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
1. Medicines	742	816	979	2.537
2. Medical Services	674	741	889	2.304
3. Support for side-effects/ complications	68	75	90	233
4. Referrals (transportation)	12	13	16	41
5. Salaries (hospitals/clinics)	1.712	1.883	2.260	5.855
6. Central BKKBN's Bureau for Contraceptives	-	218	288	746
TOTAL	3.426	3.768	4.522	11.716

Implementation Plan Narrative
Voluntary Sterilization Services

<u>Time</u>	<u>Number of Months</u>	<u>Tasks</u>	<u>Responsible Agent</u>
1. 5-6/83	1	Draft, negotiate, sign Project Agreement \$1,636,000 of FY-83 grant funds.	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
2. 6-7/83	1	BKKBN meets all general conditions precedent; USAID acknowledges them.	BKKBN/USAID
3. 7-9/83	2	Identify 87 Jakarta and Java regency hospitals and 174 sub-district clinics for improved VS services. Draft, negotiate, and sign PILs for FY-83 funds for equipment and clinic renovation as required.	BKKBN/DEPKES/ PKMI/USAID
4. 9/83- 9/84	12	Draft, negotiate, sing Project Agreement \$1,458,000 of FY-84 grant funds.	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
		FY-83 funded VS equipment delivered; renovation completed. Identify 78 Outer Islands I hospitals and 156 sub-district clinics for improved VS services.	BKKBN/DEPKES/PKMI/ USAID
		Draft, negotiate, and sign PILs for FY-84 funds for equipment and clinic renovation, as required.	BKKBN/DEPKES/PKMI/ USAID
5. 9/84- 9/85	12	Draft, negotiate, sign Project Agreement \$488,000 of FY-85 grant funds.	BKKBN/BAPPENAS/ DEPLU/AMEMBASSY/ USAID.
		FY-84 funded VS equipment delivered; renovation completed. Identify 8 implementation unit hosptilas and 16 final sub-district clinics for improved VS services.	BKKBN/DEPKES/PKMI USAID
		Draft, negotiate, sign PILs for FY-85 funds for final VS equipment and clinic renovation, as required.	BKKBN/DEPKES/PKMI/ USAID
6. 9/85- 9/86	12	FY-85 funded VS equipment delivered; renovation completed. Assess VS progress.	BKKBN/DEPKES/PKMI external evaluation team/ USAID

4. Training:

The need for training has grown rapidly as BKKBN has expanded its family planning program throughout the country. BKKBN and implementing units have expanded their in-service training capacities to meet some aspects of greater demand. However, there is a critical need for well-trained mid-level administrators and program managers and technically qualified researchers and teachers. In-country capacity remains limited with only one school of public health and one demographic institute. There are plans to develop additional professional training institutions. That development process will likely take a decade or more. Thus, the immediate task is to assist in providing training abroad for administrators and managers needed now, and to begin developing faculty members for the new training and research institutions. Upon completion of training participants return to the government departments or institutions from which they were selected. Experience to date has proven an excellent return and retention rate (almost 100%).

Expected outputs over the life of this project include 56 persons completing master's degrees and 16 persons completing doctoral degrees in the United States; 90 persons completing master's degrees and 14 persons completing doctoral degrees in Indonesia; development and adaptation of at least four specialized in-service training programs and a special program of management development training; plans for new schools of public health are completed, including identification of faculty members requiring additional academic training and specification of library and other reference requirements.

Technical assistance will be provided through a personal services contractor who would replace the current PSC upon completion of his contract. The follow-on PSC will work directly with the Center for Education and Training as a training advisor. Other technical assistance will be through short-term consultants who will work with the Public Health Sub-Committee of the Consortium of Health Sciences on development of new schools of public health.

Implementation of the training loan will follow procedures newly worked out by the BKKBN and USAID for the training loan (497-Q-069) funded under Project O270. These procedures, which reinforce institution building, vest responsibility in the BKKBN's Center for Education and Training for the nomination and selection of participants, intensive English language training in Indonesia and the U.S., filing applications, payment of fees and allowances, and participant follow-up while in training without involving AID's Office of International Training. The long-term goal of this assistance is to institutionalize the capability within the BKKBN to plan, place, monitor, and evaluate their overseas training program. In support of this goal USAID has provided a long-term training advisor to assist in this technological transfer.

USAID will provide \$5,095,000, including \$250,000 in grant funds and \$4,845,000 in loan funds, for academic training in the U.S. and in Indonesia; technical assistance for the BKKBN's National Education and Training Center and for development of new schools of public health; and books and equipment for library development at the public health schools. GOI/BKKBN inputs are estimated at \$684,000 for salaries of persons in training, language training, and air fares for long-term participants.

TABLE I
USAID INPUTS - TRAINING
NUMBER OF PERSONS AND COST

(US\$000)

	Year 1		Year 2		Year 3		TOTAL	
	No.	Amount	No.	Amount	No.	Amount	No.	Amount
I. LONG TERM - UNITED STATES	25	\$ 955	23	\$ 850	24	\$ 875	72	\$2,680
A. MASTER'S (1.5 years = \$25,000)	19	\$ 475	18	\$ 450	19	\$ 475	56	\$1,400
1. BKKBM	5	\$ 125	5	\$ 125	5	\$ 125	15	\$ 375
2. Implementing Units	1	\$ 25	1	\$ 25	1	\$ 25	3	\$ 75
*3. Schools of Public Health	8	\$ 200	8	\$ 200	8	\$ 200	24	\$ 600
*4. Demographic Institutes	3	\$ 75	2	\$ 50	3	\$ 75	8	\$ 200
5. Central Bureau of Statistics	2	\$ 50	2	\$ 50	2	\$ 50	6	\$ 150
B. DOCTORAL (5 years = \$80,000)	6	\$ 480	5	\$ 400	5	\$ 400	16	\$1,280
1. BKKBM/Implementing Units	1	\$ 80	1	\$ 80	1	\$ 80	3	\$ 240
*2. Schools of Public Health	3	\$ 240	3	\$ 240	3	\$ 240	9	\$ 720
*3. Demographic Institutes	2	\$ 160	1	\$ 80	1	\$ 80	4	\$ 320
II. LONG-TERM TRAINING - INDONESIA	34	\$ 320	35	\$ 335	35	\$ 335	104	\$ 990
A. MASTER'S (2 years \$6,000 to \$10,000)	30	\$ 260	30	\$ 260	30	\$ 260	90	\$ 780
1. BKKBM	10	\$ 60	10	\$ 60	10	\$ 60	30	\$ 180
2. Implementing Units	10	\$ 100	10	\$ 100	10	\$ 100	30	\$ 300
*3. Schools of Public Health	10	\$ 100	10	\$ 100	10	\$ 100	30	\$ 300
B. DOCTORAL (3 years = \$15,000)	4	\$ 60	5	\$ 75	5	\$ 75	14	\$ 210
1. BKKBM/Implementing Units	2	\$ 30	2	\$ 30	2	\$ 30	6	\$ 90
*2. Schools of Public Health	2	\$ 30	3	\$ 45	3	\$ 45	8	\$ 120
III. LANGUAGE TRAINING - INDONESIA	25	\$ 50	23	\$ 46	24	\$ 48	72	\$ 144
IV. LANGUAGE TRAINING - UNITED STATES	25	\$ 75	23	\$ 69	24	\$ 72	72	\$ 216
V. TRAVEL AND RESEARCH STIPENDS - DOCTORAL CANDIDATES	5	\$ 25	5	\$ 25	5	\$ 25	15	\$ 75
VI. IN-SERVICE TRAINING DEVELOPMENT		\$ 100		\$ 50		\$ 50		\$ 200
VII. MANAGEMENT DEVELOPMENT TRAINING		\$ 200		\$ 100				\$ 300
*VIII. DEVELOPMENT OF SCHOOL OF PUBLIC HEALTH								
1. Technical Assistance in Curriculum Development		\$ 100		\$ 100				\$ 200
2. Core Library Materials		\$ 40						\$ 40
IX. TECHNICAL ASSISTANCE				\$ 125		\$ 125		\$ 250
TOTAL		\$1,875		\$1,700		\$1,530		\$5,095

* Health Funds - Institutional Development Loan

TABLE J
GOI/BKKBN-INPUTS
TRAINING

(US\$000)

	Year 1	Year 2	Year 3	TOTAL
I. LONG-TERM - UNITED STATES				
a. MASTER'S DEGREE				
1. Salary (\$1,700/person)	32,3	30,6	32,3	95,2
2. International travel (\$2,500/person)	47,5	45,0	47,5	140,0
b. DOCTORAL DEGREE				
1. Salary (\$4,700/person)	28,2	23,5	23,5	75,2
2. International travel (\$2,500/person)	15,0	12,5	12,5	40,0
II. LONG-TERM - INDONESIA	-			
A. MASTER'S DEGREE (2 years)				
1. Salary	63,0	63,0	63,0	189,0
2. Travel	6,0	6,0	6,0	18,0
B. DOCTORAL DEGREE (3 years)				
1. Salary	12,0	15,0	15,0	42,0
2. Transportation	1,0	1,0	1,0	3,0
III. LANGUAGE TRAINING - INDONESIA	17,1	15,7	16,4	49,2
IV. LANGUAGE TRAINING - UNITED STATES	10,2	9,4	9,8	29,4
V. PROJECT REVIEW MEETINGS	1,0	1,0	1,0	3,0
TOTALS:	233	223	228	684

Implementation Plan Narrative

Training

<u>Time</u>	<u>Number of Months</u>	<u>Tasks</u>	<u>Responsible Agent</u>
1. 5-6/83	1	Draft, negotiate, sign Project Agreement \$2,500,000 of FY-83 loan funds (include health funds for some LT overseas training).	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
2. 6-7/83	1	BKKBN meets all general conditions precedent; USAID acknowledges them.	BKKBN/USAID
3. 7-9/83	2	Start English language training for FY-83 "health" loan-funded students before LT overseas training.	BKKBN/INDON training Institute/USAID
4. 9/83- 9/84	12	Draft, negotiate, Sign Project Agreement \$125,000 of FY-84 grant funds for LT and ST consultancy services and \$2,345,000 of FY-84 loan funds for training.	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
		FY-83 "health" loan-funded students complete English language training and go to U.S. to begin academic training.	BKKBN/ American Universities/ USAID
		Start English language training for first group of FY-84 loan-funded students before LT overseas training.	BKKBN/USAID
		Start LT in-Indonesia training for first group of FY-84 loan-funded students.	BKKBN/ Indonesian schools/USAID
		Start ST overseas training for first group of FY-84 loan-funded participants.	BKKBN/American and third country institutions/ USAID
5. 9/84- 6/85	9	Draft, negotiate, sign Project Agreement \$125,000 of FY-85 grant funds for LT and ST consultancy services	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID

Implementation Plan Narrative (Cont'd)

Training

<u>Time</u>	<u>Number of Months</u>	<u>Tasks</u>	<u>Responsible Agent</u>
5. 9-84- 6/85 (cont'd)	9	First FY-84 loan-funded LT trainees complete English language training and go to U.S. to begin academic training. Start English language training for second group of FY-84 loan funded students before LT overseas training. LT in-Indonesia training for first group of FY-84 loan-funded students completed. Start LT in-Indonesia training for second group of FY-84 loan-funded students. ST overseas training for first group of FY-84 loan funded participants completed. Start ST overseas training for second group of participants.	BKKBN/ American Universities/ USAID BKKBN/selected Indonesian institutions/ USAID BKKBN/selected American and third country institutions/USAID
6. 6/85- 6/86	12	Second group of FY-84 loan funded LT trainees complete English language training and go to U.S. to begin academic training. Start English language training for third group of FY-84 loan funded students before LT overseas training. LT in-Indonesia training for second group of FY-84 loan funded students completed. Start LT in-Indonesia training for third group of FY-84 loan-funded students. ST overseas training for second of FY-84 loan-funded participants completed. Start ST overseas training for third group of FY-84 loan-funded participants.	BKKBN/ American universities/USAID BKKBN/selected Indonesian schools/ USAID BKKBN/selected American and third country institutions/USAID
7. 6/86- 6/87	12	Third group of FY-84 loan-funded LT students complete English language training and go to U.S. to begin academic training.	BKKBN/ American Universities/USAID

V-B. Implementation Plan Narrative (Cont'd)

Training

<u>Time</u>	<u>Number of Months</u>	<u>Tasks</u>	<u>Responsible Agent</u>
7. 6/86- 6/87		LT in-Indonesia training for third group of FY-84 loan-funded students completed.	BKKBN/selected Indonesian schools/USAID
		ST overseas training for third group of FY-84 loan-funded participants completed.	BKKBN/selected American and third country institutions/USAID
8. 6/87- ?	?	Completion of LT academic training in U.S.	BKKBN/ selected American universities/USAID

5. Modern Management Technology:

Since the early 1970's, the BKKBN has utilized a computer to process data for its monthly reports of new and continuing contraceptive users, for its extensive contraceptives distribution system, and for some financial purposes. Many of the offices at BKKBN headquarters and the provincial BKKBN offices lack access to computers for data analysis useful for program planning, implementation, evaluation, and allocation of funds. They also lack access to modern word processing equipment which could improve the efficiency and effectiveness of this rapidly expanding government program. Similarly, training and research institutions, such as the School of Public Health and the Demographic Institute at the University of Indonesia, have limited access to computers. As the national family planning program expands to all provinces, the number of service points will grow, putting a greater strain on the limited computer equipment now available. At the same time there is a great need in many provinces to be able to utilize provincial data for immediate program management purposes. The recent availability of small computers makes it possible to satisfy information needs at a relatively low cost.

The same basic project proposal and funding mechanism detailed in the "Project Components" section will be used for this modern management technology component. A survey of computer and word processing needs is currently being financed by USAID under Project 0270 and will be completed in late 1983. The survey should provide definitive specifications for equipment, software, and training of secretarial and professional staff. USAID does not anticipate funding any activities under this project until the completion of the survey and joint BKKBN/USAID agreement on next steps.

USAID will provide \$869,000 in grant funds to assist the BKKBN to develop computer and word processing capabilities in sixteen provincial BKKBN offices, in headquarter offices, and in selected training and research institutions. Funds for a computer and word processing needs assessment were provided to BKKBN under Project 0270. The assessment is expected to be completed by late 1983. The assessment will form the basis for a detailed plan for procurement, installation, and utilization of computer and word processing hardware, software, and training of both professional and secretarial staff. Technical assistance will be through a long-term personal services contract with a specialist in management information systems. Specifically, the contractor's main priority would be on simplifying and focusing the multitude of existing reporting and recording data for immediate management needs. Short-term specialists will be needed to assist in adapting computer and word processing technology to the perceived needs of the BKKBN and other institutions. Equipment and software will be purchased through a U.S. manufacturer using normal AID procedures. Training will be arranged through an Indonesian firm.

The GOI/BKKBN inputs are estimated at \$104,000 for operating costs for computer and word processing equipment, supplies, and an annual maintenance contract over a three year period.

TABLE K
USAID INPUTS BY FISCAL YEAR AND BY COMPONENT ELEMENT:
MODERN MANAGEMENT TECHNOLOGY

(US\$000)

	Year 1	Year 2	Year 3	TOTAL
A. HARDWARE	185			185
B. SOFTWARE	37			37
C. SUPPLIES	37			37
D. TRAINING				
1. Professional Staff				
a. Course costs	24			24
b. Travel and Per diem	26			26
2. Secretary Staff				
a. Course costs	24			24
b. Travel and Per diem	21			21
E. ANNUAL MAINTENANCE CONTRACT	15			15
F. TECHNICAL ASSISTANCE	200	150	150	500
USAID INPUTS - TOTAL	569	150	150	869
A. SUPPLIES		37	37	74
B. ANNUAL MAINTENANCE CONTRACT		15	15	30
BKKBN INPUTS - TOTAL		52	52	104

Implementation Plan Narrative

Modern Management Technology

<u>Time</u>	<u>Number of Months</u>	<u>Tasks</u>	<u>Responsible Agent</u>
1. 5-6/83	1	Draft, negotiate, sign Project Agreement \$569,000 of FY-83 grant funds.	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
2. 6-7/83	1	BKKBN meets all general conditions precedent; USAID acknowledges them.	BKKBN/USAID
3. 7-9/83	2	Sign PILs for FY-83 funds for modern management technology computer and word processor hardware and software and for training personnel from Central BKKBN, 16 provincial BKKBN offices, and selected other institutions.	BKKBN/selected other institutions/ USAID
4. 9/83- 9/84	12	FY-83 funded modern management technology hardware/software delivered and installed; EDP training completed.	BKKBN/selected other institutions/USAID
5. 9/84- 9/85	12	Draft, negotiate, sign Project Agreement \$150,000 of FY-84 grant funds for consultancy services in modern management technology.	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
6. 9/85- 9/86	12	Draft, negotiate, Sign Project Agreement \$150,000 of FY-85 grant funds for consultancy services in modern management technology	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID

6. Research and Development

Even with the major impact already made with existing technologies and techniques, there is a continued requirement for new technologies and approaches. Field trials of new and improved contraceptives, further examination of the long term effects of existing contraceptives, and additional research on voluntary sterilization need to be undertaken.

Operations research is needed on retail sales and private sector use of contraceptives, project design and financing, management improvement, measurement and analysis of contraceptive, demographic and vital registration rates and improvements in family planning in both village and urban slower performing areas.

The approach to be used will help increase further Indonesian research capabilities while responding flexibly to research opportunities. The channels for research will be broadened - with individuals, universities, and other non-governmental organization participating along with the BKKBN and government agencies as appropriate. Findings will be disseminated to key decision makers as well as the research community.

The BKKBN currently is considering the possibility of moving gradually into a lower dose pill. A large-scale USAID-assisted field study of various brands/types/dosages of contraceptives, already underway, will assist in final determination of pill choice.

It is anticipated that the intercensal survey and 25 studies will be undertaken and 100 persons will receive short term training in population research methodologies. The BKKBN's preliminary list of studies and/or research projects include such items as: the evaluation of mobile family planning team operations; manpower needs and quality of clinic staff; studies on pilot projects related to specific population/development issues; and studies related to cost-effectiveness and continuation rates of various contraceptive methods. Apart from these, and other studies of interest to the BKKBN, USAID feels it important to give priority to such studies as aspects of cost recovery and finance, recurring costs as higher prevalence rates are achieved, and the role of the private sector especially in urban areas.

The same basic project proposal and funding mechanism detailed in the "Project Components" section will be used for this research and development component. Prior to the release of funds a research plan covering proposed research studies for the first twelve month period for review and concurrence by BKKBN and USAID must be prepared. The research plan will provide criteria to be used in the selection of studies; how the studies relate to program planning, implementation, and evaluation; and, a list of the proposed studies to be undertaken. Subsequently, a plan will be developed for each research activity, and agreed to by BKKBN and USAID via a Project Implementation Letter.

USAID inputs of \$1,900,000 of grant funds will be divided between bio-medical research and operations and social science research. The twenty-five research and development studies and a nationwide 1985 intercensal survey are estimated at an average cost of \$60,000 per study, or a total of \$1,500,000. Some studies, e.g., intercensal survey, are expected to cost significantly more than the estimated average, while most studies will cost substantially less than the estimated average. Twelve seminars and workshops on special population research methodology-related topics will cost \$5,000 on the average, or a total of \$60,000. To carry out 32 consultations on research project design and review with the researchers will cost \$16,000, or an average of \$500 per consultation. Twelve conference and meetings specifically to disseminate research findings will cost \$2,000 on average, or a total of \$24,000. Cost of short-term U.S. consultants to assist in the design, implementation, and evaluation of research, are estimated at \$100,000 per year, or a total of \$300,000.

The BKKBN contribution is estimated at \$ 1,497,000 and consists of staff time and facilities over a three year period.

TABLE L
USAID AND BKKBN - INPUTS
RESEARCH AND DEVELOPMENT

(US\$000)

USAID INPUTS:

	Year 1	Year 2	Year 3	TOTAL
25 Research Studies	500	500	500	1,500
12 Seminars and Workshops	20	20	20	60
12 Conference - Research Dissemination	8	8	8	24
Technical Assistance - Local	5	6	5	16
Technical Assistance - U.S.	100	100	100	300
Total	633	634	633	1,900

BKKBN INPUTS:

	Year 1	Year 2	Year 3	TOTAL
Staff salaries and facilities (Central BKKBN and Provincial BKKBNs) and Workshops	483	483	531	1,497

Implementation Plan Narrative

Research and Development

<u>Time</u>	<u>Number of Months</u>	<u>Tasks</u>	<u>Responsible Agent</u>
1. 5-6/83	1	Draft, negotiate, sign Project Agreement \$633,000 of FY-83 grant funds.	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
2. 6-7/83	1	BKKBN meets all general conditions precedent; USAID acknowledges them.	BKKBN/USAID
3. 7/83- 3/84	8	Start drafting, negotiating, and sign PILs for FY-83 funds for R&D activities.	BKKBN/ other institutions/USAID
4. 3/84- 3/85	12	Draft, negotiate, sign Project Agreement \$634,000 of FY-84 grant funds.	BKKBN/BAPPENAS/DEPL DEPLU/AMEMB/USAID
		Ongoing assessment of FY-83 funded R&D activities.	BKKBN/selected other institutions/ USAID
		Draft, negotiate, sign PILs for FY-84 funds for R&D activities.	BKKBN/selected other institutions/ USAID
5. 3/85- 3/86	12	Draft, negotiate, sign Project Agreement \$633,000 of FY-85 grant funds.	BKKBN/BAPPENAS/ DEPLU/AMEMBASSY/ USAID
		Ongoing assessment of FY-84 funded R&D activities.	BKKBN/selected Indonesian institutions/USAID
		Draft, negotiate, sign PILs for FY-85 funds for R&D activities.	BKKBN/selected Indonesian institutions/ USAID
6. 3/86- 3/87	12	Complete FY-85 funded R&D activities. Evaluate impact to date of all Project-funded R&D inputs.	BKKBN/selected Indonesian institutions/ external evaluation team/USAID

IV. Financial Plan and Analysis

The project financial plan is presented in a series of tables. USAID's proposed contribution is \$19,500,000. It comprises \$7,500,000 of grant funds and \$12,000,000 of loan funds; \$5,770,000 are allocated for foreign exchange costs and \$13,730,000 for local costs. The GOI contribution is estimated at the rupiah equivalent of approximately US\$66,866,000, or 71% of total project costs. From USAID's perspective, the key fact is that the GOI contributes nearly 70% of all costs for the national family planning program and all donors, including USAID, contribute about 30%. This gives the best measure of GOI support for the national family planning program.

The summary and detailed tables are included where appropriate. Tables A-L are included in the Section III-E under the relevant project components. Tables M-P in IV (this section) and Q-U appear in IX-F.1.a-f annexes for each component. The tables provide a summary as well as details of proposed USAID and GOI contributions to each of the six components of the project.

Table A = Village Family Planning.

Table B = USAID Inputs by Fiscal Year and by Component Element:
Village Family Planning.

Table C = GOI/BKKBN Inputs: Village Family Planning.

Table D = Urban Family Planning.

Table E = USAID Inputs by Fiscal Year and by Component Element:
Urban Family Planning.

Table F = GOI/BKKBN Inputs: Urban Family Planning.

Table G = USAID Inputs by Fiscal Year and by Component Element:
Voluntary Sterilization.

Table H = GOI/BKKBN Inputs: Voluntary Sterilization.

Table I = USAID Inputs: Training.

Table J = GOI/BKKBN Inputs: Training.

Table K = USAID Inputs by Fiscal Year and by Component Element:
Modern Management Technology.

Table L = USAID and BKKBN Inputs: Research and Development.

Table M = Proposed USAID Obligations by Project Component.

Table N = Proposed USAID Obligations by Fiscal Year,
by Grant and Loan, by Local Cost and Foreign Exchange
Cost, and by Component Elements.

Table O = Summary of USAID and BKKBN Inputs by Six Project Components.

Table P = Summary of BKKBN Inputs by Fiscal Year and by Component Elements.

Table Q = Village Family Planning: Target Kecamatan.

Table R = Village Family Planning: Current Contraceptive Service Points.

Table S = Urban Family Planning : Target Cities/Kodya.

Table T = BKKBN's Comprehensive Long Term Training Projects: Long Term Training Abroad and in Indonesia.

Table U = USAID Assistance for Graduate Level Training in Support of BKKBN's Manpower Development Plan.

Cost estimates are based on experience gained with previous USAID projects and current USAID and BKKBN cost guidelines.

USAID's village family planning costs for the thirteen priority provinces are calculated at the rate of approximately \$0.15 per year per current user (CU) to reach a projected 60% contraceptive prevalence rate by 1987 (See: Table B). USAID's urban family planning costs for the ten largest cities in Indonesia are calculated at the rate of \$0.35 per year per current user (CU) to reach a projected 60% contraceptive prevalence rate by 1987 (See: Table E). Other line-item calculations are based upon BKKBN, USAID, and other institutional experience with past and present urban programs. Voluntary sterilization costs are based upon AID/W cost guidelines for equipment and supplies, local experience of the Indonesian Association for Secure Contraception with projects supported by IPAVS and FPJA, and BKKBN-Ministry of Health cost guidelines. Training costs are based on guidelines in AID Handbook 10 with some USAID revisions resulting from experience under a previous training loan, Loan 497-Q-069, and GOI-BKKBN guidelines and experience with local training costs. Modern management technology costs are based upon catalog figures for computers and word processors and USAID-BKKBN estimates of local training costs and technical assistance costs.

Research and development costs are derived from past USAID-BKKBN experience under AID Project 497-0270, GOI cost guidelines, and current AID guidelines.

No specific budget line items are included for possible inflation or contingencies for several reasons. Most commodities will be purchased during the first year of the project, and prices are already known. Changes in local costs over the life of the project should be more than matched by adjustments in the exchange rate. There will be some changes over the years in participant training costs. However, these changes should be covered by savings expected to result from actual costs lower than the average estimated annual training costs used in the calculations.

The BKKBN has a proven record of capable financial management. AID and other U.S. Government Agency audits of the utilization of AID population resources by the GOI have continually reflected favorably on BKKBN administration and financial management. Recent USAID Office of Finance voucher verification of selected BKKBN activities have similarly been favorable.

The BKKBN and USAID operating mode under this and previous projects is to delegate financial responsibility to provincial, urban, or other agency implementors. As earlier described in this paper, most of the local cost expenditures will be made under annual plans in the form of AID Commitment PILs. The BKKBN/USAID Financial Procedures Manual titled "Pedoman Prosedur Kerja Bantuan USAID" will apply for both Loan and Grant Funds. AID funds will be advanced to implementing agents via BKKBN Headquarters, based on 90 day budgets. Funds will be replenished based on current needs and upon liquidation of prior advances. This decentralized approach has functioned well in the past, and we do not anticipate the BKKBN will have any problem in the administration of this project.

The GOI's share of the total family planning budget increased from \$4.6 to \$120 million during the past 10 years. Although, the GOI is currently experiencing budgetary difficulties due to lower world-wide oil demand, we believe their commitment to expanding family planning services will continue and enable them to absorb the recurring costs associated with the project; estimated to be 71% of total project costs. The concentration of project resources in thirteen (13) provinces which contain 78% of all non-contracepting married women as well as the emphasis on revenue generation in urban areas eventually are expected to reduce GOI unit costs per acceptor.

The BKKBN's Third Draft of the Population/Family Planning Program for the Fourth Five Year Development Plan, page 100, provided a table of estimated combined income (GOI and donor agencies) and projected contraceptive user targets for each year of the Fourth Plan period. Following is a table of projected costs per current user, computed from the BKKBN table:

IFY	Cost per current User	
	Rp.	US\$/1US\$=Rp.950
1984/85	9,928	10.29
1985/86	11,183	11.59
1986/87	12,271	12.72
1987/88	13,470	13.96
1988/89	14,908	15.45

USAID shares the BKKBN concern about host country capability for self-financing of an expanding budget over the next few years and plans to work with the BKKBN over the next three years to assess cost/benefit options.

The projected Fourth Plan Population/Family Planning budget, which will be undergoing significant revisions within the GOI, include both family planning and non-family planning inputs. USAID will continue to work with the BKKBN to separate out family planning costs from social welfare costs that most appropriately can be attributed to non-family planning targets, e.g., reduction in infant, child, and maternal mortality and morbidity rates.

In addition, USAID will propose to BKKBN that studies on financial and economic assessments, such as cost recovery and budgetary impact, be undertaken in the project's research and development component.

It is presently anticipated that the renovation of hospitals, clinics, and centers under the Voluntary Sterilization Component will be performed under the supervision of the International Project Association for Voluntary Sterilization (IPAVS) and the Indonesian Association for Secure Contraception (PKMI). Cost and specification criteria will be approved by USAID in advance, expenditures will be on a cost reimbursement basis, and there will be sample USAID inspections prior to payment. Fixed Amount Reimbursement (FAR) procedures are not considered appropriate in view of the varying needs and conditions of the renovation sites. Foreign exchange for commodities represent USAID procurement. Local cost commodities and furnishings will primarily be shelf-item procurement. The major portion of the Technical Assistance will be USAID-direct procurement via Personal Services Contracts (PSC).

Training will be administered by the BKKBN's Center for Education and Training, with new administrative procedures. Substantial savings are anticipated by reducing costs for overhead and tuition/maintenance fees. Payments will be made for actual costs, which are expected to be substantially less than standard costs previously absorbed under the AID PIO/P system. A Bank Letter of Commitment (L/COM) will be established with a U.S. Commercial Bank, and that bank's Jakarta branch or subsidiary will serve as the Approval Applicant. A Letter of Credit (L/C) will be established under the L/COM in favor of BKKBN. Both the L/COM and L/C will reference the terms and procedures contained in an underlying PIL. Upon presentation of the required documentation, payments may be made locally by the approval applicant or electronically transferred to specified bank accounts of institutions or participants in the U.S.

TABLE M

PROPOSED USAID OBLIGATIONS BY PROJECT COMPONENT

(US \$000)

	FY1983 Year 1			FY 1984 Year 2			FY 1985 Year 3			Total		
	Grant	Loan	Total	Grant	Loan	Total	Grant	Loan	Total	Grant	Loan	Total
Village Family Planning	162	1,500	1,662	633	1,155	1,788	104	1,500	1,604	899	4,155	5,054
Urban Family Planning	-	1,500	1,500	-	-	-	-	1,500	1,500	-	3,000	3,000
Voluntary Sterilization	1,636	-	1,636	1,458	-	1,458	488	-	488	3,582	-	3,582
Training	-	2,500	2,500	125	2,345	2,470	125	-	125	250	4,845	5,095
Modern Management Technology	569	-	569	150	-	150	150	-	150	869	-	869
Research & Development	633	-	633	634	-	634	633	-	633	1,900	-	1,900
TOTAL	3,000	5,500	8,500	3,000	3,500	6,500	1,500	3,000	4,500	7,500	12,000	19,500

TABLE N (Cont'd)
 PROPOSED USAID OBLIGATIONS BY FISCAL YEAR,
 BY GRANT AND LOAN, BY LOCAL COST AND FOREIGN EXCHANGE COST, AND
 BY COMPONENT ELEMENTS

(US\$ 000)

Activity	Year 1				Year 2				Year 3				Total				Grand Total
	Grant		Loan		Grant		Loan		Grant		Loan		Grant		Loan		
	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX	LC	FX	
5. Modern Management Technology	147	422	-	-	-	150	-	-	-	150	-	-	147	722	-	-	869
a. Technical Assistance	-	200	-	-	-	150	-	-	-	150	-	-	-	500	-	-	500
b. Training	95	-	-	-	-	-	-	-	-	-	-	-	95	-	-	-	95
c. Commodities	37	222	-	-	-	-	-	-	-	-	-	-	37	222	-	-	259
d. Local Costs	15	-	-	-	-	-	-	-	-	-	-	-	15	-	-	-	15
6. Research and Development	533	100	-	-	534	100	-	-	533	100	-	-	1,600	300	-	-	1,900
a. Technical Assistance	5	100	-	-	6	100	-	-	5	100	-	-	16	300	-	-	316
b. Training	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
c. Commodities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
d. Local Costs	528	-	-	-	528	-	-	-	528	-	-	-	1,584	-	-	-	1,584
7. Total																	
a. Technical Assistance	5	300	5	300	6	375	-	-	5	375	-	-	16	1,050	50	300	1,416
b. Training	95	-	420	1,840	-	-	1,251	1,094	-	-	-	-	95	-	1,671	2,934	4,700
c. Commodities	298	837	-	40	234	489	-	-	24	120	-	-	556	1,446	-	40	2,042
d. Local Cost	1,465	-	2,850	-	1,896	-	1,155	-	976	-	3,000	-	4,337	-	7,005	-	11,342
Total	1,863	1,137	3,320	2,180	2,136	864	2,406	1,094	1,005	495	3,000	-	5,004	2,496	8,726	3,274	19,500
Total	3,000		5,500		3,000		3,500		1,500		3,000		7,500		12,000		19,500

TABLE 0
SUMMARY OF USAID AND BKKBN INPUTS
BY SIX PROJECT COMPONENTS

(US\$000)

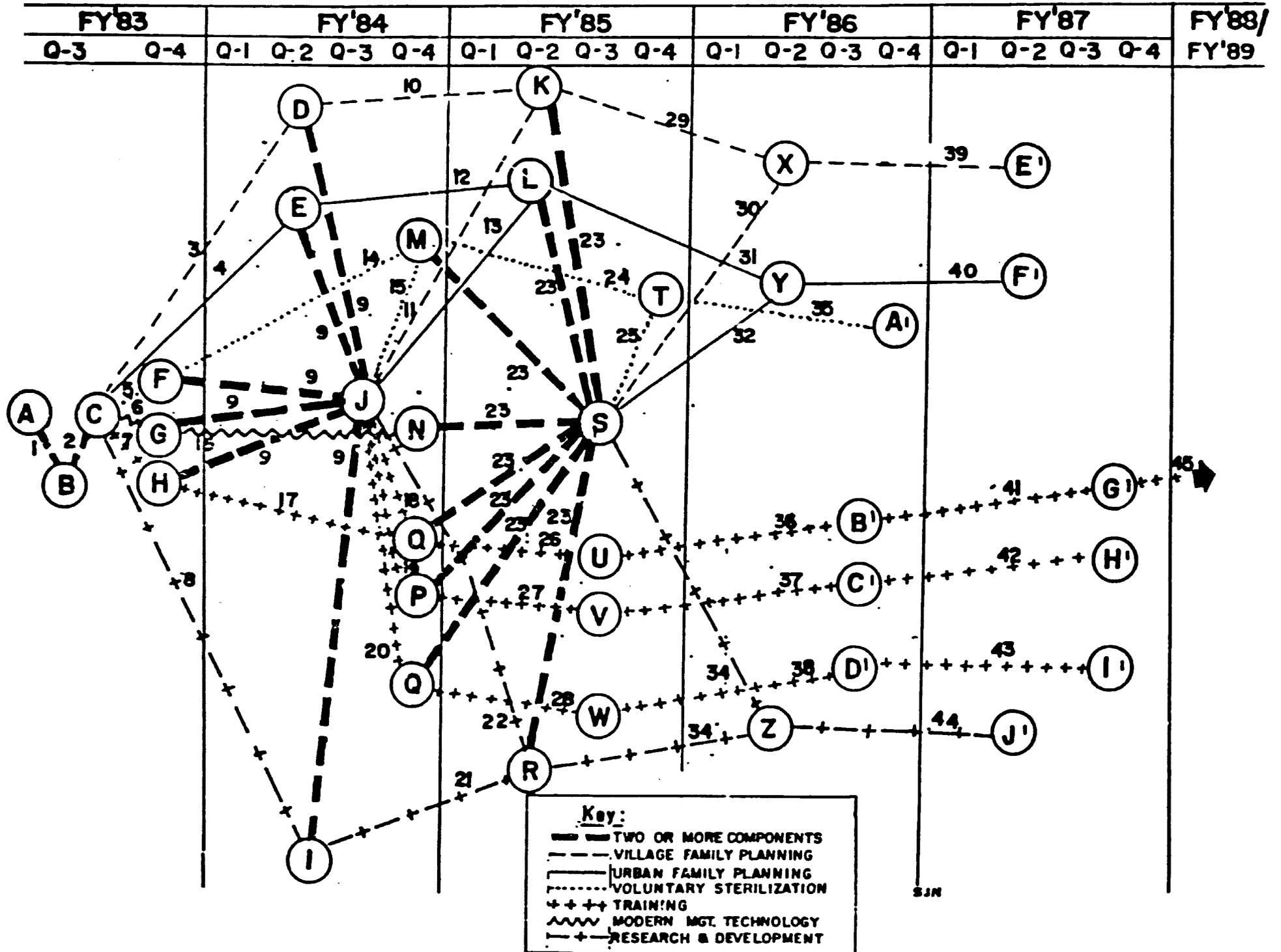
<u>PROJECT COMPONENT</u>	<u>USAID</u>	<u>BKKBN</u>	<u>TOTAL</u>
<u>1. Village Family Planning</u>	<u>5.054</u>	<u>38.692</u>	<u>43.746</u>
<u>2. Urban Family Planning</u>	<u>3.000</u>	<u>14.173</u>	<u>17.173</u>
<u>3. Voluntary Sterilization</u>	<u>3.582</u>	<u>11.716</u>	<u>15.298</u>
<u>4. Training</u>	<u>5.095</u>	<u>684</u>	<u>5.779</u>
<u>5. Modern Management Technology</u>	<u>869</u>	<u>104</u>	<u>973</u>
<u>6. Research and Development</u>	<u>1.900</u>	<u>1.497</u>	<u>3.397</u>
<u>TOTAL</u>	<u>19.500</u>	<u>66.866</u>	<u>86.366</u>

TABLE P
SUMMARY OF BKKBN INPUTS BY FISCAL YEAR
AND BY COMPONENT ELEMENTS

(US\$000)

Project Component	Year 1	Year 2	Year 3	Total
1. Village Family Planning	12.481	12.481	13.730	38.692
2. Urban Family Planing	4.282	4.710	5.181	14.173
3. Voluntary Sterilization	3.426	3.768	4.522	11.716
4. Training	233	223	228	684
5. Modern Management Technology	-	52	52	104
6. Research and Development	483	483	531	1.497
T O T A L	20.905	21.717	24.244	66.866

**Project 497-0327: Family Planning
Development and Services II
IMPLEMENTATION PLAN CHART**



Implementation Plan Narrative
All Project Activities

<u>Steps</u>	<u>Tasks</u>	<u>Responsible Agent</u>
1. A-B	Draft, negotiate, sign Project Agreement \$3.0 million of FY-83 grant funds and \$5.5 million of FY-83 loan funds (include health funds for some LT overseas training).	BKKBN/BAPPENAS/ DEPLU/AMEMB/USAID
2. B-C	BKKBN meets all general conditions precedent; USAID acknowledges them.	BKKBN/USAID
3. C-D	Joint project formulation of VFP activities in 13 provinces; start drafting, negotiating, and sign PILs for FY-83 funds for local cost support.	BKKBN/USAID
4. C-E	Determine numbers and locations of new urban service points in public sector, of private sector clinic improvement activities, and of private doctors and midwives to be trained. Start drafting, negotiating, and sign PILs for FY-83 funds for these programs.	BKKBN/YKB/selected other institutions/USAID
5. C-F	Identify 87 Jakarta and Java reGENCY hospitals and 174 sub-district clinics for improved VS services. Draft, negotiate, and subobligate FY-83 funds for equipment and clinic renovation as required.	BKKBN/DEPKES/ PKMI/USAID
6. C-G	Sign PILs for FY-83 funds for modern management technology computer and word processor hardware and software and for training personnel from Central BKKBN, 16 provincial BKKBN offices, and selected other institutions.	BKKBN/selected other institutions/ USAID
7. C-H	Start English language training for FY-83 "health" loan-funded students before LT overseas training.	BKKBN/INDON training institute/USAID
8. C-I	Start drafting, negotiating, and sign PILs for FY-83 funds for R&D activities.	BKKBN/ other institutions/ USAID

- | | | | |
|-----|-------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| 9. | D/E/F/G/
H/I-J | Draft, negotiate, sign Project Agreement \$3.0 million of FY-84 grant funds and \$3.5 million of FY-84 loan funds. | BKKBN/BAPPENAS/DEPLU/
AMEMB/USAID |
| 10. | D-K | Ongoing assessment of FY-83 USAID-funded VFP activities. | BKKBN/USAID |
| 11. | J-K | Draft, negotiate, sign PILs for FY-84 funds for VFP expansion. | BKKBN/USAID |
| 12. | E-L | Ongoing assessment of FY-83 USAID-funded urban FP expansion. | BKKBN/YKB/USAID |
| 13. | J-L | Draft, negotiate, sign PILs for remaining FY-83 funds for urban FP expansion. | BKKBN/YKB/USAID |
| 14. | F-M | FY-83 funded VS equipment delivered; renovation completed. Identify 78 Outer Islands I hospitals, and 156 sub-district clinics for improved VS services. | BKKBN/DEPKES/PKMI/
USAID |
| 15. | J-M | Draft, negotiate, and sign PILs for FY-84 funds for equipment and clinic renovation, as required. | BKKBN/DEPKES/PKMI/
USAID |
| 16. | G-N | FY-83 funded modern management technology hardware/software delivered and installed; EDP training completed. | BKKBN/selected
other institutions/
USAID |
| 17. | H-O | FY-83 "health" loan-funded students complete English language training and go to U.S. to begin academic training. | BKKBN/
American Universities/
USAID |
| 18. | J-O | Start English language training for first group of FY-84 loan-funded students before LT overseas training. | BKKBN/USAID |
| 19. | J-P | Start LT in-Indonesia training for first group of FY-84 loan-funded students. | BKKBN/
Indonesian
schools/USAID |
| 20. | J-Q | Start ST overseas training for first group of FY-84 loan-funded participants. | BKKBN/American and third
country institutions/
USAID |

- | | | | |
|-----|-----------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| 21. | I-R | Ongoing assessment of FY-83 funded R&D activities. | BKKBN/selected other institutions/
USAID |
| 22. | J-R | Draft, negotiate, sign PILs for FY-84 funds for R&D activities. | BKKBN/selected other institutions/
USAID |
| 23. | K/L/M/N/
O/P/Q/R-S | Draft, negotiate, sign Project \$1.5 million of FY-85 grant funds and \$3.0 million of FY-85 loan funds. | BKKBN/BAPPENAS/
DEPLU/AMEMBASSY/
USAID |
| 24. | M-T | FY-84 funded VS equipment delivered; renovation completed. Identify 8 implementation unit hospitals and 16 final sub-district clinics for improved VS services. | BKKBN/DEPKES/PKMI
USAID |
| 25. | S-T | Draft, negotiate, sign PIs for FY-85 funds for final VS equipment and clinic renovation, as required. | BKKBN/DEPKES/PKMI/
USAID |
| 26. | O-U | First FY-84 loan-funded LT trainees complete English language training and go to U.S. to begin academic training. Start English language training for second group of FY-84 loan funded students before LT overseas training. | BKKBN/
Bank Indonesia/
American universities/
USAID |
| 27. | P-V | LT in-Indonesia training for first group of FY-84 loan-funded students completed. Start LT in-Indonesia training for second group of FY-84 loan-funded students. | BKKBN/selected Indonesian institutions/
USAID |
| 28. | Q-W | ST overseas training for first group of FY-84 loan funded participants completed. Start ST overseas training for second group of participants. | BKKBN/selected American and third country institutions/USAID |
| 29. | K-X | Ongoing assessment of FY-84 funded VFP activities. | BKKBN/USAID |
| 30. | S-X | Draft, negotiate, sign PILs for FY-85 funds for VFP expansion. | BKKBN/USAID |
| 31. | L-Y | Ongoing assessment of FY-83 funded urban FP activities. | BKKBN/YKB/
USAID |
| 32. | S-Y | Draft, negotiate, sign PILs for FY-85 funds for urban FP expansions. | BKKBN/YKB/USAID |

- | | | | |
|-----|-------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| 33. | R-Z | Ongoing assessment of FY-84 funded R&D activities. | BKKBN/selected Indonesian institutions/USAID |
| 34. | S-Z | Draft, negotiate, sign PILs for FY-85 funds for R&D activities. | BKKBN/selected Indonesian institutions/ USAID |
| 35. | T-A' | FY-85 funded VS equipment delivered; renovation completed. Assess VS progress. | BKKBN/DEPKES/PKMI external evaluation team/USAID |
| 36. | U-B' | Second group of FY-84 loan funded LT trainees complete English language training and go to U.S. to begin academic training. Start English language training for third group of FY-84 loan funded students before LT overseas training. | BKKBN/
American universities/
USAID |
| 37. | V-C' | LT in-Indonesia training for second group of FY-84 loan funded students completed. Start LT in-Indonesia training for third group of FY-84 loan-funded students. | BKKBN/selected Indonesian schools/
USAID |
| 38. | W-D' | ST overseas training for second group of FY-84 loan-funded participants completed. Start ST overseas training for third group of FY-84 loan-funded participants. | BKKBN/selected American and third country institutions/USAID |
| 39. | X-E' | Complete FY-85 funded VFP activities. Evaluate impact to date of all Project-funded VFP inputs. | BKKBN/external evaluation team/
USAID |
| 40. | Y-F' | Complete FY-85 funded urban FP activities. Evaluate impact to date of all Project-funded urban FP inputs. | BKKBN/YKB/external evaluation team/
USAID |
| 41. | B'-G' | Third group of FY-84 loan-funded LT students complete English language training and go to U.S. to begin academic training. | BKKBN/
American universities/
USAID |
| 42. | C'-H' | LT in-Indonesia training for third group of FY-84 loan-funded students completed. | BKKBN/selected Indonesian schools/
USAID |
| 43. | D'-I' | ST overseas training for third group of FY-84 loan-funded participants completed. | BKKBN/selected American and third country institutions/
USAID |

- | | | |
|----------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| 44. Z-J' | Complete FY-85 funded R&D activities.
Evaluate impact to date of all
Project-funded R&D inputs. | BKKBN/selected
Indonesian institutions/
external evaluation
team/USAID |
| 45. G'-? | Completion of LT academic training in
U.S. | BKKBN/Selected
American universities/
USAID |

VI. Monitoring Plan

USAID inputs are monitored by the Population Division staff consisting of three U.S. direct hire professionals, one Indonesian professional, and two Indonesian secretaries. In July 1983, the Office of Population and the Office of Health and Nutrition are merging. The chief of the Population Division is the project officer, with other staff members' assuming responsibility for one or more of the six project components.

USAID utilizes contractors to assist in monitoring project implementation. A full-time U.S. personal services contractor is assigned to BKKBN's National Education and Training Center. Part of the contractor's responsibility is to assist in planning and implementing USAID-supported training activities. Other contract technicians, whose functions are described briefly in the Project Paper, will also assist in project monitoring.

USAID's Finance, Program, Management, Contract, and Legal Offices will work directly with the Population Division staff, as required, for smooth project execution.

Monitoring functions are carried out in regular meetings with appropriate staff of BKKBN or other agencies, during field site visits, and through analysis of monthly service statistics and quarterly financial and activities reports from BKKBN.

VII. Conditions and Covenants:

A. Conditions Precedent to Disbursement

1. Condition Precedent to Disbursement for Village Family Planning, Urban Family Planning, and Voluntary Sterilization Activities. Prior to disbursement or issuance by A.I.D. of documentation pursuant to which disbursement will be made for Village Family Planning, Urban Family Planning, and Voluntary Sterilization Activities, the GOI/BKKBN shall, except as A.I.D. may otherwise agree in writing, furnish in form and substance satisfactory to A.I.D., on an annual basis, a work plan for the succeeding year, including details of planned activities, budgets and planned disbursement schedules.

2. Condition Precedent to Disbursement for Modern Management Technology Activities. Prior to disbursement or issuance by A.I.D. of documentation pursuant to which disbursement will be made for modern management technology activities, the GOI/BKKBN shall, except as A.I.D. may otherwise agree in writing, furnish in form and substance satisfactory to A.I.D.:

(a) evidence that an assessment has been made of computer and word processing needs at BKKBN headquarters, BKKBN provincial offices, and implementing units and universities; and

(b) prior to activities in Indonesian FY 1984/85, evidence that BKKBN has included in its FY 1984/85 budget sufficient funds for maintenance and supplies.

3. Condition Precedent to Disbursement for Research and Development. Prior to disbursement or issuance by A.I.D. of documentation pursuant to which disbursement will be made for research and development, the Grantee shall, except as A.I.D. may otherwise agree in writing, furnish in form and substance satisfactory to A.I.D., on an annual basis:

(a) research plan covering proposed research studies for the succeeding twelve month period of the project, which includes criteria to be used in the selection of studies; the relationship of the studies to program planning, implementation and evaluation, and a list of the proposed studies, and approximate costs.

B. Special Covenants.

1. Project Evaluation. The Parties agree to establish an evaluation program as part of the Project. Except as the Parties otherwise agree in writing, the program will include, during the implementation of the Project and at one or more points thereafter: (a) evaluation of progress toward attainment of the objectives of the Project; (b) identification and evaluation of problem areas or constraints which may inhibit such attainment; (c) assessment of how such information may be used to help overcome such problems; and (d) evaluation, to the degree feasible, of the overall development impact of the Project.

2. Training. The GOI/BKKBN agrees that it will budget sufficient funds from sources other than A.I.D. for international transportation costs of participants who will receive long-term training (one year or more) under the Project.

3. Consent to Participate in Program. The GOI/BKKBN shall assure that all individuals participating in family planning programs (whether involving distribution of contraceptives or sterilization, or both), supported in whole or in part by funds provided hereunder, do so on the basis of an informed consent voluntarily given with knowledge of the benefits, risks, principal effects and available alternatives; and assure that all individuals practice methods of family planning consistent with his or her moral, philosophical, or religious beliefs.

4. Abortions. The GOI/BKKBN agrees not to use any part of the funds provided hereunder for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions.

5. Involuntary Sterilization. The GOI/BKKBN agrees not to use any part of the funds provided hereunder to pay for the performance of involuntary sterilization or to coerce or provide any financial incentive to any person to practice sterilization.

6. Voluntary Sterilization Activities. The GOI/BKKBN agrees that any agreements between the GOI/BKKBN and any public or private sector institution which concern voluntary sterilization activities will apply the provisions of Sections 3, 4, and 5 of this Agreement to such institution.

VIII. Evaluation Arrangements

The project will be evaluated periodically in accordance with AID evaluation procedures. In addition, several other evaluation techniques will be used to assess project progress.

In mid-1984, USAID plans for an extensive evaluation by a team composed of persons from AID/Washington, USAID, BKKBN, and a private or academic institution. The scope of this "outside" evaluation would follow that used by a similar team in 1979. However, the scope of the 1984 team should be broadened to include expertise in financial and economic assessment. By mid-1984 most activities financed under USAID Project 0270 (Family Planning Development and Services) and Project 0271 (Oral Contraceptives Loan) will be completed, and initial activities financed under Project 0327 will be in progress.

The team also will review BKKBN plans for the Fourth Five-Year Development Plan (1984-85 through 1988-89) in order to assess the relationship of the project to the Development Plan goals and objectives. The report of the team will be used as the final project evaluation for Projects 0270 and 0271 and as an early effort to assess Project 0327 activities.

Under the evaluations planned for this project, emphasis will be given to the costs of alternative services and sales both public and private, in order to strengthen overall program effectiveness and to help guide program design. For this, the BKKBN will continue to maintain and make available recurring and development costs, acceptor rates, and other data for its continuing and pilot programs.

The BKKBN's monthly service statistics system provides the basis for regular review of program performance. This system provides information on new and current users by contraceptive method at the national, provincial, regency, and sub-district levels. Other regular reporting and sampling systems of the BKKBN provide additional information for monitoring program performance. In addition, all local cost financing sub-projects are agreed upon between USAID and BKKBN in Project Implementation Letters. Prior to agreement on a sub-project, representatives from the BKKBN headquarters, USAID, and the province or agency involved typically visit the project site and collaboratively agree upon a scope of work and budget. A brief evaluation of project progress is done quarterly, prior to the next release of funds. And, if a follow-on sub-project is proposed, the representatives make an assessment of provincial or agency capabilities and previous success in implementing joint projects.

Evaluation at the goal and purpose levels will be based on data collected from the October 1980 population census, from the BKKBN's Modular Survey, from a 1985-86 national fertility survey (inter-censal), and additional ad-hoc demographic and vital registration studies and surveys.

With external assistance, USAID will conduct an ad hoc assessment of voluntary sterilization progress in mid-1986; and in early 1987, USAID, with external assistance, will evaluate impact to date of project-funded village family planning, urban family planning, and research and development inputs.

TO BE APPLIED IN REACHING CLIENTS THROUGH COMMERCIAL SERVICES.

5. VOLUNTARY STERILIZATION. THE APAC SUPPORTS THIS ELEMENT OF THE PROJECT, BUT INSTRUCTS THE USAID TO PROVIDE A THOROUGH STATEMENT IN THE PP OF PAST EXPERIENCE, HOW THE ACTIVITY ACTUALLY WORKS AND HOW COMPLIANCE WITH PD 7P (NOW PD 3) WILL BE ASSURED. THIS SHOULD INCLUDE REVIEW OF THE VOLUNTARY CONSENT FORM AND ITS USE AND REVIEW OF BY PAYMENTS MADE IN THE INDOONESIAN SYSTEM TO ACCEPTORS OR PROVIDERS OF U.S. SERVICES TO ENSURE COMPLIANCE WITH PRINCIPLES OF INFORMED VOLUNTARY CONSENT EMBODIED IN PD 3. PLEASE ADVISE IF ANY ISSUES ARISE ON THESE MATTERS DURING PROJECT DESIGN.

6. VILLAGE FAMILY PLANNING SERVICES. THE PID INCLUDES DOLS 5 MILLION OF LOCAL COST FUNDING FOR THIS ELEMENT, EQUAL TO 25 PERCENT OF PROPOSED USAID SUPPORT. THE APAC DISCUSSED THE RATIONALE FOR CONTINUED USAID INVOLVEMENT IN VFP AND RELIED ON THE OPINION OF SI/POP AND ASIA/TR THAT THE PREVIOUS PRACTICE OF USAID FUNDING OF VFP HAD BEEN INSTRUMENTAL IN MOVING BKEM INTO NEW VILLAGES WHERE SOCIO-CULTURAL OR OTHER FACTORS REQUIRED ADJUSTMENTS IN PROGRAM APPROACH. THIS CATALYTIC ROLE SHOULD BE FULLY EXPLAINED IN THE PP, INCLUDING THE CRITERIA FOR SELECTION OF VILLAGES TO BE SUPPORTED WITH USAID FUNDS. ONE CRITERION FOR USAID SUPPORT SHOULD BE A VILLAGE'S LEVEL OF CONTRACEPTIVE PREVALENCE, I.E. THERE SHOULD BE AN ESTABLISHED LEVEL BEYOND WHICH AID INVOLVEMENT WOULD BE PHASED OUT.

7. COUNTERPART CONTRIBUTION. THE PID CITES THE ENTIRE BKEM BUDGET OVER A THREE-YEAR PERIOD AS THE GOI CONTRIBUTION. THIS MAY BE THE ONLY PRACTICAL WAY TO PRESENT THE FINANCIAL PLAN FOR THE PROJECT. HOWEVER, IT WOULD BE MORE USEFUL IF SPECIFIC BKEM COSTS COULD BE RELATED TO EACH OF THE FIVE PROPOSED PROJECT ELEMENTS. THE FINANCIAL PLAN WOULD THEN SHOW CLEARLY THE PERCENTAGES OF EFFORTS OF EACH ELEMENT TO BE FUNDED BY USAID AND THE GOI, AS WELL AS THE SPLITS BETWEEN FOREIGN EXCHANGE AND LOCAL CURRENCY COSTS. IN SO DOING, THE BKEM COUNTERPART CONTRIBUTION WOULD BE SIGNIFICANTLY LESS THAN THE DOLS 475 MILLION CITED IN THE PID AND THERE WILL BE A BETTER INDICATION OF THE IMPORTANCE AND NEED FOR USAID FUNDS AT THE MARGIN. MORE CAREFUL COSTING WILL ALSO BE NECESSARY TO PREPARE THE PROJECT ECONOMIC ANALYSIS.

8. AID/W CENTRAL FUNDING. THE APAC UNDERSTANDS THAT

THIS PROJECT WILL ASSUME SOME VOLUNTARY STERILIZATION ACTIVITIES CURRENTLY FUNDED BY ST/POP. USAID'S FUTURE RELIANCE ON CENTRAL FUNDS IS EXPECTED TO DECREASE ACCORDINGLY. TO CLARIFY THIS SUBJECT, THE PP SHOULD INCLUDE INFORMATION DEFINING THOSE ACTIVITIES THAT WILL REMAIN OUTSIDE THE SCOPE OF THE PROJECT AND FOR WHICH THE USAID WILL CONTINUE TO SEEK CENTRAL FUNDING.

9. CONSTRUCTION. THE APAC ASSUMES THAT NO NEW CONSTRUCTION OF FREE-STANDING BUILDINGS IS PROPOSED FOR THE PROJECT. THE APAC UNDERSTANDING IS ALSO THAT ANY PROJECT CONSTRUCTION WILL BE LIMITED TO RENOVATIONS OF PUBLIC CLINICS AND EQUIPPING OF DEDICATED SPACE WITHIN PUBLIC HOSPITALS WHERE VOLUNTARY STERILIZATIONS ARE PERFORMED. THE PP SHOULD CLEARLY SET FORTH THE CRITERIA, COST AND PROCEDURES FOR ANY PROJECT-FUNDED CONSTRUCTION.

10. CONTRACEPTIVES SUPPLY. THE APAC PRAISED USAID'S SUCCESS IN ASSISTING THE GOI TO THE POINT WHERE FUTURE CONTRACEPTIVE REQUIREMENTS WILL BE MET BY ITS OWN BUDGET. CONTINUED ASSISTANCE, AS NEEDED, SHOULD BE OFFERED TO THE GOI IN FORECASTING, PROCURING, BUDGETING AND DISTRIBUTING

CONTRACEPTIVES. AS PROMISED IN THE PIL, THIS LOGISTICAL MECHANISM SHOULD BE DETAILED IN THE PP.

11. OTHER CONCERNS. BESIDE ITEMS DISCUSSED ABOVE, APAC WAS CONCERNED BY LACK OF PID ATTENTION TO: COST ESTIMATES FOR PROPOSED ACTIVITIES; THE MIX, SOURCE AND SCOPE OF PERSONAL SERVICE AND INSTITUTIONAL CONTRACTING ANTICIPATED WITHIN THE TOTALITY OF PROPOSED TECHNICAL ASSISTANCE; SOCIAL STRUCTURES PARTICULARLY IN THE URBAN AREAS; THE STRUCTURE, MAGNITUDE AND LENGTH OF PROPOSED SUPPORT FOR PUBLIC HEALTH SCHOOLS; ETC. A COPY OF THE APAC ISSUES PAPER IS BEING SENT FOR USAID REFERENCE IN PP PREPARATION.

12. EVALUATION. THE PP SHOULD INCORPORATE PRINCIPAL FINDINGS OF ANY EVALUATIONS OF FAMILY PLANNING DEVELOPMENT AND SERVICES I (PROJECT 497-0278). SPECIAL ATTENTION SHOULD BE GIVEN ALSO TO THE EVALUATION PLAN FOR THE NEW PROJECT.

13. PP PREPARATION. THE APAC CONFIRMED THAT THIS WILL BE A MISSION-AUTHORIZED PROJECT CONSISTENT WITH REDELEGATED AUTHORITIES. THE APAC ENCOURAGES USAID, HOWEVER, TO SEEK PARTICIPATION OF AID/V STAFF IN FINAL PI DESIGN TASKS. IN PARTICULAR WE RECOMMEND INVOLVEMENT OF ST/POP AND, IF NEEDED TO SUPPLEMENT USAID STAFF, A PROJECT DEVELOPMENT OFFICER. ASSISTANCE OF THE CC/ASIA IS AVAILABLE, IF NEEDED, IN DESIGN OF THE VOLUNTARY STERILIZATION ELEMENT TO ASSURE COMPLIANCE WITH PD 3. SMULTZ

LOGICAL FRAMEWORK
Project 07-0327
Family Planning Development and Services II

OBJECTIVE STATEMENT	OBJECTIVE VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS															
Decrease crude birth rate to 22-23 births per 1,000 population by October 1990.	Crude birth rate (per 1,000 people): 1971 44-46 1980 31-34 1985 26-27 estimated 1990 22-23 estimated	1990 Census. 1985-86 Mid-decade fertility survey.	Continued GOI commitment to rapid fertility reduction, evidenced by political support, adequate budget, and assignment of competent staff. Willingness of GOI to innovate and experiment to extend services more rapidly and widely. Increasing contraceptive prevalence will have major impact on fertility.															
Increase contraceptive use from 43% of all married women of reproductive age (15-44 years) in December 1982 to 56% by March 1987.	The percent of married women of reproductive age using contraceptives through the National Family Planning Program by March 31, 1987 to expand as follows: <table border="1" data-bbox="524 663 1048 882"> <thead> <tr> <th></th> <th>Urban</th> <th>Semi-Urban</th> <th>Rural</th> <th>All India</th> </tr> </thead> <tbody> <tr> <td>1982</td> <td>43</td> <td>38</td> <td>32</td> <td>38</td> </tr> <tr> <td>1987</td> <td>56</td> <td>50</td> <td>44</td> <td>50</td> </tr> </tbody> </table>		Urban	Semi-Urban	Rural	All India	1982	43	38	32	38	1987	56	50	44	50	Mid-decade fertility survey. BKKBN service statistics. Survey of contraceptive prevalence and continuation rates.	<ul style="list-style-type: none"> - Family planning continues to be viewed as essential aspect of improve family welfare. - There is substantial unmet demand for family planning services. - BKKBN will provide contraceptives, budget, and staff required for program expansion.
	Urban	Semi-Urban	Rural	All India														
1982	43	38	32	38														
1987	56	50	44	50														
1) Strengthen quality of village family planning outlet services 2) Strengthen quantity/quality of urban family planning services in 10 largest cities. 3) Wide availability of voluntary sterilization services. 4) GOI personnel trained to manage, implement, and evaluate enlarged program. 5) Improvement through introduction of modern management technologies 6) Research and development studies for program improvement.	1) Increase number of family planning service points from 162,000 in March 1981 to 200,000 by March 1987. 2) Double active FP service points in 10 largest cities by March 1987. 3) Establish voluntary sterilization centers in 173 hospitals and 346 health centers by March 1987. 4) 16 PhD's and 56 MA's trained overseas 90 MA's & 14 Ph.D trained in-country 5) Computer - word processing capacity at 16 provincial headquarters and central office. 6) 25 operations research studies completed.	<ul style="list-style-type: none"> - BKKBN service statistics, especially acceptor and logistics data. - Special reports and surveys. - Report from US training institutions. - Review of research reports. - Regular field visits to review village family planning, urban family planning and voluntary sterilization programs. 	BKKBN will continue promoting village family planning concept. BKKBN willing to undertake expanded program in urban areas and in voluntary sterilization. BKKBN and other institutions will release staff for training. Increasing use of AID loan funds will not hinder flexibility of program. 5) GOI policy will include voluntary sterilization as a family planning method.															
Technical assistance Training - U.S. Commodities Local cost support for expansion of village family planning, urban family planning, voluntary sterilization centers, in-country training, and research studies.	<table border="1"> <tr> <td>Technical assistance</td> <td>\$ 1,416,000</td> </tr> <tr> <td>Training</td> <td>4,700,000</td> </tr> <tr> <td>Commodities</td> <td>2,042,000</td> </tr> <tr> <td>Local Costs</td> <td>11,342,000</td> </tr> <tr> <td>Total</td> <td>19,500,000</td> </tr> </table>	Technical assistance	\$ 1,416,000	Training	4,700,000	Commodities	2,042,000	Local Costs	11,342,000	Total	19,500,000	(Annual) Project Agreements. PIO/Ts. PIO/Ps. PIO/Cs. Project Implementation Letters.	<ul style="list-style-type: none"> - Continued high priority for project within USAID and AID/W. - Funds will be available. - USAID will have staff to plan, manage and evaluate its inputs. 					
Technical assistance	\$ 1,416,000																	
Training	4,700,000																	
Commodities	2,042,000																	
Local Costs	11,342,000																	
Total	19,500,000																	

107

STATUTORY CHECK LIST

5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable generally to projects under the FAA and project criteria applicable to individual funding sources: Development Assistance (with a subcategory for criteria applicable only to loans); and Economic Support Funds.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1982 Appropriation Act; Sec. 523; FAA Sec. 634A; Sec. 653 (b).

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;
(b) Is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that amount)?

The committees on appropriations of Senate and House were notified of this project through the FY 83 Congressional Presentation (ASIA Programs, page 76) and through a Technical Notification to the Congress advising AID's intention to increase loan level and shift of appropriation account.

2. FAA Sec. 611(a)(1).
Prior to obligation in excess of \$100,000, will there be (a) engineering financial other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

Yes, cost estimates are based on past project experiences and current known prices for commodities and services

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? No further legislative action is required.
4. FAA Sec. 611(b); FY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973? N.A.
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project? N.A.
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. No

7. FAA Sec. 601(a).
Information and
conclusions whether
project will encourage
efforts of the country
to: (a) increase the flow
of international trade;
(b) foster private
initiative and
competition; and (c)
encourage development and
use of cooperatives, and
credit unions, and
savings and loan
associations; (d)
discourage monopolistic
practices; (e) improve
technical efficiency of
industry, agriculture and
commerce; and (f)
strengthen free labor
unions.

i N.A.

8. FAA Sec. 601(b).
Information and
conclusions on how
project will encourage
U.S. private trade and
investment abroad and
encourage private U.S.
participation in foreign
assistance programs
(including use of private
trade channels and the
services of U.S. private
enterprise.)

N.A.

9. FAA Sec. 612(b), 636(h);
FY 1982 Appropriation Act
Sec. 507. Describe steps
taken to assure that, to
the maximum extent
possible, the country is
contributing local
currencies to meet the
cost of contractual and
other services, and
foreign currencies owned
by the U.S. are utilized
in lieu of dollars.

COI will gradually assume
ongoing local costs obligations.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? No
11. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes
12. FY 1982 Appropriation Act Sec 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity? N.A.
13. FAA 11B(c) and (d). Does the project take into account the impact on the environment and natural resources? If the project or program will significantly affect the global commons or the U.S. environment, has an environmental impact statement been prepared? If the project or program will significantly affect the environment of a foreign country, has an environmental assessment been prepared? Does the This project will have no adverse environmental impact. This project is essentially to increase the use of all types of legal contraceptives methods in Indonesia.

project or program take into consideration the problem of the destruction of tropical forests?

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

N.A.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

- a. FAA Sec. 102(b), 111, 113, 281 (a).

N.A.

Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and

otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?

Yes

c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

N.A.

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes

e. FAA Sec. 110(b).
Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?

N.A.

f. FAA Sec. 122(b).
Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes

g. FAA Sec. 281 (b).
Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.

This project will increase the use of all legal types of contraceptive methods.

2. Development Assistance
Project Criteria (Loans
Only)

a. FAA Sec. 122(b).
Information and conclusion on capacity of the country to repay the loan, at a reasonable rate of interest.

The GOI is able to repay the loan.

b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterprise's annual production during the life of the loan?

N.A.

c. ISDCA of 1981, Sec. 724(c) and (d). If for Nicaragua, does the loan agreement require that the funds be used to the maximum extent possible for the private sector? Does the project provide for monitoring under FAA Sec. 624(g)?

N.A.

3. Project Criteria Solely for Economic Support Fund

a. FAA Sec. 531(a). Will this assistance promote economic or political stability? To the extent possible, does it reflect the policy directions of FAA Section 102?

N.A.

b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities?

N.A.

c. FAA Sec. 534. Will ESF funds be used to finance the construction of the operation or maintenance of, or the supplying of fuel for a nuclear facility? If so,

N.A.

has the President certified that such use of funds is indispensable to nonproliferation objectives?

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

N.A.

e. FAA Sec. 133. Notwithstanding any other provision of this joint resolution, none of the funds appropriated under section 101(b) of this joint resolution may be available for any country during any 3-month period beginning on or after October 1, 1982, immediately following the certification of the President to the Congress that such country is not taking adequate steps to cooperate with the United States to prevent narcotic drugs and other controlled substances (as listed in the schedules in section 202 of the Comprehensive Drug Abuse and Prevention Control Act of 1971 (21 U.S.C. 812) which are produced, processed, or transported in such country from entering the United States unlawfully.

N.A.



- A-14-15 -

IX-D

REPUBLIC OF INDONESIA
NATIONAL DEVELOPMENT PLANNING AGENCY
JAKARTA, INDONESIA

No. : 1332/D.I/6/1983

Jakarta, June 1, 1983

Dr. William P. Fuller
Director
USAID
American Embassy
Jakarta

-
Re : Family Planning Development and
Services II Project

Dear Dr. Fuller,

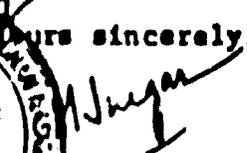
On behalf of the Government of Indonesia, we hereby request a loan of up to twelve million United States Dollars (\$ 12,000,000) and a grant of up to seven million five hundred thousand United States Dollars (\$ 7,500,000) to implement the above Project. The Government of Indonesia will provide the rupiah equivalent of \$ 66,866,000 to support this project over its planned three (3) years life.

The purpose of the project is to increase the use in Indonesia of all legal types of contraceptive methods. The project consists of six components appropriate to this purpose :

- 1) Expansion of village family planning services in thirteen priority provinces;
- 2) Development of urban family planning programs in the ten largest cities;
- 3) Extension of voluntary sterilization services in twelve priority provinces;
- 4) Management and institutional improvement through training;
- 5) Management and institutional improvement through the introduction of modern management technologies; and
- 6) Research and development support to measure program progress, test new ways of delivering information and services, and strengthen monitoring and supervision of program operations.

The project will be implemented by the National Family Planning Coordinating Board (BKKBN) and its Implementing Units.

Looking forward to your favorable consideration.

Yours sincerely,

Muchtarudin Siragar
Deputy Chairman


IX-E.

FAA. SECTION 611(e) CERTIFICATION (NOT APPLICABLE)

IX-F
PROJECT ANALYSES

1. Technical Analysis

a. Village Family Planning

The BKKBN has selected thirteen priority provinces for special attention through REPELITA IV. USAID's VFP assistance, both historically and for the future, will concentrate efforts in these same provinces. Provinces were selected on the basis of population size, numbers of current or new MWRA to be recruited into the program, organizational and managerial capabilities, and demographic importance to the program. The first priority (penyangga utama) provinces are West Java, Central Java, and East Java. Second priority (penyangga) provinces are North Sumatra, South Sumatra, West Sumatra, Lampung, South Sulawesi, Nusa Tenggara Barat, and Nusa Tenggara Timur. Third priority, or special provinces (khusus), are Aceh, Riau, and West Kalimantan. With a combined 1980 population of approximately 122 million persons and with over 19 million married women of reproductive age (15-44 years; MWRA), these thirteen provinces must achieve a substantial increase in contraceptive prevalence if the national goal is to be achieved by 1990. As of December 1982, an estimated 10.6 million eligible couples were classed as current contraceptive users (55%); some 8.6 million couples plus approximately 1.5 - 2 million new currently single women who will marry over the project period still need to be recruited into the program.

For program planning and strategy purposes, BKKBN has classified each province, regency, sub-district, and village by five phases, or levels, of contraceptive prevalence: Phase I (0-14%); Phase II (15-34%); Phase III (35-54%); Phase IV (55-74%); and Phase V (over 75%). As of December 1982, the thirteen provinces contained 2,482 sub-districts with contraceptive prevalence rates spread across each of the five phases. Over 8.5 million eligible couples in the thirteen provinces were not enrolled in the national family planning program in December 1982. However, if the currently high contraceptive prevalence rate provinces of Central Java and East Java are excluded, over 7 million eligible couples still need to be recruited in the remaining provinces. Similarly, excluding Central and East Java, the current contraceptive user rate drops from 55% to 33%. Program strategies, budgets, manpower requirements, and other program elements are developed separately for provinces in each Phase, and shift both inter- and intra-province as the province moves from one Phase to another.

USAID support will be concentrated in, but not necessarily limited to, sub-districts still in Phases I, II, or III. See Table F for details. Prevalence rate, however, is just one indicator of overall family planning practice in any given area. The socio-psychological factors or conditions must also be taken into account. For example,

kecamatan listed at 60% prevalence rate in the BKKBN summary feedback may indeed be only at 40-50%, or lower, in terms of philosophical understanding and/or participation in the program. In the thirteen target provinces there are:

Phase I -- 341 sub-districts with nearly 1.7 million MWRA.
Phase II -- 614 sub-districts with nearly 5.3 million MWRA.
Phase III -- 718 sub-districts with nearly 5.9 million MWRA.

Illustratively, the thirteen provinces include 50,858 villages of Indonesia's 65,478 villages.

In each province, regency, sub-district, and village, the BKKBN strategy is to:

- increase the number of new family planning acceptors and contraceptive prevalence;
- re-recruit program dropouts;
- shift acceptors to the more effective methods of fertility control;
- bring information and services closer to the people;
- increase community participation in the family planning program;
- increase BKKBN and Implementing Unit personnel, administrative, supervisory, and managerial skills; and
- integrate population and family planning programs into other sectors of community life.

To carry out this strategy, the BKKBN relies on three main types of service points in the village family planning (VFP) program. The clinic, usually located at the sub-district (kecamatan) health center, provides health and family planning services for a population of 50,000 persons. Clinics generally offer oral contraceptives, IUDs, condoms, injectibles, and, increasingly, voluntary sterilization for men and women. BKKBN's 13,000 fieldworkers work out of the camat's office and the clinic. Each clinic is linked with between 30-55 village family planning posts in Java, 15-40 in Outer Islands I, and 4-6 in Outer Islands II, on the average. Each post, which is the primary source for contraceptive supply or re-supply, information and motivation, and data collection, is managed by a village volunteer; and it may be located in a private home, the headman's house, a village office, or other convenient building. Stocks of oral contraceptives and condoms are maintained in the post and resupplied to acceptors as well as sub-village posts or acceptor groups which act as the end distributors in the logistics chain. The volunteer provides supplies to members of the community and keeps simple records which are fed into the clinic reporting system. The lowest-level units are sub-village posts and hamlet family planning acceptors groups; they were formed to maintain peer support for family planning and to assure resupplies of contraceptives. One member of the group may pick up contraceptives at the village post for members of the group or neighborhood, generally consisting of 30-50 married women. Over 80 per cent of all oral contraceptives currently are re-distributed at the village and sub-village levels.

Couples who elect voluntary sterilization utilize regency hospitals or sub-district clinics.

Previous studies indicated a direct relationship between the easy availability and accessibility of information and contraceptive services and the level of contraceptive use. In Java and Bali and certain outer island provinces, such as Nusa Tenggara Barat and South Sulawesi, this relationship has been borne out by experience. However, trying to provide equity of information and services in other outer island provinces, such as South Sumatra, West Kalimantan, Nusa Tenggara Timur, and other geographically difficult provinces, has resulted in a somewhat different experience. Through past USAID assistance to such provinces it has become apparent that total equitable provision of contraceptive services is neither manageable nor cost effective. In these areas contraceptive service points should be carefully placed in areas which are easy or relatively easy to reach and supervise; are comparatively densely populated; and in which remaining numbers of MWRA are still sufficient to warrant a service point.

It has become clear over the last several years of experience with village family planning in Indonesia that the basic foundation of any strategy must be the ready availability of information and services. However, the mere increase in number of service points, or the too close reliance on ratios of service points to MWRA, is too simplistic an approach. Right from the beginning of village family planning in the mid-1970s priority attention was given to the 80% of the population living in rural areas. Over time a reliable VFP Model was developed, and that basic model is now being implemented throughout the twenty-seven provinces. This model attempts to provide equity of information and services to every village in Indonesia through a progression of village family planning posts (Pos KB desa), sub-village posts (sub-Pos KB desa), and acceptor groups (kelompok akseptor). As a model for the provinces on Java and Bali, where populations are dense, distance as well as transportation and communications widespread, and supervisory staffs larger than on other islands, this style of VFP application has been highly successful. However, when one looks at this same application of the VFP model in the outer islands, certain problems emerge. In most of the outer island provinces, topography, transportation and communication, size of administrative areas, lack of fieldworkers and other supervisory staff, heterogeneous populations, socio-cultural-religious and economic variations impinge on the successful implementation of the model along Java/Bali lines. In most respects the philosophy and program implementation remain the same; it is with the provision of information and services that modifications must be made. One simple example points up the problem. BKKBN rule of thumb allows for one village family planning depot (Pos KB desa) per village where operational costs are provided. This is fine on Java and Bali where village size allows for a decent ratio of service points to MWRA; it becomes far more difficult in West Kalimantan or South Sumatra where villages are often 3-6 time larger than those on Java and distances great.

According to 1983/84 BKKBN data there are approximately 188,500 registered contraceptive service points throughout the country. This figure includes hospitals, clinics, village and sub-village service points. Of this figure, 181,590 are village and sub-village service points. The fact that these service points are registered does not necessarily mean that they are active in providing information and services, let alone quality services. In March 1981, for example, the BKKBN's Bureau for Reporting and Recording listed approximately 162,000 registered service points. However, the special reporting/recording form used to gather village and sub-village service point information, which was de-programmed later in 1981, indicated 143,000 active service points, or 82% of the total. In 1983 it is difficult to assess exactly how many active service points there are. More difficult yet is the ability to predict how many service points should be added . . . or subtracted. Table G shows the approximate situation of service points in the thirteen provinces. This data is from the Bureau for Planning and is the basis for the 1983/84 budgets.

While one stated goal of USAID support is to increase the absolute number of service points, the more important goal is to strategically place and strengthen the quality of services. This may mean an increase of service points over the life of the project, but it might also mean a decrease. To see this situation more clearly, and to assist in making a reasonable determination, it is necessary to look at BKKBN's and USAID's thirteen priority-provinces. Reference to Table F shows the three levels or priorities of provincial strategy and effort. Clearly, demographically critical to program success are the three large provinces of West, Central, and East Java. While the provinces of Central Java and East Java are beyond routine types of village family planning activities and will no longer receive major VFP assistance under this project, there may be specific areas of interest or need where USAID supplementary assistance could be applied. Even though these two provinces will be receiving assistance for urban family planning, voluntary sterilization, and research and development assistance under this project (see Sections b, c, and e of this technical analysis), USAID should remain flexible and sensitive to discrete types of VFP maintenance and strengthening in these two important provinces. In terms of strengthening and expanding routine types of village family planning, West Java is the highest priority province.

The next priority provinces are listed in Section B, Table F. USAID has provided supplementary assistance to most of these provinces over the past several years. In certain cases like South Sulawesi, Nusa Tenggara Barat, and Lampung, USAID assistance has continued unabated since 1979. The provinces of North and West Sumatra have not received USAID assistance since the curtailment in 1981 of PIL arrangements signed in 1979. Obviously, these two provinces will require a somewhat different emphasis and approach than those listed above. To date, USAID has not provided any assistance to Nusa Tenggara Timur. This province, with its many islands and difficult terrain, will require very focused assistance to the most densely populated and accessible regencies and sub-districts.

Section C, Table F, shows three special provinces, two Sumatran and one Kalimantan. Both Aceh and West Kalimantan have received USAID assistance in the past; Aceh's has not been renewed since 1981 while West Kalimantan is currently receiving focused attention. Consequently, contraceptive prevalence rates are improving there. Riau has not yet received any USAID assistance.

What this brief analysis points out is that each of these three priority geographical areas, as well as the individual provinces within each strategic category, require tailored approaches based on priority to the program, past performance, future potential, and ability to perform. USAID must remain open to these specific needs and respond accordingly as the program reaches for its 1990 target.

TABLE B
VILLAGE FAMILY PLANNING
TARGET REQUIREMENTS

	Total Kab/Kodya	Total Kec.	Total Desa	1980 Population	MRA Total	MRA Balance	Phase I Kec.		Phase II Kec.		Phase III Kec.		Phase IV Kec.		Phase V Kec.	
							(0-14%) MRA Kec.	(15-34%) MRA Kec.	(35-54%) MRA Kec.	(55-74%) MRA Kec.	(over 75%) MRA Kec.	(over 75%) MRA Kec.				
A. West Java	24	466	6,250	27,453,525	4,342,302	2,733,965	165,531	17	1,005,565	167	1,700,947	155	406,756	43	101,207	12
Central Java	35	497	8,481	25,372,009	3,952,310	1,957,137	117,455	24	553,091	49	1,790,990	231	1,180,921	155	268,175	37
East Java	37	569	8,340	29,188,852	4,510,121	1,543,299	98,978	19	249,327	14	723,116	75	1,986,642	246	1,431,019	197
Sub-total:	96	1,532	23,111	82,015,266	12,804,813	6,234,401	381,964	60	2,687,983	230	4,231,053	461	3,574,319	444	1,800,401	266
B. North Sumatra	17	194	5,632	8,360,894	1,349,637	896,247	71,780	16	730,346	89	434,732	67	70,275	11	33,639	3
West Sumatra	14	101	3,518	3,406,816	538,515	369,400	79,960	14	268,810	48	113,754	17	60,381	7	11,681	3
South Sumatra	10	90	2,340	4,629,801	728,643	522,390	237,876	19	414,873	42	125,332	16	31,087	7	17,397	3
Lampung	4	75	1,511	4,624,785	788,213	545,082	154,541	17	331,299	29	227,423	18	75,950	8	0	0
South Sulawesi	23	175	1,288	6,062,212	947,836	531,052	96,529	19	245,786	38	349,869	69	132,851	24	122,693	28
Rusa Tenggara B.	6	60	569	2,724,664	431,245	250,214	29,648	6	114,408	15	184,354	25	62,636	9	34,687	4
Rusa Tenggara T.	12	98	1,720	2,737,166	378,947	340,853	303,594	83	60,042	15	4,101	1	2,253	1	2,253	1
Sub-total:	86	794	16,578	32,546,338	5,155,236	3,465,158	873,929	174	2,165,564	276	1,439,565	213	434,633	67	223,358	34
C. Aceh	10	133	5,462	2,611,271	416,146	321,889	117,681	36	186,335	60	80,481	22	10,468	3	0	0
Riau	6	72	1,022	2,168,535	319,472	282,232	250,964	48	58,138	15	8,729	2	0	0	1,641	2
West Kalimantan	7	108	4,685	2,406,068	390,053	272,641	49,644	23	181,726	33	93,263	20	31,347	11	4,317	2
Sub-total:	23	313	11,169	7,265,874	1,125,671	876,762	418,289	107	426,199	108	182,473	44	41,815	14	5,958	4
TOTALS: A., B., C.:	205	2,639	50,858	121,827,478	19,085,720	10,556,321	1,674,182	341	5,279,746	614	5,853,091	718	4,050,767	525	2,029,709	284

Sources: (1) Columns 1-3 : BKKD's Bureau for Planning "Data Basis Tahun Anggaran 1983/84"
 (2) Column 4 : 1980 Census figures from the Central Bureau of Statistics.
 (3) Columns 5-10 : BKKD's Bureau for Reporting/Recording "Summary Ranking - C.U. and MRA," December 1982.

TABLE A
VILLAGE FAMILY PLANNING
CURRENT CONTRACEPTIVE SERVICE POINTS

<u>Province:</u>	<u>Kab.</u>	<u>Kec.</u>	<u>Desa</u>	<u>Sub-desa</u>	<u>Hospitals</u>	<u>Clinics</u>	<u>PKKD</u>	<u>Sub-PKKD</u>
West Java	24	466	9,290	19,809	41	800	6,440	19,809
Central Java	35	497	9,481	33,230	50	795	9,529	33,230
East Java	37	569	9,340	33,248	56	1,385	8,340	33,248
North Sumatra	17	194	5,632	2,683	30	400	5,632	2,583
West Sumatra	14	101	3,518	3,232	17	236	3,518	3,232
South Sumatra	10	89	2,340	1,813	15	300	2,340	1,813
Lampung	4	76	1,511	4,715	6	150	1,511	4,715
South Sulawesi	23	175	1,288	3,812	30	350	1,288	3,812
N T B	6	60	569	1,674	7	140	569	1,674
N T T	12	98	1,720	-	13	135	1,100	-
Aceh	10	133	5,462	1,462	13	172	3,800	1,462
Riau	6	72	1,022	-	10	130	400	-
West Kalimantan	7	108	4,685	2,579	10	145	3,500	2,579
TOTALS:	205	2,638	59,858	108,157	298	5,138	47,967	108,157

*Source: BKKBN Bureau for Planning's "Data Basis Tahun Anggaran 1983/84."

b. Urban Family Planning

Although clinic-based family planning services have been available in cities since the start of the national family planning program, rural areas received, and continue to receive, priority attention because 80% of Indonesia's people live in rural areas. Until recently, family planning program services have not been extended effectively to the country's major urban areas, particularly Jakarta. Extending effective services, especially to the urban poor, poses a serious challenge to the BKKBN, USAID, and the private sector.

The considerable family planning success in Java and Bali, and increasingly in various Outer Island I provinces, has occurred largely in rural areas. It has not been possible to adapt the successful village family planning strategy to the cities. Indeed, through various studies, it has been made clear that the cities demand their own family planning strategy, especially in reaching the under-educated urban poor, let alone low to middle income clientele. Both experience and research show that there is substantial latent demand for family planning in urban areas, but easy access to contraception in a familiar, informal setting is essential for its adoption. The foundations for the village program are the tight-knit community organization in a homogeneous population, an excellent distribution system, and free supplies. Urban government clinics, where program services are provided, are poorly utilized by the populations they are meant to serve; neighborhoods are loose-knit and the population heterogeneous, so neighborhood communities are not strong; and the private sector service providers and service points are vastly under-utilized or over-priced. Although government involvement in meeting the contraceptive needs of the poor is essential, a successful program has to be extended beyond the limited and already stretched government delivery system, to include the multi-faceted and more acceptable delivery channels of the private sector.

In May 1976, BKKBN estimates put the proportion of women who use family planning in Jakarta at 11.6%, lower than any Java/Bali province and less than half the levels of East Java and Bali. This figure was embarrassing for the city which had pioneered the government program in 1968 and which boasted all the outward signs of "development."

In the 1970's successful birth control programs ranked high in the litany of modernism, and both Jakarta and other major urban centers lagged seriously behind most rural areas in this respect. Through the late 1970's and into the early 1980's the situation remained the same with urban areas being increasingly left behind in terms of contraceptive prevalence rates. For example, Jakarta has retained its sixth ranked position of the Java/Bali provinces since the early days of the program.

An explanation for this urban failing is not hard to find. As commercial centers and homes to the majority of Indonesia's physicians, the major urban centers have many private outlets for family planning services which, up until recently, were not part of the BKKBN's national reporting and recording network. For example, the 1976 World Fertility

Survey (WFS) found that 20% of Jakarta's MWRA used modern contraceptive methods. The WFS also found that 10% of all married, fecund women -- nearly a third of all contraceptors -- were using a traditional method. New acceptors are hard to recruit where many people are satisfied with traditional methods. Other independent studies also revealed that higher income, schooled women were most likely to use a traditional method (rhythm), mainly due to fear of modern contraceptive side-effects. It was also found that few of these women had ever been visited by program fieldworkers, a programmatic problem in attempting to use a village family planning strategy in an urban context. Finally, program administrators felt that the VFP strategy would work since the bulk of Jakarta's population, drawn from Sundanese West Java and Javanese Central Java and Yogyakarta, live in cramped kampungs and villages on the city's fringes. During the 1970's these kampung ties were strong, and life in the city did not greatly revolutionize traditional orientations. Now, however, these orientations are rapidly changing, and life in Jakarta's urban kampungs lack homogeneity while potential clients demand different, more anonymous services.

Jakarta's difficulties are not unique. Java's other main cities of Bandung, Semarang, and Surabaya, as well as the off-Java cities of Medan, Ujung Pandang, Palembang, and Padang, have relatively low contraceptive prevalence rates. Prospects for the future depend ultimately on the cities themselves. With growth rates over the 1971-1980 period ranging between 1.39% for Surakarta to 10.35% for Padang, serious attention needs to be given to the cities. The educational and social structure of urban populations has a potential for change -- both positively and negatively -- unmatched by that of the provinces. It is probably safe to say that Jakarta and the other major urban centers are destined to remain areas of great variety in terms of birth control method, choice, and source of supply. The BKKBN and USAID intend to capitalize on this variety through the provision of quality contraceptive services.

In early 1980, President Suharto directed the BKKBN to give special attention to problems of the cities. Urban populations have grown twice as fast as the nation as a whole, creating unusual demands for social services and putting heavy stress upon a limited urban infrastructure. Since the President's directive, the BKKBN staff has devoted much time and energy to develop an urban strategy. The present strategy is to utilize both public and private service points and service providers in a two-pronged initiative to increase awareness and to strengthen the delivery of family planning information and services.

According to the 1980 census and subsequent projections, the ten largest cities in Indonesia have a total population of about 15.4 million persons. These cities contain approximately 2.5 million married women of reproductive age with widely varying rates of contraceptive prevalence. For the ten cities combined, the contraceptive prevalence rate as of December 1982 was 36.5% (with a range of 20.5% in Ujung Pandang to 53.1% in Malang) with approximately 900,000 current users.

The target for March 1987 is approximately 1,085,000 current users, or a prevalence rate of 60%. Apart from major concentrations of population and lower than average contraceptive prevalence rates in these ten cities, Table H shows that the majority of married women of reproductive age and numbers of kecamatan are spread across the first three Phases of contraceptive prevalence: 0-54%. Over 2 million of 2.5 million MWRA, residing in 102 of the total 119 kecamatans, fall into these three phases. If Jakarta and the other cities are to achieve prevalence rates of 60%, major efforts are needed to boost these 102 kecamatans to Phases IV and V prevalence rates. The task of the BKKBN is to maintain current users, convert acceptors to more effective methods of fertility control, and develop information and service activities which will be attractive and affordable to present non-users.

Family planning services in urban areas, particularly the larger cities, are available through a wider range of public and private outlets than in the rural areas which are served almost entirely by the government family planning program. In urban areas, family planning information and contraceptives are offered through government hospitals, clinics, and family planning centers; through private hospitals and clinics; through pharmacies and other commercial channels; and through private physicians and midwives. The challenge facing the BKKBN through the 1980's is how to involve more fully all current and potential service points and providers in better quality, urban-style information and services.

The two main geographic-priorities of the BKKBN and USAID for urban family planning are:

1. The ten largest cities in Indonesia -- Jakarta, Surabaya, Bandung, Medan, Semarang, Palembang, Ujung Pandang, Malang, Padang, and Surakarta (Solo).

2. The other large cities and towns (kotamadya) of thirteen high priority provinces -- West Java, Central Java, East Java, North Sumatra, West Sumatra, South Sumatra, Lampung, South Sulawesi, Nusa Tenggara Barat, Nusa Tenggara Timur, Aceh, Riau, and West Kalimantan. In these thirteen provinces there are 32 potential cities and towns.

Table H provides basic data on the ten largest cities and the kotamadya in the thirteen provinces which may receive some USAID support as part of the village family planning supplementary assistance in those provinces. These are the same thirteen priority provinces listed in Table F for village family planning. USAID assistance will be concentrated in, but not necessarily limited to, the urban sub-districts (kecamatan) with lower contraceptive prevalence rates, i.e., those ranked by BKKBN as Phase I (0-14% prevalence), Phase II (15-34% prevalence), and Phase III (35-54% prevalence).

Further reference to Table H clearly shows that the ten largest cities are in need of rapid improvement. Prevalence rates are low when compared among various kotamadya. For example, for

December 1982, Jakarta's prevalence rate was 34.2%, Bandung's was 42.6%, Medan's 35.1%, and Ujung Pandang's 20.5%. At the same time a number of kotamadya are well advanced in the provision of family planning to their constituents. This is especially true in East Java where prevalence rates range from 53.1% in Malang to 83.4% in Probolinggo, as compared to 40.5% in Surabaya. In great part these variances are due to approach. Until recently there has been no clearly stated or applied urban approach. Instead, the village family planning model has been applied, apparently with satisfactory success in the smaller cities and towns where mental attitudes and practices are still rural or semi-urban. This model, however, does not work for major urban centers and therefore needs to be modified to meet the stated needs of the urbanite.

The BKKBN has developed a dual strategy to increase contraceptive prevalence in urban areas. One approach, is to strengthen the delivery of family planning information and services through the governmental hospitals, clinics, family planning centers, and service providers.

USAID will assist BKKBN to expand family planning services in hospitals and clinics in ten urban areas in eight provinces. These cities have a population of 15.4 million, with 2.5 million MWRA and a current combined contraceptive prevalence rate of 36.5%.

The second approach is to expand family planning information and services through the private sector by using the model and pilot project results of a private foundation, Yayasan Kusuma Buana, currently being funded by USAID through the BKKBN. This model utilizes private clinics, referral centers, and networks of private physicians and midwives who provide quality family health and family planning services to couples in the lower and middle income brackets who are willing to pay reasonable fees for services. One of the main goals of this model is partial to full economic self-sufficiency for the clinics within three years after start-up.

At present it is difficult to clarify exactly how many private clinics and service provider networks can be established in these ten major cities. Some of the answers can be estimated on the basis of numbers of private clinics, doctors, and midwives in each city after more information is available from the city assessments carried out by various institutions.

Further answers will have to wait until more experience has been gained by private sector initiatives. The urban program is still in its initial stages in so many areas. Time is needed to see which of the new activities are successful and can be expanded as well as what other things can be tried. The BKKBN-YKB-USAID initiative is a brand new undertaking. All three parties have high hopes that this project, and others of its kind, will provide the necessary answers for urban family planning programs.

TABLE 5
URBAN FAMILY PLANNING
TARGET CITIES/SUBVIA

Cities/City	No. Kec.	Total Pop. (from 1980 census)	Phase I Kec. (0-145)		Phase II Kec. (15-345)		Phase III Kec. (35-545)		Phase IV Kec. (55-745)		Phase V (above 755)		Total	MRA Balance
			*MRA Kec.	Kec.	*MRA Kec.	Kec.	*MRA Kec.	Kec.	*MRA Kec.	Kec.	*MRA Kec.	Kec.		
A. NAT./PROV. CAPITALS:														
1. Jakarta DKI	30	6,503,449		20	781,368	181,523	6	21,787	1	77,077	3	1,061,755	689,592	
2. Surabaya	16	2,027,913		6	133,116	164,207	9			25,693	1	323,018	192,348	
3. Bandung	16	1,462,637		9	128,280	48,611	3	6,722	1	35,418	3	219,237	125,900	
4. Medan	11	1,378,955		8	179,904	41,109	2			26,700	1	247,713	160,793	
5. Semarang	10	1,026,671		2	108,626	24,473	3	28,507	1			173,478	112,465	
6. Palembang	6	787,187		1	11,646							126,369	98,551	
7. Ujung Pandang	11	709,038		6	40,518	11,835	1			7,293	1	117,167	93,123	
8. Malang	3	511,780		2	42,746					37,632	1	80,378	37,660	
9. Padang	11	480,922		5	19,993	1,953	1	20,769	2			80,018	58,399	
10. Surakarta (Solo)	5	469,888		1	21,685	20,769	2	13,476	1	14,954	1	70,884	32,274	
Sub-total	119	15,358,440		14	1,569,884	494,686	27	91,261	6	224,767	11	2,500,017	1,610,105	
B. PROV. SUBVIA:														
1. West Java Subv:														
- Bogor	5	247,409		3	23,109	16,291	2			8,801	1	39,409	23,852	
- Sukabumi	2	109,994		1	8,226							17,027	8,199	
- Cirebon	4	223,776		2	14,973	12,510	1			7,118	1	34,601	20,636	
2. Central Java Subv:														
- Magelang	2	123,484				9,861	1	9,136	1			18,997	7,030	
- Pekalongan	2	132,558		1	8,683	11,783	1					20,466	13,803	
- Salatiga	1	85,849										13,511	5,824	
- Total	2	131,728		1	10,426							13,511	5,824	

TABLE S (Cont.)
URBAN FAMILY PLANNING
TARGET CITIES/KODYA

Cities/Kodya	No. Kec.	Total Pop. (from 1980 census)	Phase I Kec. (0-14%)*MRA	Phase II Kec. (15-34%)*MRA	Phase III Kec. (35-54%)*MRA	Phase IV Kec. (55-74%)*MRA	Phase V (above 75%)*MRA	Total	Balance	
3. East Java Kodya:										
- Blitar	1	78,503					12,173	1	12,173	3,004
- Kediri	4	221,830			14,986	2	20,936	2	35,922	10,487
- Majaerto	1	68,849					10,618	1	10,618	6,224
- Madiun	1	150,562					23,086	1	23,086	5,355
- Pasuruan	1	95,864					14,838	1	14,838	5,947
- Probolinggo	1	100,296					15,764	1	15,764	2,616
4. North Sumatra Kodya:										
- Binjai	1	76,464							12,156	5,550
- Pematang Siantar	1	150,376		23,378	1				23,378	17,977
- Sibolga	1	59,897					9,692	1	9,692	4,227
- Tanjung Balai	1	41,894		6,604	1				6,604	4,910
- Tebing Tinggi	3	92,087		10,832	2			5,339	16,171	9,456
5. West Sumatra Kodya:										
- Bukit Tinggi	1	70,771					10,902	1	10,902	4,341
- Padang Panjang	1	34,517				5,314			5,314	2,942
- Payakumbuh	1	78,836				12,452			12,452	6,680
- Saroh Lunto	1	13,561						2,073	2,073	491
- Solok	1	31,724					5,046	1	5,046	2,109
6. South Sumatra Kodya:										
- Pangkal Pinang	2	90,096					13,991	2	13,991	8,471
7. Lampung:										
- Tanjung Karang	4	284,275	15,050	1	26,131	2	8,773	1	49,954	38,482
8. South Sulawesi Kodya:										
- Pare-Pare	3	86,450				9,513		2	9,513	2,000

16

TABLE 5 (Cont.)
URBAN FAMILY PLANNING
TARGET CITIES/KODYA

Cities/Kodya	No. Kec.	Total Pop. (from 1980 census)	Phase I (0-14%) *Mwra	Kecs. Kec.	Phase II (15-34%) *Mwra	Kecs. Kec.	Phase III (35-54%) *Mwra	Kecs. Kec.	Phase IV (55-74%) *Mwra	Kecs. Kec.	Phase V (above 75%) *Mwra	Kecs. Kec.	Total Mwra	Balance
9. Nusa Tenggara Barat:														
- Mataram (Kota Administratif)	2	7			9,937	1	10,984	1					20,921	13,937
10. Nusa Tenggara Timur:														
- Kupang (Kota Administratif)	5	7	8,966	2	14,134	2							23,100	18,724
11. Aceh:														
- Banda Aceh	2	72,090					11,573	2					11,573	5,966
- Sabang	1	23,821					2,374	1					2,374	1,464
12. Riau:														
- Pekanbaru	6	186,262	12,408	2	18,197	4							30,605	24,546
13. West Kalimantan:														
- Pontianak	4	304,778	17,844	2			30,711	2					48,555	28,340
Sub-total	68	3,783,388	54,268	7	174,630	21	174,499	20	92,812	9	99,273	10	595,482	326,991
TOTALS: 42 Cities	187	19,141,828	173,687	21	1,744,614	82	669,185	47	184,073	15	324,040	21	3,095,499	1,937,096

*Figures based on BKKBN's statistical "Summary Ranking, CU and Mwra," December 1982.

c. Voluntary Sterilization Services

Over 660 physicians and over 660 supporting staff have been trained and certified to perform sterilizations. Similarly, 1,566 service centers are currently classed as capable of providing sterilization services. In fact, however, the number of active service centers is small. An active voluntary sterilization (VS) service center is defined as a hospital or clinic that has a full range of contraceptive information and services; dedicated space for VS counseling, operations, and recovery; modern equipment, including mini-laparotomy and vasectomy kits, and laparoscopes or laparotomies where appropriate; one or more physicians and staff trained and certified to perform voluntary sterilization operations; services available on a daily basis; and, in order to maintain high-quality skill levels, performing at least 500 procedures annually for hospitals and clinics and at least 100 procedures annually for health centers.

The BKKBN, in collaboration with the Ministry of Health and the private Association for Secure Contraception (PKMI), currently provides voluntary sterilization services in 308 provincial and regency-level hospitals and to 1,258 sub-district health centers throughout Indonesia. USAID funds will support expansion of these services to approximately 173 provincial and regency hospitals and to approximately 346 sub-district health centers over the next three years in the 12 priority provinces. Expansion of voluntary sterilization will be carried out through renovating and equipping facilities and training of staff will follow a phased schedule:

(1) Hospitals and Clinics.

(a) Year 1--DKI Jakarta and 3 Java provinces:
--87 hospitals and 174 clinics.

(b) Year 2-- 8 other provinces:
--78 hospitals and 156 clinics.

(c) Year 3--Implementing Unit hospital and health centers:
-- 8 hospitals and 16 clinics.

Approximately 346 health centers will be renovated, equipped, and staffed over the three year period. Selections will be made from among the 1,562 sub-districts in Jakarta and the three Java provinces and from among the 887 sub-districts in the eight other Outer Islands provinces. Selection of sub-districts will be based upon the level of contraceptive prevalence, potential demand for voluntary sterilization, and degree of support from provincial-level and sub-district officials and informal leaders.

All facilities, both hospitals and clinics, will provide information and a full range of contraceptives to insure that each family planning acceptor can make an informed choice.

Three Indonesian agencies will be closely involved in the expansion of voluntary sterilization services:

(1) The BKKBN is responsible for development of policy, for overall coordination of the national family planning program, for financial contributions for medicines and other supplies, for handling complications, and for training its extensive field staff to provide information to eligible couples.

(2) The Ministry of Health is responsible for health services and operates most government hospitals, clinics, and health centers; for providing space, equipment, and staff; and for training its health staff to provide information and referral of eligible couples.

(3) The Indonesian Society for Secure Contraception (PKMI) is responsible for training and certifying physicians and other staff in voluntary sterilization procedures; for distributing equipment to certified physicians; for developing standards of quality service; for operating equipment repair and maintenance centers; for developing and maintaining a service statistics reporting system by which information can be provided to BKKBN for integration into the national family planning services monthly statistics reports; and for making recommendations to BKKBN and the Ministry of Health on ways to improve services.

Selected American organizations have used AID/Washington funds to help with voluntary sterilization training, equipment, repair and maintenance of equipment, and minimal hospital and clinic renovation. USAID bilateral funds have been used for sterilization equipment. This new project will provide additional bilateral funds for sterilization and other clinical equipment and for clinic renovation. All past, present, and proposed AID funds, whether from AID/W or from bilateral funding sources, have been and will continue to be fully consistent with all the terms and provisions of Policy Determination PD-3 (September 1982) titled "A.I.D. Policy Guidelines on Voluntary Sterilization."

For example:

-- AID/W and USAID/Jakarta have reviewed and approved the informed consent form that is being reviewed and signed by patients before they receive voluntary sterilizations, and appropriate wording on this form has been included in all documents that include AID support for sterilization services. A similar statement will be written into each Project 0327 Program Agreement or Amendments that includes reference to sterilization services.

--The International Program of the Association for Voluntary Sterilization (IPAVS), with AID/W funds, has assumed ongoing monitoring of informed consent form procedures (e.g. patients reviewing and signing, the clinics' retaining for three years after procedure is performed). Other American organizations (FPIA, Pathfinder Fund) that use AID/W funds for voluntary sterilization assistance provide similar monitoring. USAID

plans to continue to delegate to the professionals in the voluntary sterilization field (IPAVS, etc.) the ongoing monitoring of these forms.

--All hospitals and clinics in Indonesia that provide voluntary sterilization services also provide a free choice of other contraceptive methods. This also will be written into each Project 0327 obligating document that includes voluntary sterilization.

--There are no incentive payments to acceptors or providers of voluntary sterilization services in Indonesia. Except for transportation costs to acceptors in certain circumstances and institutional payment to providers for recurrent costs associated with the procedure, there have been no payments either to acceptors or to providers that could be viewed as "incentive payments"

--The Indonesian Association for Secure Contraception (PKMI) has assumed responsibility for training and quality control in the field of voluntary sterilization in Indonesia. USAID's assistance in this field will be subject to the continuing quality control role of the PKMI or similar Indonesian organization(s) and the IPAVS or similar American organization(s) to help assure continuing high quality sterilization services.

--As indicated earlier, sterilization remains a health matter in Indonesia. Although the BKKBN increasingly will become involved in it, primary responsibility will continue to rest with the Ministry of Health; and sterilization services will continue to be integrated fully within the health system.

Informed Consent Form for Voluntary Sterilization

PERMOMONAN DAN PERBETUJUAN

BAGI YANG DAPAT MEMBACA DAN MENULIS

Kami yang bertanda tangan di bawah ini setelah mendapat penjelasan dan mengerti sepenuhnya tentang tubektomi sukarela, bersama ini memohon dapat dilakukan operasi tersebut pada

(nama yang akan dioperasi)

oleh para dokter di :

(nama klinik yang akan mengoperasi)

Kami mengerti dan memahami sepenuhnya bahwa :

BAGI YANG TIDAK DAPAT MEMBACA DAN MENULIS

Saya : _____
(Nama dokter yang akan mengoperasi)

dengan ini menyatakan yang sebenarnya bahwa kepada pasangan :

a. Nama Istri : _____

b. Nama suami : _____

Telah dijelaskan dengan selengkap-lengkapnya dan mereka telah mengerti dan memahami sepenuhnya bahwa :

1. Pada saat ini di samping tubektomi sukarela masih ada lagi berbagai cara kontrasepsi lainnya yang bersifat sementara dan dapat dipergunakan untuk merencanakan keluarga.
2. tubektomi sukarela merupakan tindakan pembedahan.
3. Tindakan pembedahan pada tubektomi sukarela mempunyai risiko.
4. Jika tindakan pembedahan berhasil, maka tidak akan mempunyai keturunan lagi.
5. Hasil tindakan tubektomi tidak dapat dipulihkan kembali.
6. Telah diberikan kesempatan untuk mengubah pemahamannya ini tetapi pemahamannya tetap dipertahankan tanpa ada paksaan apapun atau keterpaksaan lainnya antara kami (pasangan yang bersangkutan) dengan dokter (saya)

Pemahaman ini dibuat dengan sebenarnya, dengan disaksikan oleh saksi yang kami pilih

10

Nama pasangan yang memahami

Istri

Suami

(_____)
Nama lengkap dan tanda tangan

Saksi

(_____)
Nama lengkap dan tanda tangan

Dokter

(_____)
Nama lengkap dan tanda tangan

(_____)
Nama lengkap dan tanda tangan

Selanjutnya dengan kesadaran sendiri mereka memahami agar kepada

(nama yang akan dioperasi) dapat dilakukan tubektomi sukarela.

Pernyataan ini dibuat dengan disaksikan oleh saksi yang mereka pilih

10

Saksi

Dokter yang memberikan pernyataan

(_____)
Nama lengkap dan tanda tangan

Nama pasangan yang menandatangani pernyataan/mengakhiri pemahamannya

Istri

Suami

(_____)
Nama lengkap dan tanda tangan

(_____)
Nama lengkap dan tanda tangan

The six points listed on this Indonesian language "informed consent" form comply fully with AID's P.D. No. 3. These points provide an explanation to the client in his/her own language of the nature of the procedure; its risks and benefits; and its irreversibility. The clients witnessed signature or mark is required on the consent document.

d. Training

During the past decade over 100 persons have completed master's and doctoral degrees in the United States and over 250 have received short-term specialized training in the U.S. and other developing countries.

The aim of USAID-supported graduate-level training is two fold: first, to strengthen management capability of staff of the BKKBN and other implementing units involved in the national family planning program; second, to develop and strengthen the institutional capability of Indonesian training and research organizations so that they can assume a greater role in providing trained manpower in the future.

BKKBN staff, in collaboration with training and research institutions, have developed a training plan for the remainder of the 1980's. The BKKBN National Educational and Training Center conducted a survey of training needs for the 1982-85 period and then made linear extrapolations of the results until 1990 to provide crude projections of training needs for the 1980's. The results were classified into long-term and short-term training, both in Indonesia and overseas. Training needs were classified into six areas, listed below in perceived order of priority by the BKKBN:

- (1) Management and
(including financial and economic assessment)
- (2) Population studies
- (3) Public Health
- (4) Sciences, including social, behavioral, computer,
library, medical, and economics
- (5) Education
- (6) Communications and audio-visual

Based upon the survey, the number of persons requiring training by 1990 are:

Long-term training in Indonesia	1,248 persons
Short-term training in Indonesia	13,818 persons
Long-term training overseas	342 persons
Short-term training overseas	1,508 persons

The mission of BKKBN's Center for Education and Training (PUSDIKLAT) is to provide Indonesia's national family planning program with the trained, competent, and responsible manpower necessary for the program to reach its social and demographic goals by 1990. PUSDIKLAT's training strategy and future directions for the remainder of this decade are:

1. Improving institutional capabilities of collaborative training institutions, such as schools of public health, demographic institutes, and population studies and research institutes;

2. Conducting the great majority of its future training, both academic and in-service short term training, in Indonesia.
3. Improving the coordinating and supporting role of PUSDIKLAT through
 - responsive determination of training needs,
 - developing linkages with collaborative training institutions,
 - strengthening hardware and software training technologies,
 - training evaluation, review, and assessment.
4. Decentralizing training responsibilities to peripheral levels;
5. Establishing an organizational development capability to improve institutional performance;
6. Developing an international training capacity within BKKBN.

A detailed three-year plan for long-term academic training both overseas and in Indonesia prepared by BKKBN is provided in Table J. This plan represents an ideal training program to be fully implemented if funds are readily available and if qualified candidates can be selected. The plans call for 186 master's candidates and 39 doctoral candidates to be sent for training overseas and 150 master's candidates and 27 doctoral candidates to receive training at Indonesian institutions. The plan has the following major components:

1. Development of Baccalaureate and Graduate Public Health Training Programs at Four New Schools of Public Health in Indonesia at Hasannudin University, Ujung Pandang; University of Diponegoro, Semarang; Airlangga University, Surabaya; and the University of North Sumatera, Medan. In this context BKKBN will provide assistance in:

a. Training faculty members at the four new schools of Public Health, and continuing support for the existing Faculty of Public Health at the University of Indonesia. Once established these schools will be able to educate an additional 100 persons yearly at the level of Bachelor of Science in Public Health (S₁), and an additional 100 persons yearly at the level of Masters in Public Health (S₂), and to increase existing public health training capacity in Indonesia fourfold. In order to establish this public health capacity, BKKBN estimates that a minimum of 3 persons in each of the 5 academic departments in each school need specialized graduate training in Public Health, two at the masters level and one at the PH.D. level. Of the

60 master's degrees and 32 Ph.D's which will be necessary, 30 master's degree and 15 Ph.D's will be obtained in Indonesia, and the remainder abroad. USAID funds will support 24 persons for masters training and 9 persons for PhD training overseas, and 30 masters degrees and 8 Ph.D's in Indonesia.

b. Curriculum development. Teams consisting of members from each faculty plus technical consultants identified by the Consortium of Health Sciences, which is responsible for coordinating development of the new schools of Public Health, will develop curricula and teaching materials to be used at each school based upon program emphasis and individual needs. USAID will provide funds to support technical assistance to this effort in the form of short term consultants.

c. Develop library facilities in each of the new schools of Public Health. This will involve the purchase of library materials and development of appropriate library indexing system. USAID will provide the assistance necessary to establish core library facilities in each faculty.

2. Training Faculty Members at 14 Demographic Institutes Currently Being Developed in Indonesia. When established the demographic institutes will offer S1 (Bachelors) and S2 (Masters) training in demography. Currently no specialized graduate demographic training is available in Indonesia. BKKBN estimates that a minimum of 5 persons with masters level training and one person with doctoral training will be necessary to establish this capacity at each institution. Table J list the 14 institutes with the number of faculty at each institute already trained at the masters or doctoral level in brackets. A total of 54 masters degrees and 13 Ph.D's will be needed for this purpose. USAID will provide funds for 8 master's and 4 Ph.D degrees overseas during the duration of this project. USAID assistance will be targeted on two demographic institutes listed in Table J with an aim toward providing comprehensive faculty development sufficient to enable those two institutes to develop masters (S2) programs in demography.

3. Manpower Development for BKKBN and Its Implementing Units. This activity provides graduate training both in Indonesia and abroad for key persons with potential for career advancement and greater management responsibility. Overseas training will emphasize public administration and management which would include training in the techniques of assessing financial and economic efficiency, population studies, and public health in areas where graduate training is not currently available in Indonesia. In country graduate training will be used in support of BKKBN's efforts to upgrade the educational qualifications of persons holding echelon III and IV management level positions whose education is not in accordance with GOI requirements for the position. In-country training for implementing units will focus on public health and population education. BKKBN estimates that 66 master's degrees and 9 Ph.D's will be necessary for this purpose; USAID funds will support 24 of the overseas masters degrees and 3 of the Ph.D's requested for this purpose. BKKBN also estimates that 120 master's degrees and

12 Ph.D's will be necessary in Indonesia to meet its manpower development objectives. USAID funds will support 60 masters degrees and 12 Ph.D's during the course of this project.

4. Development of In-service Training Programs.

Approximately 50,000 persons yearly receive both basic and refresher training at the thirty seven provincial and regency level training centers situated throughout Indonesia with development funds provided by the GOI. Currently, nearly 50 distinct categories of training are conducted yearly for managerial, technical, and operational personnel. The training curricula in these 50 categories must be periodically assessed, revised, and upgraded so that training can remain dynamically responsible to changing program needs. Periodically, training categories and programs must be eliminated and new ones developed.

During this project USAID will provide funds to develop a minimum of 4 new training programs and curricula, pilot test the materials developed, and evaluate the training program. Based upon evaluation results, these training programs will be adopted for routine use at provincial training centers supported with funds from the GOI's yearly development budget.

5. Management Development Training. These funds will be used to support a broad range of activities which will contribute to the development of management skills in middle level managers from BKKBN and the implementing units. These activities will include among others, in-country training in management of population programs, discrete short term training programs abroad and the provision of specific technical assistance related to manpower development and management.

BKKBN's Center for Education and Training will manage all training inputs to the project. With respect to long term training in the U.S., this will constitute a departure from previous USAID policy for long term participant training who were previously processed and coordinated through USAID/Washington's office of International Training. Consequently, one of the major outputs of this project will be the development of the Center's institutional capability to provide logistical and financial support to its long term training participants.

The training plan which was developed and refined during USAID's training loan O69 to BKKBN will be used for implementation of the long term training portion of this project. This plan establishes a definite time schedule for the selection of candidates, English language training in Indonesia, application to universities, additional English language training and orientation prior to commencement of studies, and financial and logistical support during their studies. Financial support to participants will be provided directly by BKKBN through procedures developed during implementation of the previous training loan.

Implementation of the full training plan would depend upon large contributions from USAID, World Bank, UN agencies, and other donors. At present all of the estimated funds needed are not available from the donor community, and are not likely to be in the near future. USAID has

provided in the past almost all funds for long-term training of population-family planning personnel as part of a domestic division of labor and will continue this role in the next few years as well.

TABLE T
BKKBN'S COMPREHENSIVE LONG TERM TRAINING PROJECTIONS
1. LONG TERM TRAINING ABROAD

	1985		1986		1987	
	Masters	Ph.D	Masters	Ph.D	Masters	Ph.D
<u>Schools of Public Health</u>						
1. University of Indonesia	2	1	2	2	2	2
2. University of Hasannudin	2	1	2	1	2	1
3. University of Airlangga	2	1	2	1	2	1
4. University of Diponegoro	2	1	2	1	2	1
5. University of North Sumatra (Medan)	2	1	2	1	2	1
Sub-total	10	5	10	6	10	6
<u>Demographic Institutes</u>						
1. University of Indonesia	1	1	2	1	2	1
2. University of Padjajaran (0)	1	1	2	-	2	-
3. University of Diponegoro (0)	1	1	2	-	2	-
4. University of Airlangga (0)	1	1	2	-	2	-
5. University of Udayana (4)	1	1	2	-	-	-
6. University of Hasannudin (2)	1	1	1	-	1	-
7. University of Brawijaya (2)	1	1	1	-	1	-
8. University of N. Sumatra (0)	1	1	2	-	2	-
9. University of Sriwijaya (2)	1	-	1	-	-	-
10. University of Mataram (0)	1	1	2	-	2	-
11. University of Andalas (2)	1	-	1	-	1	-
12. University of Syawallah (1)	2	1	1	-	-	-
13. University of Lambung Mangkurat (1)	2	-	2	-	1	-
14. University of Sam Ratulangi (2)	1	1	1	-	-	-
Sub-total	16	11	22	1	16	1

TABLE T (cont'd)
BKKBN'S COMPREHENSIVE LONG TERM TRAINING PROJECTIONS
 1. LONG TERM TRAINING ABROAD

	1985		1986		1987	
	Masters	Ph.D	Masters	Ph.D	Masters	Ph.D
<u>Training Capacity in Demography</u>						
1. University of Kalimantan Barat	1	-	1	-	1	-
2. University of Jendral Sudirman	1	-	1	-	1	-
3. University of Sebelas Maret	1	-	1	-	1	-
4. University of Lampung	1	-	1	-	1	-
5. Teacher Training Institute of Bandung	1	-	1	-	1	-
6. Teacher Training Institute of Ujung Pandang	1	-	1	-	1	-
7. Teacher Training Institute of North Sumatra	1	-	1	-	1	-
8. Teacher Training Institute of Padang	1	-	1	-	1	-
9. Teacher Training Institute of Jogjakarta	1	-	1	-	1	-
10. Teacher Training Institute of Medan	1	-	1	-	1	-
11. Teacher Training Institute of Jakarta	1	-	1	-	1	-
12. Teacher Training Institute of Malang	1	-	1	-	1	-
<u>Sub-total</u>	<u>12</u>	<u>-</u>	<u>12</u>	<u>-</u>	<u>12</u>	<u>-</u>
Central bureau of Statistics	5	-	5	-	5	-
BKKBN	10	1	10	1	10	1
Implementing Units	7	2	7	2	7	2
<u>Sub-total</u>	<u>22</u>	<u>3</u>	<u>22</u>	<u>3</u>	<u>22</u>	<u>3</u>
<u>GRAND TOTAL</u>	<u>60</u>	<u>19</u>	<u>66</u>	<u>10</u>	<u>60</u>	<u>10</u>

TABLE T (cont'd)
BKKBN'S COMPREHENSIVE LONG TERM TRAINING PROJECTIONS
2. LONG TERM TRAINING IN INDONESIA

	1985		1986		1987	
	Masters	Ph.D	Masters	Ph.D	Masters	Ph.D
<u>Schools of Public Health:</u>						
1. University of Indonesia	2	1	2	1	2	1
2. University of Hasanudin	2	1	2	1	2	1
3. University of Airlangga	2	1	2	1	2	1
4. University of Diponegoro	2	1	2	1	2	1
5. University of North Sumatra	2	1	2	1	2	1
<u>Sub-total</u>	10	5	10	5	10	5
BKKBN	20	2	20	2	20	2
Implementing Units	20	2	20	2	20	2
<u>Sub-total</u>	40	4	40	4	40	4
<u>GRAND TOTAL</u>	50	9	50	9	50	9

TABLE U
USAID ASSISTANCE FOR GRADUATE LEVEL TRAINING
IN SUPPORT OF BKKBN'S MANPOWER DEVELOPMENT PLAN

	OVERSEAS				INDONESIA			
	(1) Total BKKBN Requirement		(2) USAID Assisted Portion 1/ Masters Ph.D.		(3) Total BKKBN Requirement		(4) USAID Assisted Portion 1/ Masters Ph.D.	
	Masters	Ph.D.	Masters	Ph.D.	Masters	Ph.D.	Masters	Ph.D.
New Schools of Public Health	30	17	24	9	30	15	30	8
Demographic Institute	54	13	8	4	-	-	-	-
Training Capacity in Demography	36	-	-	-	-	-	-	-
Manpower Development BKKBN and Implementing Units	66	9	24	3	120	12	60	6
	186	39	56	16	150	27	90	14

1/ Total BKKBN requirements (Columns 1 and 3)
include USAID portion (Columns 2 and 4).

e. Modern Management Technology

Computer technology is not new to the BKKBN. Computerized systems for monthly service statistics and for monthly logistics reports were developed in the early 1970's. Reports were processed by a private computer firm until the BKKBN acquired its own computer in 1981. The computer has limited capability. At the same time, microcomputers have become widely available. There is presently no computer or word processing capability at the provincial BKKBN offices and only limited capability at headquarters. A survey of computer-word processor needs is being financed by USAID under Project O270 and will be completed in late 1983. The survey should provide more definitive specifications for equipment, software, and training of secretarial and professional staff.

The planned output of computer and word processor capability at 16 selected provincial BKKBN offices and for most offices at national headquarters and other institutions will provide the BKKBN with modern management technologies it now lacks. Availability of this technology is expected to be of most benefit for rapid feedback of data to provincial and lower levels; improved financial accounting, planning, and budgeting; extending research capabilities to provincial levels; logistics management; preparation of reports; personnel management, assignment, evaluation, and training; field supervision; and analysis of program performance.

f. Research and Development

Research and development support will focus on the introduction and utilization of new technologies and on operations research. Areas of new technology may include expanded research and field trials on new or improved contraceptives, on longer-term effects of existing contraceptives, and on voluntary sterilization. Operations research funds may be used for management improvement; project design and financing; improvement of village and urban family planning in slower-performing areas; contraceptive marketing; retail sales and private sector use of contraceptives; and measurement and analysis of contraceptive, demographic, and vital registration rates.

This section of the Project is designed to respond flexibly both to anticipated and to unanticipated research needs; to help increase even further Indonesian research capabilities; and to help broaden the channels through which research findings rapidly are disseminated to other researchers and to decision-makers.

The BKKBN's Biomedical Research Steering Committee will select, supervise, coordinate, and analyze biomedical research. The BKKBN's Research and Program Development Bureau will select, supervise, coordinate, and analyze social science research. All BKKBN Bureaus, other GOI agencies, universities, non-government agencies, and individual researchers will have opportunities to assist with research need articulation.

The criteria for study selection are based on international standards and protocols. Particular studies often include collaboration by internationally recognized institutions such as Family Health International (ex-IFRP), Westinghouse Health Systems, Population Council, etc.

Because of the continuing close USAID relationship with the BKKBN and selected other research institutions, USAID's role in need articulation, project formulation, and review of research funded under this Project primarily will be informal. USAID and BKKBN jointly will sign PIL's on large-scale research projects. On other projects, USAID will provide funds to the BKKBN for supporting small scale research projects with both public and private institutions. BKKBN will assume complete authority for selection and approval, with quarterly summaries to USAID on each small project.

Research will be carried out by individual Indonesian researchers, by Indonesian institutions such as the Central Bureau of Statistics, Indonesian universities, and private sector organizations. With some USAID funds through the BKKBN, institutions such as the Indonesian Fertility Research Secretariat in Bandung and the Population Studies Center at Gajah Mada University will coordinate, review, and finance research by other institutions and individuals, on behalf of the BKKBN.

2. Economic Analysis

Overview

The progress made in Indonesia's family planning program is impressive and well documented. Because of the decline in the crude birth rate during the 1970s, the government has been able to translate more of its oil earnings into development investments than it would have otherwise. Because the population did not grow as fast as originally projected, food requirements, with their claim on foreign exchange resources, and primary school requirements, particularly on Java, were less than originally projected at the beginning of the Third Five Year Plan. As a result, average per capita income has grown at over 5% annually during the 1970s. Overall, BKKBN has already made a remarkable contribution to the nation's growth and well-being.

Just as BKKBN met the challenges of the 1970s', it also will need to meet new challenges of the 1980s. Factors have appeared that were not of great concern in the program's first decade:

- BKKBN, like all government agencies, faces a period of budget stringency. Real budget levels are declining for many programs at a time when BKKBN is planning to reach into more and more villages and sub-villages. It also is planning greater urban coverage. This budget trend is occurring at a time when donor contributions also are level in real terms, and the GOI contribution to family planning efforts is increasing as a percentage of total donor/recipients disbursements. As results, both the BKKBN and donors are being forced to prioritize their activities.

- Interesting population shifts are occurring --from Java to the Outer Islands, rural to rural, and urban to urban, as well as a continuing rural to urban shift on Java itself. Mobility is up sharply over the early 1970s. For example, a little over one million people who lived outside Java at the time of the October 1980 census stated that they lived in Java in 1975; and under half a million who lived in Java at time of census stated that they lived outside Java in 1975. With an estimated natural population increase of more than 8 million in Java during the 1975-1980 period, the net out-migration of half a million from Java was insignificant. But local effects in settlement areas outside Java, particularly in Sumatra and Kalimantan, were significant. Population shifts suggest that it will become progressively more costly to reach non-acceptors who reside in (impersonal) urban centers and in remote outer islands. Program field workers, particularly volunteers, and participants, might be less willing to provide and use family planning services simply because services remain a government priority.

- We also note the absolute declines that had occurred in numbers of new acceptors in a few provinces on Java - Bali and the Outer Islands between 1981 and 1982. However, data for the latter part of 1982 and early 1983 suggest that these declines were not trend-setting; and

absolute declines in total acceptance are not taking place. An upward adjustment in married women age 15-44 years (MWRA) led to a temporary decline in numbers of current contraceptive users in official programs as percentages of MWRA.

Lastly, the BKKBN is now a large program with about 21,000 staff, over 162,000 known service points, and over 11 million acceptors. The program has a sufficiently large staff and budgeting responsibility for maintaining services to its present acceptor population.

In short, BKKBN is facing a new set of challenges over and above the central ones of maintaining coverage and improving motivation and services to the nation. Without continued aggressive steps to meet these challenges, the program risks a dilution in its effective coverage. BKKBN has a successful program. In USAID's judgment, it will continue to remain flexible and innovative to master new realities.

Challenges facing BKKBN

USAID's third FP project will assist the BKKBN in its efforts to test and institutionalize three new aspects of institutional maturity. Both BKKBN and USAID believe these will be necessary to reach the GOI's family planning goal of a 50% reduction in the CBR by 1990.

The six components of USAID assistance are designed to effect and test, amongst other areas,

- a. Improvements in management efficiency within BKKBN;
- b. The testing of user fees for family planning services and products; and
- c. The testing of new ways in which both the government and the private sectors may expand their contributions to family planning targets.

Each of these aspects are examined here to help determine ways in which family planning investments can continue to be worthwhile for the country.

Management Efficiency

Over time, operational costs of large family planning programs usually increase per acceptor. In Indonesia, additional coverage, mostly off Java, will be increasingly expensive. BKKBN already is aware of this cost dilemma, as is evidenced by its selection of 13 relatively high density provinces for more intensive Village Family Planning coverage. Further capacity for assessment will be needed if BKKBN is to reach goals above the minimum. Here, USAID's support for education, training, management, and logistics will be important, not just for expansion, but for assessment of existing BKKBN coverage. There is always a risk that the BKKBN could lose old acceptors faster than it can reach new ones, although recent data prove otherwise.

Because this USAID project leaves much of the detailed resource decisions to annual budgets for each sub-activity, criteria guiding these choices are emphasized here. Each type of BKKBN service requires analysis of its cost efficiency to guide design decisions. While sufficient field data are not available to guide each annual budget proposal, USAID will continue to review all new proposals with a stress on cost efficiency.

Voluntary sterilization, as an example of one specialized activity, may prove to be a cost effective way to increase the numbers of births averted if families accept this technique early in their child bearing years. Because this project includes testing of this approach, ongoing financial and economic evaluation will continue to be important as experience is gained.

Cost efficiency analyses also encompass cost variations by province and by management techniques, including, as discussed below, the pilot testing of user fees in the private sector.

Fees for Service and the Role of the Market

The BKKBN has started to consider possible fees for service in the public sector and an expanded private sector role for the delivery of family planning services. As explained earlier, there are several reasons for entering this experimental stage.

For reasons of budget alone, increasing numbers of beneficiaries may have to pay all or part of the cost of services offered to them, as the private sector expands its partnership role in development. To free resources for the Outer Islands, for new acceptors, and for pilot work in research and development, BKKBN will consider a strategy of fees for some service and a reliance on the private sector in mature program areas.

Separate efforts are being made in neighborhoods that were becoming increasingly impersonal. This includes a continuation of market approach work already underway in non-Javanese cultural settings. Changes in the program approach to urban areas already are acknowledged elsewhere in the Project Paper.

Should these pilots be successful, the numbers of married women of reproductive age who practice family planning and depend on private services and supplies might grow substantially in mature program areas, particularly amongst the relatively well-to-do families. The implications of such a shift for BKKBN are important, particularly for its ability to reach new acceptors and to develop a cost effectiveness monitoring capacity for the many national family planning services.

As these pilots are initiated, they will provide valuable lessons on the ways in which BKKBN might rely on market oriented approaches to program maintenance and expansion. It is already clear that for all of Java and for many areas of the other islands, commercial sales systems and advertising for consumer goods are very well developed. These systems can be drawn on to promote family planning.

In the Training portion of the project, attention will be paid to the training of staff in the techniques of assessing financial and economic efficiency.

Under the evaluations planned for this project, emphasis will be given to the costs of alternative services and sales, both public and private, in order to strengthen overall program effectiveness and to help guide program design. For this, the BKKBN will continue to maintain and make available recurring and development costs, acceptor rates, and other data for its continuing and pilot programs.

3. Social Soundness Analysis

The comparability of this project with the socioculture environment in which it is to be introduced

The Government of Indonesia is concerned with the size, rate of growth, composition, and distribution of the Indonesian people. Indonesia, the world's fifth most populous nation, has over 153 million people living in the archipelago. In 1967, President Suharto officially recognized Indonesia's population problem when he signed the World Leader's Declaration on Population; and in 1970 he established the National Family Coordinating Board (BKKBN), empowering the Board to report directly to him. Since that time, family planning performance results have been impressive.

- ... The crude birth rate has dropped 31%;
- ... The population growth rate has fallen 26%;
- ... Current users of contraceptives in the official program increased from 0.2 million in 1970 to 9.9 million by December 1982; and
- ... The prevalence of contraceptive use in the official program grew from 1% in 1970 to 43% of married women of reproductive age by December 1982. —USAID estimates that an additional 5%-6% utilize the private sector for contraceptive requirements.

These are significant indicators indeed. They portray a highly effective program that is being carried out by the Indonesian Government, a program which has found wide acceptance from the population in general. Yet such success has not come easily. Each Indonesian province has its own sociocultural, religious, demographic, and geographic characteristics. The BKKBN has permitted some flexibility to respond to varying provincial needs. However, a greater response will be called for as BKKBN deals with the provinces outside Java/Bali, with their substantially lower levels of infrastructure; more primitive modes of transportation and communications; differing attitudes toward the roles of women and children; smaller and more distant villages; fewer field staff; and weaker governmental apparatus. Yet, past performance by BKKBN has been so impressive that one expects results over the next few years to be no different from the BKKBN "norm," which has proved to be high acceptance of family planning by the Indonesian people within the sociocultural environment.

The likelihood that the project's activities which are introduced among the initial project target population will be diffused among other groups (i.e. the spread effect)

This project itself represents the "Spread Effect" of earlier projects. The BKKBN, with USAID and other donor assistance, has done a remarkable job of indoctrinating the Indonesian people into the merits of family planning. The numbers 20-2-3-30 are gaining significance today to many Indonesian women. On health grounds, don't get pregnant before age twenty. Have only two children. Space the birth of one's children by at least three years. And don't get pregnant after age thirty. When visiting villages in Java/Bali and the more advanced provinces of the Outer Islands, the foreigner is often surprised by a typical village's dedication to family planning. Women talk openly and loudly to each other and to visitors, generally about family planning and specifically about their own use of a method. The 'message' has already been received. The difficulty (which this project helps surmount) is a need for program expansion, equipment, training, further study, and the commodities involved in family planning.

Aside from an expansion of the village family planning program, this project will, as one sub-activity, concentrate resources into Jakarta and the next nine largest cities, then possibly expanding to other urban centers. Here, because of the concentration of people, USAID expects that the spread effect will be large. Improving family planning services in Jakarta is top priority because of the size of the city and its long standing lower contraceptive performance. Since it is the largest and initial urban effort, Jakarta will get a larger proportion of AID funds than other cities. The President of Indonesia has made urban family planning a special priority because of the need to ease social pressures caused by rapid urban growth and consequent demands for social services and employment. Following up on information developed from a pilot project, USAID will promote the use of public and private clinics, physicians, midwives and other commercial channels in poor and lower middle class working and residential areas. USAID expects that all of these activities will result in a significantly large spread effect as the urban population begins to make fuller use of the availability of family planning needs as well as the merits of family planning itself.

The social impact, distribution of benefits and burdens among different groups, both within the initial project population and beyond

While it is expected that all economic groups will benefit from this family planning project, the principal target groups are the poor to lower middle class urban dweller and the rural poor. The village family planning program has already been successful in Bali, and large parts of Java and several Outer Islands provinces. Now the plan is to reinforce program efforts in other priority Outer Islands provinces, West Java, Central Java, and urban areas. As in the past, we expect the pace of family planning efforts to vary widely in these areas, but we do not expect to encounter insuperable sociocultural barriers. We do expect

this program to impact largely upon the poor and lower middle class. Further, because of its nature, particularly in the village areas, we expect widespread participation by the poor themselves in shaping the program. Where we encounter a new start in a village served by a village family planning program, for example, we will continue to 'piggy back' other activities. Past village family planning programs have had widespread participation by the poor. We anticipate no change in the future.

4. Administrative Analysis

a. Introduction

The National Family Planning Coordinating Board (BKKBN) is the Indonesian agency responsible for coordinating all family planning and population programs and activities. The BKKBN was established in 1970 and has developed into one of the most effective agencies of the Government of Indonesia. It has been responsible for organizing one of the most successful family planning programs in the developing world.

b. Organization

(1) Legal Status

The National Family Planning Coordinating Board (BKKBN) is a chartered Indonesian non-departmental government agency reporting directly to the President and fully responsible for all government and private family planning activities. The BKKBN was created under the terms of Presidential Decree No. 33/72.

The main functions of the BKKBN are formally defined as coordinating, planning, supervising, and evaluating all aspects of family planning activities, both public and private. Its authority for overseeing these activities stems from its budgetary control over all family planning matters. The BKKBN itself does not directly provide contraceptive services to the public. Instead, it coordinates the work of various "implementing units" that manage the day-to-day activities of the family planning program, such as conducting information and motivation campaigns and the actual provision of contraceptive services. These implementing units consist of government ministries (i.e., Ministries of Health, Information, Education and Culture, Social Affairs, and Religion), other government bodies (i.e., the Armed Forces Family Planning Institute), and private associations (including the Indonesian Planned Parenthood Association, the Muslim Association, the Indonesian Council of Churches, and the Indonesian Catholic Social Welfare Organization). Complementing these units are the BKKBN's staff of fieldworkers, currently numbering more than 13,000 in all 27 provinces. These fieldworkers are directly responsible for face-to-face motivational work, recruiting new acceptors, supervising various acceptor group activities, and providing a major logistical link for contraceptive resupply, reporting and recording, and medical backup between the clinic and the acceptors.

In 1974/75 it became clear that the ability of the program to reach the masses of population spread across a string of islands could not be achieved primarily through a clinic-based program. Two major program objectives emerged from this conclusion.

Primary emphasis was to be placed on making the family planning program a village-oriented rather than clinic-oriented activity. Primary responsibility for managing fertility limiting activities, such as motivating, recruiting, and maintaining family planning acceptors, was to be transferred from the government directly to the people and their communities.

The second objective was to enlist the cooperation and active support of other government agencies in order to use their programs and activities to reinforce the motivation of individuals to practice fertility limitation and accept a small family norm and also to encourage communities to assume responsibility for their own fertility limitation programs. Since the mid-1970's the BKKBN has broadened its role from coordinating and funding to implementing selected activities through their 27 provincial BKKBN offices.

In addition, the BKKBN undertakes a variety of joint projects with other ministries, including the ministries of Health, Agriculture, Manpower, Transmigration and Cooperatives, Internal Affairs, and the National Economic Development Planning Board (BAPPENAS). Activities include such interventions as nutrition, immunization, and management of diarrheal diseases, and rural development projects, as indirect supports for specific fertility objectives. By linking the allocation of development resources to community achievements in fertility control programs, the family planning program can communicate to the population the critical connection between fertility limitation and its consequences: improvement in the quality of life for the individual, the family, the community.

Coordinating takes place best if the coordinator has responsibility for approving (or stopping) the flow of funds. The BKKBN has that responsibility for virtually all Indonesian family planning-related activities and most population-related activities separate from family planning.

(2) Financial status

The BKKBN receives both routine and development funds from the Ministry of Finance. The funds are released based upon reasonably detailed annual budgets. The budgets are subject to detailed negotiations amongst the BKKBN, the State Development Planning Organization (BAPPENAS), various technical ministries, and the Ministry of Finance.

The BKKBN releases budgeted funds to Provincial BKKBN offices, for use by officials of BKKBN, of other government agencies, and of non-governmental organizations (e.g., IPPA, YIS) to carry out activities agreed upon in advance. In 1982, over 70 per cent of all Indonesian Government funds for BKKBN-assisted activities were used at the provincial and lower levels.

The BKKBN's funds from the Indonesian Government budget have increased steadily over the years, from \$5.1 million equivalent in 1972 to \$86.2 million equivalent in 1982.

In addition to Indonesian Government funds, the BKKBN receives significant funds from donor agencies. The largest single donor has been USAID, with substantial assistance from the UNFPA and the World Bank. In 1982, for example, USAID obligated \$23.2 million and other donors provided \$10.4 million.

The Indonesian Government's funds as percentages of total BKKBN funds (Indonesian and donor support) have increased annually from 52 per cent in 1972 to 72 per cent in 1982.

The BKKBN has received substantial increases in Indonesian Government funds each year since its inception. However, due to economic shortfalls, the Indonesian Government's family planning/population budget for the fiscal year beginning April 1, 1983, has been reduced by 14 per cent. Although BKKBN did not receive a budget increase for the 1983/84 fiscal year, recurring costs that specifically include contraceptive procurement will increase significantly and non-recurring (capital) expenditures will account for a smaller percentage of total funds. This indicates the importance of a strong system for management and program priorities and internal financial controls.

(3) Pattern of organization

Following the Presidential elections and the naming of a new Cabinet in March 1983, the BKKBN was placed under the policy coordinating umbrella of the Ministry for Population and the Environment whose mandates are: (a) the formulation of a Population Policy and the expansion of the successful family planning program; (b) formulation of an Environmental Policy; and, (c) formulation of policy for the interaction between population and environment. Other ministries or departments under this purview are the Ministries of Health, Manpower, Transmigration, Industry, etc. However, the BKKBN, as a non-departmental government agency (badan) still reports directly to the President and is fully responsible for all government and private population and family planning activities. The BKKBN's three main tasks through REPELITA IV are: (a) the formulation of comprehensive and integrated population and family planning policies; (b) coordination of all aspects of the implementation of the family planning program; and, (c) coordination of the development and implementation of population (beyond family planning) activities.

At this writing, the Central BKKBN is in the process of reorganization in response to the three tasks listed above. The reorganization is expected by March 1984, and USAID would prefer not to predict in advance the final outcome of that reorganization. However, a Central BKKBN reorganization in late autumn 1978 did not seriously hamper the flexible approach that the Central BKKBN had separately with each of

the provincial BKKBN chairmen and their staffs. We have no reason to suggest that this flexibility will not continue after another reorganization.

Internally, the Central BKKBN organizational pattern has a Chairman; a Vice Chairman; and, reporting to them several deputies for both administrative and technical responsibilities. Reporting to these deputies are functional bureau chiefs.

c. Management

(1) Delegation of authority

The Chairman and Vice Chairman provide the operating framework for the Deputies and the Director of the Center for Education and Training.

The Deputies, provide the operating framework for their Bureau Chiefs, who are responsible for the day to day operation of Central BKKBN's activities.

One more level down, Division Chiefs within each Bureau have authority and responsibility as set forth by their respective Bureau Chiefs. It is possible that USAID's focus on management improvement in this new project will lead, over time, to the delegation of more authority to the division chiefs. _

Almost all efforts of the Central BKKBN are in support of the 27 provincial BKKBN chairmen and their activities at the provincial, regency, sub-district, village, and sub-village levels.

At the provincial level, provincial BKKBN chairmen have a dual reporting responsibility. They must report to the Central BKKBN which provides advice and counsel, personnel, funds, contraceptives, and other supplies. In addition, the provincial BKKBN Chairman must report to the provincial governors who assist the Central BKKBN as it assigns, promotes, transfers, and removes provincial BKKBN chairmen. Thus on a day-to-day basis, the provincial BKKBN chairmen report to the provincial governors.

In addition to the BKKBN, it should be noted that the Ministry of Internal Affairs advises the President on selection of provincial governors and has direct authority over the hiring and firing of regency heads (bupati), sub-district chiefs (camat), and village headmen (lurah). The success of family planning, by province, is related quantitatively to the numbers of service points and qualitatively to the degree of commitment of the governor, the bupati, the camat, and the people. One of the eight criteria under which they are evaluated is family planning. With sustained presidential support, the BKKBN at Center and Province Level has enlisted these officials in the expanding family planning effort.

(2) Experience and capability of managers

The BKKBN will be expanding its staff from 21,000 employees in December 1982 to an estimated 48,700 employees by the end of the fourth five year plan period, i.e., March 1989. They will comprise 1,200 at Central BKKBN, 4,900 at the provincial level, 14,600 at the regency level, and 32,000 at the operational field level, interfacing between sub-districts and villages. Separately, the BKKBN projects family planning/population work by an additional 1,268,000 personnel from other ministries and departments.

The staff of most Indonesian Government agencies are assigned and promoted based on fairly rigid procedures regarding educational level, age, and length of service. There has been little opportunity in most ministries to circumvent this system.

However, the BKKBN, however, when new, was able to recruit and assign to high-level positions a key number of younger, well-motivated staff; and as late as autumn 1978, during its reorganization, the Central BKKBN was able to promote to division chief, bureau chief, and deputy levels several officials who could not have met the normal governmental procedures.

With World Bank, UNFPA, and USAID assistance, the BKKBN provides ongoing training and retraining of staff at all levels. This USAID project will provide substantial additional support for training.

6. Contraceptive Supply

One of the goals of Indonesia's Third Five Year Development Plan (REPELITA III) ending in March 1984 was movement toward self-sufficiency in most major forms of contraception. Major forms presently being used in Indonesia in large amounts are oral contraceptives (pills), intra-uterine devices (IUD's), condoms, and injectibles. Also available in increasing amounts will be voluntary sterilization and currently experimental methods such as Norplant (a subcutaneous implant).

1. Pills.

An estimated 60 per cent of all contraceptive users currently are taking the pill. Assuming that pills continue to protect 60 per cent of all current users, and that the BKKBN target of a CBR of 22 per 1,000 population by 1990 is attained, the following working table projects pill availability and use in Indonesia through 1990:

Working Projections of Pill Availability and Use								
	Monthly cycles (millions), by calendar year							
	83	84	85	86	87	88	89	90
Start of year balance	98	123	141	127	133	139	144	151
AID-funded deliveries	62	56	--	--	--	--	--	--
Kimia Farma production	46	53	83	110	125	135	145	150
Other BKKBN procurement	4	8	13	16	8	3	--	--
T o t a l	210	240	237	253	266	277	289	301
Usage estimates	87	99	110	120	127	133	138	143
End of year balance	123	141	127	133	139	144	151	158

This table portrays remaining deliveries under the current five-year USAID loan for oral contraceptive procurement, conservative annual increases in Kimia Farma, Bandung, production, and equally conservative BKKBN procurement of pills separate from Kimia Farma through CY 1986, followed by a two-year phase-out. The GOI can determine the procurement mix between Kimia Farma and other sources.

End of year pill balances exceed subsequent year usage projections.

The BKKBN currently is considering the possibility of moving gradually into a lower dose pill. A large-scale USAID-assisted field study of various brands/types/dosages of contraceptives, already underway, will assist in final determination of pill choice.

Syntex, Schering, and Organon are private foreign pharmaceutical companies that are considering the possibilities of expanding their roles in Indonesian pill production, in marketing both in the private sector and directly to the BKKBN, in distribution, and/or in quality control assistance.

2. IUD's

The IUD currently protects 22 per cent of all current contraceptive users. The following working table, taken from the BKKBN's Third Draft of the Fourth Five Year Development Plan (REPELITA IV), projects IUD insertions during the Fourth Five Year Plan Period (PELITA IV) as follows:

Working Projection of IUD Use						
IUD insertions (millions) by calendar year						
Indonesian FY:	1984/85	1985/86	1986/87	1987/88	1988/89	Totals
Insertions: (million)	1.6	1.7	1.8	1.9	2.0	9.0

The BKKBN presently is encouraging the use of clinical contraceptive methods such as the IUD, both on continuation rate and cost/benefit grounds. The BKKBN projections of IUD insertions are based on annual increases in IUD wearers as percentages of all users.

With USAID funds, two Kimia Farma officials recently completed a one-month training program in the United States in the manufacture of Lippes Loop and Copper T IUD's. With Ford Foundation funds, PIACT is providing loan funds to Kimia Farma for additional technical assistance and raw materials for initial Kimia Farma production of Lippes Loop and

Cooper T IUD's. Separately, Organon, a Dutch pharmaceutical company, will be helping Kimia Farma manufacture "Multiload," the third IUD to become available for wide use by the BKKBN.

3. Other methods

Condom users now are estimated to be 5 per cent of all users. The GOI presently uses its own funds to procure condoms, usually from Japan, Korea, or Taiwan. With Japanese Government funds, Kimia Farma will be constructing a condom factory in Bandung. USAID expects that the first Kimia Farma-produced condom will be available in early 1985.

The BKKBN's Third Draft of REPELITA IV projects condom use during PELITA IV as follows:

Working Projection of Condom Use						
(thousands of gross (144 pieces))						
Indonesian FY:	1984/85	1985/86	1986/87	1987/88	1988/89	Totals
Thousands of gross	383	370	351	327	347	1,778

Injectibles, currently Depo-provera, are being used by 5 per cent of all contraceptive users. However, 33 per cent of new acceptors in March 1983 were using this method. Each injection is good for three months of protection. The BKKBN is buying them from an American pharmaceutical company, UpJohn, which makes them in its Indonesian factory.

The Third Draft of REPELITA IV projects injection use during REPELITA IV as follows:

Working Projection of Injection Use						
Millions of Injections						
Indonesian FY:	1984/85	1985/86	1986/87	1987/88	1988/89	Totals
Millions of injections	2.0	2.7	3.2	3.7	4.3	15.9

The last major method, voluntary sterilization, presently is available in over 1,566 hospitals and clinics throughout Indonesia. An estimated 18,861 male sterilizations and 70,595 female sterilizations were performed in GOI FY 1982. With bilateral funds, USAID has provided to date 1,300 vasectomy kits, 1,330 minilap kits, 100 lapracators, 40 culpotomy kits, 250 tubal ligation kits, and 400,000 fallope rings.

Selected American non-profit organizations have provided additional sterilization equipment with AID/Washington funds. All AID-funded sterilization equipment is being distributed to physicians only after they are trained and certified. USAID expects to have funds available for additional voluntary sterilization equipment as required. However, the main need for assistance in this "method" is for hospital and clinic renovation and clinical equipment, as described earlier in this PP.

4. Conclusions

The Indonesian Government expects to become self-sufficient in the production of major contraceptive methods within the next two to three years. And BKKBN officials continue to state that they will secure sufficient funds from the Ministry of Finance for expanded contraceptive procurement.

With informal assistance from USAID and other donors, the BKKBN projects and continually modifies the numbers of contraceptive users needed each year in order to reach its 1990 target of a crude birth rate reduction to 22-23 births per 1,000 population.

Based on past and present trends, the BKKBN also projects and continually refines the mix of contraceptive methods.

Going one step further, the BKKBN projects and continually modifies its budgetary outlays necessary to procure in advance sufficient supplies to meet the expanding contraceptive demands.

Per BKKBN's request, USAID is bringing in (under AID/W funding) U.S. Center for Disease Control experts in logistics for one-month consultancy services (starting near the end of May 1983). They, along with an AID/W logistics expert, will assess once again BKKBN's logistics system, provide recommendations for strengthening the system even further, and help BKKBN prepare a logistics manual both in the Indonesian and English languages, for use in Indonesia and other countries around the world.

Although USAID will be reducing its staff by one professional American, the Indonesian professional in the USAID Population Office is fully competent to help the BKKBN with contraceptive projections, budgets, procurement, storage, and distribution of contraceptives. More importantly, he is fully able to work with BKKBN to identify additional needs, if any, in these areas, so that USAID will be able to provide additional technical assistance if required.