

AN INSTITUTIONAL ASSESSMENT OF USAID SUPPORT TO
THE INDONESIA NATIONAL FAMILY PLANNING PROGRAM: 1980-1984

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I. INTRODUCTION AND OVERVIEW

The Indonesia National Family Planning Coordinating Board (BKKBN), a government agency reporting directly to the President, has stated responsibility for coordinating, planning, supervising, and evaluating all aspects of national family planning activities, both public and private. It does not directly provide contraceptive services to the public; rather it coordinates and supplements the work of various other implementing units including government agencies as well as certain private organizations.

Since 1968, USAID has provided nearly \$175 million in grant and loan assistance to the BKKBN for local program costs, technical assistance, domestic and overseas training, contraceptives and other commodities, and research. The specific focus of this evaluation is \$27.92 million provided since 1978 under the Family Planning Development and Services Project (No. 0270). Over half of these funds have been used to provide supplemental grant funding for local costs of program implementation in selected provinces. This flexible mechanism is widely recognized as a major contributor to program success to date. Related projects include the recently concluded \$56.1 million Oral Contraceptive Loan (No. 0271) and the new \$23.40 million continuation project, Family Planning Development and Services II (No. 0327). This latter project, although not a subject of this evaluation, represents a thoughtful response to much that has been learned by the BKKBN and USAID in the course of Project 0270 implementation.

This report examines institutional impacts of USAID assistance to the BKKBN. Companion studies, recently completed by John Ross and Dennis Chao respectively, contain analyses of the demographic and public expenditure impacts of the Indonesian family planning program. These studies report that a significant number of births have been averted by contraceptive use and that consequent long-term savings in estimated public health and education expenditures result in a very favorable benefit-cost performance for the family planning program.

In 1984, total direct and indirect 1984 USAID assistance to the Indonesia family planning program reached \$12.25 million out of total BKKBN expenditures of \$90.1 million (including other donor funds). Budgeted Government of Indonesia funding of over \$65 million in 1984 thus represents over 70 percent of total BKKBN expenditures, an increase from 60 percent in 1978 and under 50 percent in the first decade of the program.

To large degree this assessment builds on the findings of the December, 1979 evaluation report, "USAID's Role in Indonesian Family Planning" by James Heiby, Gayl Ness, and Barbara Fillsbury. That report concluded that fertility was declining, the Indonesian Family Planning Program was playing a major role in that decline, and USAID was providing highly effective support to the program.

Those conclusions remain generally valid six years later. Since 1978, the percentage of Indonesian Married Women of Reproductive Age (MWRA) who are active contraceptive users, as monitored by BKKBN service statistics, has doubled from 30 to 60 percent, reaching a current total of nearly 15 million. In the same period, the crude birth rate (births per 1000 population) has dropped from 36 to 29 while the number of family planning service points has increased from 65,000 to over 200,000. The 13,000 BKKBN field workers and countless village volunteers working in this network remain the key to program success, carrying out critical face-to-face motivational and informational functions, recruiting new acceptors, supervising acceptor group activities, and providing a major logistical link for contraceptive resupply and program data.

Sources of program strength cited by the 1979 report centered on institutional factors such as a strong goal orientation, program and funding flexibility, administrative capacity, and support for decentralization, attributes observed in both the BKKBN and USAID and enhanced by the high quality of collaboration between these agencies. Sources of concern included potential problems associated

with expansion of the successful Java/Bali program strategy to very different settings in remote rural locations and large cities. Subsequent experience has demonstrated the validity of those conclusions.

The present assessment reports the successful institutionalization within BKKBN of critical management processes and procedures previously dependent to large degree on USAID initiative and technical support. The USAID-assisted emphasis on training and other technical support for participants throughout the family planning network has visibly contributed to program implementation at all levels.

On the other hand, the report also cautions that the rapid expansion of the Indonesian family planning program has led to a growing bureaucratization, threatening the vigor and flexibility that undergird past program success. The realities of the demographic pyramid and contraceptive mix in Indonesia are such that new cohorts of MWRAs in need of contraceptive services will tax BKKBN systems at the same time that the demands of simply maintaining the growing user base severely test administrative capacities. Successful application of the Java-Bali Village Family Planning model to Indonesia's outer islands and urban areas remains a serious question mark. In addition, Indonesian budget austerity will limit the availability of resources to support the quality and creativity of services that the Indonesian demographic situation increasingly requires.

The BKKBN program and USAID support for it are well documented. The rest of this report examines key measures of program effectiveness, highlights major strategic initiatives, and considers their institutional implications. The focus is on the specific impacts of USAID assistance in the 1980-1984 period rather than the BKKBN program as a whole. The report concludes with a summary of findings and recommendations in terms of lessons learned for the Indonesian family planning program and for USAID assistance to it.

II. 1980-1984: THE PROGRAM MATURES

Measures of Effectiveness:

A nationwide family planning reporting and feedback system is in place and is utilized by the BKKBN and its implementing units for management, supervision, and planning purposes. Analysis of data from this system provides a useful basis for assessing program effectiveness. This section uses selected indicators to illustrate program progress in the 1980-1985 period. The reader is also referred to the John Ross and Dennis Chao chapters.

The national family planning program was officially started at the beginning of the First Repelita (Five-Year Development Plan) but then only covered 6 provinces in Java and Bali. In the Second Repelita, coverage of the program was expanded to 10 other provinces which were categorized as Outer Islands I. In the Third Repelita program coverage was extended through the remaining provinces in the country. The gradual expansion throughout the country reveals a priority approach based upon the population size, density, and institutional and community readiness.

The ambitious goal of the family planning program is to reduce the level of fertility by 50 percent by 1990 to about 22 births per one thousand persons. In order to achieve this, BKKBN has set up its extensive implementation network to motivate eligible couples, supported by nationwide contraceptive distribution centers and a comprehensive reporting and feedback system which to date, has been utilized for management, planning, and supervision purposes.

Family Planning Service Centers:

Within the period of Repelita III, the Indonesian family planning program has grown rapidly through expanding service centers linked to village level supply posts. This strategy has helped extend the delivery system from sub-district health clinics to

village-level posts. Within the village, extension of services was extended down to smaller neighborhood implementing units. The villages therefore have been encouraged to form and organize acceptor groups in which the clinic can extend itself closer to the individual acceptors and target groups.

TABLE 1. FAMILY PLANNING SERVICE DELIVERY CENTERS
1981 AND 1984

	1981	1984
<u>Java and Bali:</u>		
Hospital and Health Clinics	3,140	3,970
Village Depots	20,613	31,069
Village Groups	75,919	99,352
Service points per 1000 MWRA	10.7	8.0
Ratio Village Groups to Clinics	24.1	25.0
<u>Outer Islands I:</u>		
Hospital and Health Clinics	1,589	2,319
Village Depots	13,398	24,262
Village Groups	18,199	33,418
Service Points per 1000 MWRA	6.1	10.0
Ratio Village Groups to Clinics	11.4	14.4
<u>Outer Islands II:</u>		
Hospital and Health Clinics	680	1,249
Village Depots	300	6,292
Village Groups	-	1,047
Service Points per 1000 MWRA	0.6	4.0
Ratio Village Groups to Clinics	-	0.8
<u>Indonesia:</u>		
Hospital and Health Clinics	5,609	7,536
Village Depots	34,311	61,623
Village Groups	94,118	133,857
Service Points per 1000 MWRA	9.0	8.0
Ratio Village Groups to Clinics	16.6	17.8

The idea of family planning in Java and Bali has matured. It has become an accepted movement, and the community has maintained its motivation by forming kelompok akseptor (acceptor groups). This indicates that communities have developed a sense of ownership in the program and the belief that family planning contributes to family welfare. The formation of PosYandu (integrated service post) reflects community participation in an integrated and wholistic approach to family welfare. However, this development is not yet evident in all the outer islands which is understandable in view of the relative duration of the program and the spatial distribution of communities from each other.

While considerable success has been met with the experience in Java-Bali, outer island strategy should be careful in adopting a similar structure of service delivery because of socio-cultural and demographic differences. Hence, community institutions such as pacuyuban, Apsari, and others which have been used effectively in Java-Bali need to be considered carefully before applying family planning strategies in outer islands. Social investigation in group behavior of communities in outer islands need to be reexamined. However, there is encouraging evidence on further expansion of contraceptive service points in Java-Bali, and the Outer Islands I areas. For Java-Bali the number of service points per 1000 MWRAs has actually declined in recent years. This is a result of the fact that the number of MWRAs has increased demographically. The important point to note is that the extension of services in the clinics has wider coverage in Java-Bali (15 family planning acceptor groups per clinic) as compared to 14 acceptor groups per clinic in the Outer Islands I provinces.

Acceptors and Current Users:

The performance of the family planning program is clearly impressive. The number of new acceptors has increased from 3.2 million to 17.4 million during Repelita III (1979-1984) which constitutes about 129 percent of the targeted number of 13.5 million new acceptors. Current users by the end of 1984 reached 14.4 million, representing almost sixty percent of Married Women of Reproductive Age (MWRAs). Acceptor and current use data is summarized in Table 2.

TABLE 2. FAMILY PLANNING ACCEPTORS AND CURRENT USERS
AS OF REPELITA I, REPELITA II, REPELITA III

	Total New Acceptors (000)			Current Users (000)			Percent Current Users to MWRA		
	I	II	III	I	II	III	I	II	III
Java and Bali	3,201.5	8,972.8	12,713.7	1,680.6	5,001.8	10,776.2	12.4	33.3	66.8
Outer Islands I		1,263.8	3,748.4		539.7	3,137.2		9.9	51.2
Outer Islands II			917.5			509.0			22.5
All Indonesia	3,201.5	10,236.6	17,379.6	1,680.6	5,541.5	14,422.4	12.4	27.0	58.8

Source: BKKBN

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Regional performance during the three Repelitas reveals an interesting picture. During the early stages of the family planning program, East Java became the leading province in recruiting new acceptors. However, by the end of Pelita III, the status of East Java was replaced by West Java followed by Central Java in terms of the number of new acceptors. This may be attributed to the concerted special campaigns (SAFARI) in West Java. Maintenance of this surge of new acceptors has proven difficult, however.

Looking at the age structure of the new acceptors, from Repelita I to III, there is a trend toward younger women entering the program (Table 3). The implication to the program is an increased demand for contraceptives as younger cohorts of MWRAs become eligible.

TABLE 3. MEDIAN AGE OF NEW ACCEPTORS

	INDONESIA	JAVA-BALI	OUTER ISLANDS I	OUTER ISLANDS II
REPELITA I	28.2	28.3		
REPELITA II	25.6	25.9	27.6	
REPELITA III	25.4	24.9	27.0	26.5

Source: BKKBN

The use of a modern contraceptive mix has been eagerly promoted by BKKBN. There was a tendency in Repelita I and II among contraceptive users to prefer the pill over the IUD. In Repelita III the trend has been reversed and, moreover, the use of the Depo-Provera injection shows a consistently increasing trend. This implies that women are now looking for more secure convenient, and economical methods of contraception. Therefore, the trend of increased usage of injectables has implications for service, logistics and funding of this type of contraceptive. (Figure 1 shows contraceptive mix trends in the 1970-1984 period.)

Figure 1.

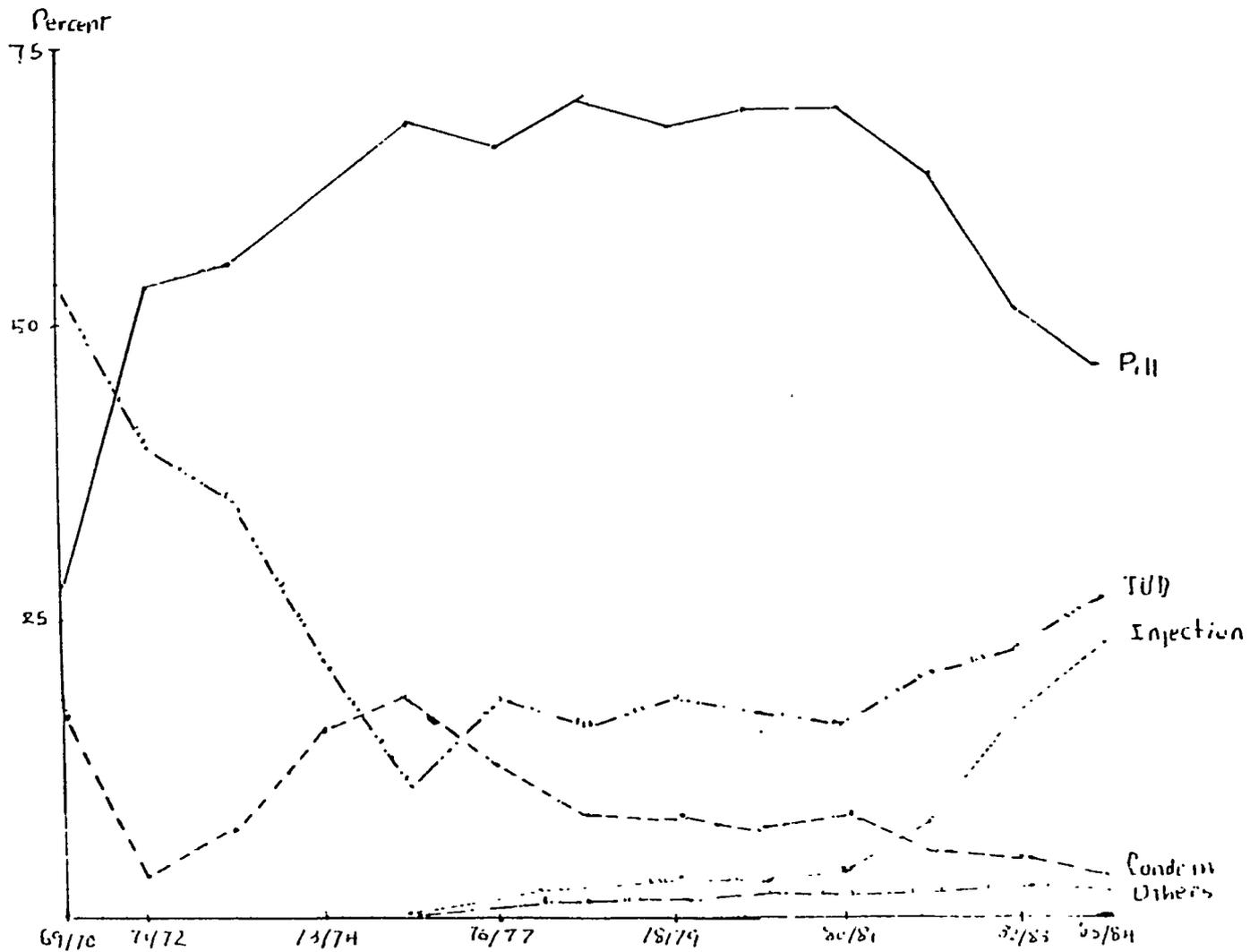


FIGURE 1 PERCENTAGE OF NEW ACCEPTORS ACCORDING TO METHODS OF CONTRACEPTIVES, PELITA I, PELITA II, PELITA III

Source: BKKBN

Realizing the motivations of women to adopt contraceptives, efforts to promote accurate information on the strengths and weaknesses of contraceptive options will have to be intensified. Feedback from community leaders has revealed some deficiencies in the evenness of service delivery. In part of West Java, for example, there was a strong promotion of the use of IUDs, even for women who may have voluntarily chosen an injectable or pill. The risk of losing these acceptors because of the "hard sell" on one specific method is possible.

Cost Effectiveness:

The cost effectiveness of alternative contraceptive techniques currently provided by the program is not available from current BKKBN statistics. Better availability of data on cost per new acceptor, cost of couple year of protection, and cost per birth averted would greatly enhance successful planning and implementation of the program. The difficulty in computing these costs can be attributed to non-specification of budget items for the specific program output. For this reason it would be useful to develop a costing system which will allow the computation of critical cost-related indicators.

Cost per Acceptor:

In the geographic area of Java and Bali, high population density and better infrastructure facilities contribute to the fact that program costs per acceptor have remained low. In outer island areas, cost-per-user are correspondingly higher (Table 4).

TABLE 4. COST PER CURRENT CONTRACEPTIVE USER
1980 -1985

	1980 - 81		1982 - 83		1984 - 85	
	Rp.	\$	Rp.	\$	Rp.	\$
	Java - Bali	2,256	3.61	3,479	5.31	1,514
Outer Islands I	4,877	7.80	6,929	10.58	3,037	3.04
Outer Islands II	11,665	18.66	1,9779	30.20	8,380	8.39

Source: BKKBN

The data suggest that it will be more beneficial to pay future attention to areas with low costs. Although this approach may be economically sound, a much broader aim of the small and prosperous family norm is the concern of BKKBN. This also implies equitable opportunities for all Indonesians to achieve this aim. In this context, while provinces such as Irian Jaya, Maluku, Southeast Sulawesi, and others may initially incur a higher cost than in Java-Bali, BKKBN is now at a stage where expansion to other areas is politically mandated.

Cost Per Couple-Year of Protection:

Couple-year of protection is based on the number of years the couple is protected against pregnancy while using program-supplied methods of contraceptives. Based on the budget available for each fiscal year, the cost per couple-year of protection can be calculated by dividing the budget for that fiscal year with the estimated couple-years of protection obtained. These data are summarized in Tables 5 and 6.

TABLE 5. COST PER COUPLE-YEAR OF PROTECTION
1979 - 1984

	1979/80	1980/81	1981/82	1982/83	1983/84
Java - Bali	1,583	2,037	2,100	2,207	1,462
Outer Islands I	3,791	4,857	5,461	4,376	2,584
Outer Islands II	14,559	16,314	15,267	13,276	7,098
INDONESIA	3,110	4,674	4,296	4,363	2,784

Source: BKKBN

TABLE 6. COST PER COUPLE-YEAR OF PROTECTION
REPELITA III (Rp.)

	1979/80	1980/81	1981/82	1982/83	1983/84
DKI. Jakarta	2,344	3,155	3,352	3,727	2,051
West Java	1,977	2,964	2,591	2,438	1,534
Central Java	1,657	1,832	2,155	2,384	1,422
Yogyakarta	2,687	2,361	2,310	2,258	1,806
East Java	1,179	1,562	1,593	1,693	1,286
Bali	2,455	3,666	3,379	3,380	1,919
- Java-Bali:	1,583	2,037	2,100	2,207	1,462
Aceh	8,088	11,014	14,394	10,481	6,282
North Sumatra	3,501	3,682	5,056	3,645	1,569
West Sumatra	4,560	6,636	6,782	5,674	4,333
South Sumatra	5,300	6,671	6,721	4,671	2,603
Lampung	1,801	2,423	2,673	2,469	1,134
N.T.B.	3,817	4,562	3,781	3,289	2,082
W. Kalimantan	8,403	10,188	12,788	8,374	4,775
S. Kalimantan	4,930	5,285	6,734	6,708	4,274
N. Sulawesi	2,592	3,851	5,043	5,269	1,963
S. Sulawesi	4,453	4,232	3,529	3,152	2,239
- Outer Islands I:	4,034	4,857	5,481	4,479	2,583
Riau	15,001	12,173	10,104	8,287	5,541
Jambi	10,910	14,746	10,495	8,476	5,122
Bengkulu	5,880	6,227	6,069	7,494	4,608
N.T.T.	33,969	20,557	20,217	14,477	6,649
Central Kalimantan	22,051	18,761	26,735	22,538	10,448
E. Kalimantan	10,425	13,398	10,447	9,636	5,342
Central Sulawesi	20,165	17,495	15,842	12,082	5,167
SE Sulawesi	17,515	23,050	42,857	20,623	10,954
Maluku	12,910	25,158	22,004	23,297	8,337
Irian Jaya	17,609	59,459	58,285	43,117	24,902
East Timor	-	-	49,127	36,733	19,922
- Outer Islands II:	14,559	16,314	15,277	13,276	7,098
INDONESIA	3,110	4,674	4,296	4,363	2,784

Note: SE Sulawesi shows a sharp increase in 1981/82 due to increased expenditures of GOI resources by the province.

Source: BKKBN

The result of this computation reveals that cost to protect against pregnancy in Java-Bali is initially lower than the cost in outer islands. However, by the end of 1983/84 costs in all areas showed a declining trend.

Strategy Issues:

Since 1974, the strategic underpinning of the Indonesia family planning program has been an approach called Village Family Planning (VFP), a program of information, motivation, and contraceptive services centered at the village and, in some areas, neighborhood level. The VFP model attempts to supplement clinic-based activities and provide equity of information and services to every village in Indonesia through a progression of village family planning posts, sub-village posts, and acceptor groups. The VFP strategy is based on the assumptions that:

- there is a direct relationship between access to information and contraceptive services and the level of contraceptive use, and
- family planning behaviour should be institutionalized as a village social process.

In outer island provinces, problems emerge with this model due to problems of communication, administrative infrastructure, and socio-cultural-religious variations. Thus a major issue for the Indonesia program is whether the VFP model developed in Java/Bali is flexible enough to accommodate regional differences both provincially and interprovincially in the outer islands.

Foundations for the village program are the relatively homogeneous populations, tight-knit community structures, and the extensive BKKBN contraceptive distribution system. These characteristics are often weak or absent in Indonesian urban areas.

As a result, family planning progress in cities has not kept pace with the rural program despite the availability of clinic-based services since the start of the program. In general, urban clinics are poorly utilized, neighborhoods are loose-knit, populations heterogeneous, and community structures relatively weak. Key questions for the family planning program are what factors significantly influence urban program performance and, especially, what unique strategies can be used to bring information and services to this elusive population segment.

This section examines the BKKBN's village and urban strategies as illustrations of how the program has matured and how USAID assistance has strengthened the institutional capacity of the BKKBN to implement these strategies.

Village Family Planning:

For several years BKKBN, with USAID assistance, has continued to extend, expand and refine its village family planning (VFP) program. Based upon successful experience on Bali and most of Java, a basic model for this program has been developed and applied to the other islands in the archipelago. The basic aim of the VFP approach is to not only bring information and contraceptive services close to the people, but also to place responsibility for program growth and maintenance in the hands of acceptors at the village and sub-village level. Through community participation and emphasis on self-reliance, it is hoped that family planning norms and values will be institutionalized in village society.

In essence, the VFP model is a generic form which allows for local variation as the need arises. Usually, however, it involves the establishment of a contraceptive depot in the village managed by a village volunteer (PPKBD). There is one PPKBD per village. Furthermore, sub-village posts (sub-PPKBD) and neighborhood acceptor groups (kelompok akseptor) may be formed, drawing their contraceptive supply from the village depot. These village and

sub-village units provide support and motivation for their members and seek to recruit new family planning acceptors as well. Supervision and support of the PPKBD is carried out by the BKKBN field worker (PLKB) who forms the crucial link between the sub-district health center (PUSKESMAS) and sub-district administration on the one hand and the village community on the other. He/she is responsible for resupplying the PPKBD with contraceptives and other supplies, collecting reports, assisting in recruiting new acceptors, approaching formal and informal village leaders, and helping where need arises. The PLKB is supervised by the fieldworker supervisor (PPLKB) who works at the sub-district level.

Currently, there are more than 33,000 PPKBD and 148,000 sub-PPKBD on Java and Bali. On the other islands there are more than 27,000 PPKBD and more than 26,000 sub-PPKBD listed.

During the past five years, USAID assistance to the VFP program has provided selective supplementary funding for the operational costs of, for example, increased coverage of travelling family planning teams; strengthening institutional linkages through meetings on program policy and implementation at provincial, regency and sub-district levels and coordination, orientation and guidance meetings at village level; training in population and family planning at all levels; administrative and material support for printing of forms, certificates and manuals; and program review. Whenever possible, USAID has assisted innovative activities or problem-solving approaches. For example, providing a new level of extension worker in one province to extend limited community health center services to the community. Funds have been used in sixteen priority-provinces where more than 80% of the Indonesian population live.

Flexibility of the VFP Model in the Outer Islands:

As the village family planning program has been extended to the outer islands, it has become clear that flexibility and adaptation to diverse local conditions are key factors in program success. Area differences in topography, population densities, settlement patterns, means of communication and transportation, administrative infrastructure, social networks, cultural and religious beliefs and economic means are great. It would be unwise to assume that VFP model based solely on the successful Java/Bali experience could be applied with equal success to all the islands of Indonesia.

Fortunately the BKKBN program strategy leaves sufficient room for flexibility and adaptation to varied local settings. This strategy aims at increasing the number of new acceptors and contraceptive prevalence, re-recruiting dropouts, bringing information and services closer to the people, increasing community participation, shifting acceptors to more effective contraceptive methods, increasing BKKBN and implementing unit personnel skills, and integrating population and family planning into other sectors of community life.

BKKBN is aware of the need for program innovation and creativity to fit local conditions and promotes these values in its informational and motivational activities with the local government apparatus. However, it is in the implementation of its strategy that constraints to flexibility arise. The BKKBN must work through local government administrative and implementing units to reach down into the community. These units from province to regency, sub-district and finally village may or may not represent responsive, manageable and cost-effective components for applying the VFP model as developed on Java and Bali. In thinly populated, heterogeneous, and isolated outer island areas, new models that more directly address the cost-effectiveness issue may be needed. In the face of Indonesian budget austerity this issue takes on added importance. USAID assistance to the VFP concept should now be

directed to supporting BKKBN efforts to better incorporate considerations of cost-effectiveness in its outer islands strategy and program development.

Quality of Services:

Besides developing new VFP models for outer islands areas, another issue is gaining in importance as the VFP program matures. This important issue is the quality of services at the village and sub-village level. Although insuring the quality of services is a stated policy of the family planning program, it became apparent in talking with field workers, family planning acceptors and non-acceptors that more and higher quality education and information on family planning and contraceptives are desired. Many of those concerned with recruiting new acceptors to the program are unsure of their knowledge and ability to convince non-acceptors to join. As the VFP program matures, non-acceptors and drop-outs will represent an increasingly difficult group to win over and enhanced training will be required to support village and sub-village level efforts at recruitment and maintenance. This will require more attention to improving fieldworker capabilities and skills. They are the ones to whom the village volunteers first turn for advice and support in family planning matters.

In addition to increased education and training, village volunteers also express a desire for better follow-up services such as prompt repayment of expenses for contraceptive (IUD) complications requiring treatment in the health center or hospital. Long delays in reimbursement can undermine program credibility and thus the ability to recruit new acceptors.

In many villages, availability of a wide range of contraceptive methods is considered desirable, but not yet sufficiently convenient to meet needs. For example, in one West Java village women desiring sterilization had to wait until resources could be pooled with other women in order to pay for transportation and other costs to the nearest facility (a distant hospital).

Perhaps one of the most distinctive and valuable features of the VFP program is the pattern of frequent meetings among the various levels of the system. One of these is the monthly meeting of the village volunteer workers (PPKBD) at the sub-district level. At these meetings the village volunteers present their monthly reports on contraceptive performance to the BKKBN fieldworker supervisor. These meetings are also a forum for informing village volunteers about new developments and urgent issues, if any, but more importantly they allow the volunteers to discuss problems they are facing and to ask advice on how to solve them. This is an important feedback mechanism that deserves continuing serious attention by BKKBN and local officials. That this mechanism does not always work as it should was typified by one district visited in West Java. There the various village volunteers and BKKBN had signaled for months that their inability to readily offer more than IUD contraception (the local district government policy) was resulting in difficulties in recruiting new family planning acceptors and, in some cases, causing dropouts. Only after BKKBN service statistics started showing poor performance was the regency head persuaded to allow a more flexible contraceptive mix.

It seems obvious that, as the VFP program continues to mature, quality of services at the lowest levels of the system will require increasing attention from BKKBN. USAID assistance should address this concern and support BKKBN in its efforts to improve the qualitative aspects of the VFP program as its successful organizational infrastructure expands and matures.

The Urban Program:

The growth of Indonesian cities is taking on explosive proportions. Many city growth rates are higher (some two, three or four times higher) than the national growth rate and this current population is estimated at 25% of the total population with a projected increase to 35% by the year 2000. The demographic importance of cities continues to grow and with it the attention of

BKKBN to urban problems. For several years it has been recognized that in large urban areas fertility control through family planning has not performed as well as had been anticipated and application of successful village family planning approaches has proven problematical.

Urban Initiatives:

For the past several years, BKKBN has devoted much time and energy to obtaining urban-specific information and to searching for approaches to increase family planning acceptance in urban settings. In 1977, the first in a series of workshops and seminars devoted to urban issues was conducted. In 1980, donor funds began to flow for urban programs and a large scale market research survey using a commercial market research firm was carried out in Jakarta. This survey not only established a better estimate of contraceptive prevalence (33% of currently married women) but also answered questions of how consumers perceived the family planning program and its services. Prior to this quantitative survey work, qualitative research in the form of focus group discussions was conducted. Results of both quantitative and qualitative research showed that there was a large unmet need for family planning services, that women did not know where to get services, and that their knowledge of different contraceptive methods and effectiveness was limited. In short, the existing BKKBN system of clinics, fieldworkers and volunteers, developed in the VFP program, was not reaching the majority of urban women. Private sector providers were only passively involved in the system.

Using Jakarta as the focus for experimentation, the BKKBN began a number of initiatives aimed at improving program performance. In the public sector, on-site assessment of government clinic equipment and staff training needs was carried out. Family planning clinics were renovated and re-equipped and clinic staff retrained. A mass media campaign was designed and launched by a commercial company. The media campaign was plagued with bureaucratic problems, however.

In the private sector, BKKBN, with USAID assistance, asked a private foundation, Yayasan Kusuma Buana (YKB), to develop semi-commercial family planning clinics as an experiment in new ways of service delivery. These clinics, located in lower income neighborhoods, are geared to the urban acceptor who wants to pay for what he/she considers better quality service yet who cannot afford the expensive services of a specialist. The clinics are midwife-managed and these midwives are the primary service providers. Physicians function as back-up and perform certain technical procedures when necessary. Due to client demand, basic health services are also offered. Contraceptive implant field trials are part of the clinic activities. By 1984, there were a total of nine YKB-sponsored clinics functioning, one of which is economically self-sufficient.

In addition, BKKBN asked YKB to activate networks of private physicians and midwives to increase their participation in family planning services. These networks were to provide further service points in neighborhoods surrounding the clinics. YKB organized, trained, supplied and monitored these practitioners. YKB receives its supplies from BKKBN and pharmaceutical companies who sell at cost. It should be noted that this and many of YKB's other activities have been hampered by BKKBN and city government bureaucratic redtape and delays.

Additional initiatives were undertaken by BKKBN. An assessment was made of private sector potential in five other cities - Semarang, Surabaya, Ujung Pandang, Medan and Palembang. In 1983, with USAID assistance, a large contraceptive prevalence survey in Jakarta and the previously mentioned cities, except Palembang, was conducted. Survey results showed that prevalence rates in Jakarta had increased to 42.3%. Information was gathered on factors influencing contraceptive acceptance, the influence of women's jobs on contraceptive services, various possible communication channels for conveying family planning messages and public perceptions of the

family planning program. Several specific recommendations were made on information, education and communication (IE&C) programs; voluntary sterilization; worksite programs; postpartum approaches; and logistics.

Toward an Urban Strategy:

In reviewing urban program progress in the past five years, it is obvious that BKKBN has been active on many fronts, in some instances with USAID-funded assistance. Training of physicians and midwives, development of public and private clinic and service provider networks, providing equipment and supplies, expanding information, education and communication campaigns, experiments with fee for services, and testing of new contraceptive methods have all been tried. Acceptor prevalence rates in Jakarta, where most of these activities received special attention and support, have risen, albeit to levels still below the national average. However, as one reviews the various activities and the processes by which they occurred, it becomes clear that development of a comprehensive urban strategy for Indonesian cities is still lacking sufficient support. A wealth of information and experience has been generated and both public and private resources tapped, but fitting these into an integrated urban framework, backed by strong political commitment, has not yet occurred. It is as if the BKKBN is hesitant to act on the consequences of the conclusions being drawn from its own findings. These findings point to the need for BKKBN to take a strong stand as a facilitator of a wide variety of both public and private family planning services and initiatives. It must serve rather than control. This means, for example, that certain practical urban specific needs must be met such as reducing bureaucratic procedures and redtape for licensing private sector providers (midwives and small private maternity hospitals, for instance); providing IE&C services such as specifically listing service points, providers, costs and methods including voluntary sterilization; facilitating the availability of services in cases of contraceptive complications and failures; retraining fieldworkers

for more urban-specific roles; promoting social market research for a wide variety of products; insuring quality of services through training and retraining of public and private providers; and encouraging worksite family planning programs for men.

One way BKKBN could expedite creation and implementation of a sound urban family planning strategy would be to form an operational urban program task force with the mandate to cut through bureaucratic redtape and support urban specific initiatives in a coordinated way. Such a task force could overcome some of the limitations imposed by BKKBN's functional structure and lend credence to BKKBN's commitment to solving urban problems. To be effective, however, such a task force would have to be given financial and political clout as well as creative and knowledgeable staff. Similar task forces could be formed at the provincial level. USAID should assist BKKBN in this endeavor through technical assistance, local cost funding and increased staff training in urban planning.

III. INSTITUTIONAL IMPLICATIONS

Observation of the development and outcomes of the two major USAID-assisted BKKBN program strategies discussed in the previous section permits certain conclusions about institutional aspects of the Indonesian family planning program and related impacts of USAID assistance.

From the standpoint of Project 0270, anticipated outcomes included national family planning service availability, an increase in trained personnel for program administration, in-country manpower development capability, Government of Indonesia funding of ongoing activities, and a series of program-related population policy studies. These objectives have largely been realized as have expectations for the expansion of family planning service points and increases in contraceptive use. Highly optimistic USAID projections for life-of-project reductions to a crude birth rate of 24 and population growth rate of 1.3 percent (expectations not shared by the BKKBN or any outside researchers) have proved unrealistic. Nonetheless, as reported earlier in this report, progress in measures of fertility reduction has been significant.

In retrospect, particular contributions of USAID assistance have included thorough testing and expansion of the village family planning concept, the development of national contraceptive supply, training for key leaders and program participants at all levels, support for improvements in management systems and coordination, and research and development to support new ways of delivering information and services. As emphasized in the 1979 evaluation, a key factor behind the particular value of USAID assistance has been the unique (for USAID in Indonesia) supplemental funding mechanism employed to provide advances of quarterly funding needs for flexible and prompt support for local initiatives, including some perceived as too risky for normal Government of Indonesia funding channels. This mechanism stimulates local initiative by responding to that initiative with timely, visible, and effective support.

Ironically, in view of past and continuing program success, several major 1979 evaluation findings regarding USAID's role do not seem to have been clearly translated into "lessons learned". That report summarized conditions essential to effective USAID support of the Indonesian family planning program as "1) mutual interest in moving money rapidly to the people who need it; 2) mutual commitment to outcomes rather than procedures; and 3) personal and trusting relationships between USAID and BKKBN staff." Five years later, although the local cost funding mechanism for the BKKBN program (and other population and health projects) has survived, the USAID mission has not approved this flexible approach for other programs for reasons that risk appearing as a "commitment to procedure". Within the population program itself, the time required for processing and funding BKKBN proposals to USAID has lengthened from the 1979 standard. Reasons include more attention to planning quality and tighter financial accountability.

Two factors are significant with regard to the staff issue. First, despite the earlier evaluation's discussion of the benefits of an independent population office, the office was subsequently merged with health and nutrition, diluting staff attention to population matters and creating a perception of deemphasis on the part of some Indonesian officials. Second, despite the 1979 report's citation of the importance of a "high quality, technically competent, and culturally sensitive" population staff, a very effective departing staff member who has superb professional and personal relationships with BKKBN personnel is not being immediately replaced, and there is fear that, given current USAID personnel policies, factors of technical competence and suitability for the Indonesian program may not be dominant factors in selection of his eventual successor.

Several specific elements of USAID's assistance to the BKKBN have aimed at strengthening its institutional capacity for planning and implementation. This assistance is discussed below in terms of

five interrelated program elements: program planning; information systems; manpower development; and procurement, production, and logistics. This discussion is preceded by a brief look at BKKBN organization.

Organization:

The BKKBN has been justly praised for its effective organization and its flexible, experimental, action-based approach to achieving its goals. Unlike most government bureaucracies, it did not initially organize its programs around functionally defined and centrally determined purposes but, instead, demonstrated considerable capacity to adapt its programs to local needs and conditions.

Rapid growth of the BKKBN and certain Indonesian political realities now place some of these attributes at risk. Following the Indonesian elections of 1982 and subsequent naming of a new cabinet, the BKKBN was placed under the policy coordinating umbrella of the State Ministry for Population and the Environment (KLH), mandates of which include formulation of broad population policy and, in that context, expansion of the family planning program. The BKKBN, however, still reports directly to the President and remains responsible for coordinating all government and private family planning activities. The relationship between BKKBN and KLH is not yet entirely clear and their respective perceptions of role differentiation vary. As one example, the previously noted BKKBN goal of reduction in crude birth rate to 22 by 1990 is seen by the BKKBN as a national goal. KLH, by contrast, cites the current Indonesia Five-Year Plan target of 31.5 by 1989, and views the BKKBN goal as only an internal "working" target. Such differences of perception suggest potential problems of coordination at the highest levels of family planning policy. The situation is further complicated by the critical role of the Ministry of Health in family planning service delivery.

Working relations between this Ministry and the BKKBN are strained at several points of bureaucratic overlap. This important issue is outside the scope of this report but is cited as an example of the need for further high-level policy guidance to assure that the various key actors in the family planning drama are reading the same script.

Reorganization:

Although its mandate was narrowed by the creation of KLH, the BKKBN subsequently (1983) reorganized into a larger and more complex structure. An arrangement that included 14 operational bureaus reporting to four deputy chairmen ballooned into one with 24 bureaus (or centers) and 6 deputy chairmen. In some cases, this expansion has diffused management responsibility, particularly for fieldworkers who now have administrative and operational accountability to several bureaus. The problem of overlapping responsibilities has also increased. Nonetheless, on paper, the organizational structure represents a logical functional breakdown of duties and, with time and effective supervision, should serve administrative needs.

More fundamentally, however, some question the rapid growth of BKKBN organization and staffing as inconsistent with the off-stated objective to transfer program management to local communities. Others see it as the inevitable result of the accretion of programs, projects, and donors by the BKKBN, some of which may be inappropriate. In any case, the BKKBN must carefully guard against the attractive but fatal bureaucratic lure of organizational growth for its own sake.

Decentralization:

Most of the efforts of the central BKKBN are in support of the 27 provincial BKKBN chairmen and their activities at provincial and local levels. This support includes definition of program parameters and targets, advice, training support, personnel, funds,

contraceptive supply, and interface with the national budget approval process through BAPPENAS, the national planning body, and the Ministry of Finance. Provincial BKKBNs also report to their respective provincial governors who have political charge over the entire local government apparatus. In view of the importance of local officials (over whom the BKKBN has no control) to the success of Village Family Planning, these relationships are crucial. One structural incentive for local officials to support family planning is that it is one criteria by which they are officially evaluated. More important are the quality of relationships between the BKKBN apparatus and local officials and the family planning training and motivation provided to them through the BKKBN. BKKBN performance in these areas has been very good, in part due to extensive and timely USAID assistance for the costs of widespread local coordination and training activities.

Staffing:

The BKKBN estimates that its total staff will nearly double to a total level of over 48,000 by 1989. Of these, about 1200 will be at the central office, an increase from the current 800. Over half of the total current staff are local fieldworkers. The BKKBN estimates that the total involvement of personnel in the program (including all implementing units) is over 1 million.

As a relatively new agency, the BKKBN historically has been able to recruit, assign, and promote younger, competent, and well-motivated staff to positions of responsibility. Individual staff quality and creativity remains unusually high but there is evidence of a declining ability to circumvent rigid government assignment and promotion procedures. A number of effective field personnel have been transferred to Jakarta where their skills are less well used. A growing focus on administrative and procedural orthodoxy in place of creativity also characterizes some recent personnel actions.

Strategy Development:

A loss of creativity is only one price of the growth and bureaucratization of the BKKBN. Another risk is the rigidity of an organization structured along highly functional lines. Such an organization typically finds it difficult to do new things because it is deliberately designed to do what it already does but more efficiently.

This generalization accords well with the actual experience of BKKBN. Expansion of the Village Family Planning model within Java/Bali and to the more densely populated outer islands has been a remarkable success story. The BKKBN does this very well indeed. But, as noted previously, when the context changes -- as in the more remote outer islands or large cities -- the model around which the organization was built bumps into a series of new and unexpected constraints. Even though these constraints are now understood by the BKKBN, it has not performed well in the development of imaginative strategies to meet the new challenges. This is not for a lack of ideas. In the urban program, for example, many things have been tried from focus group research to training beauticians as family planning informants to private clinic development. But after several years of groping, a comprehensive urban strategy that goes much beyond the overlay of village family planning in the cities is still not in evidence anywhere but in Surabaya (where implementation has been threatened by removal of the key strategist for administrative reasons, a quintessential bureaucratic response to innovation and an unfortunate precedent for the BKKBN).

The BKKBN is organized to deliver services efficiently. This it does well but the future will require a broader ability to deal with social marketing -- incentives and demand creation -- in a wide variety of settings.

A related constraint may be seen at lower program levels, one that is primarily a consequence of the way the Indonesian planning system works. At any level in the system, major strategy innovation is difficult. For example, if a Camat (sub-district chief) wishes to include an experimental new approach in his annual plan, he is unlikely to obtain approval from higher levels unless the innovation can be introduced into all the sub-district programs in that regency. Since, in the Indonesian system, most cities are treated as the equivalent of a Kabupaten (Regency) or, in the cases of Jakarta and Jogjakarta, as provinces, it is difficult for peculiarly urban strategies to be approved at the next level up if they require a unique package of budget proposals. In the city of Ujung Pandang, for example, a special urban program DIP (budget proposal) was rejected at the center the last two years. This experience is not unique.

Responses to the Strategy Constraint:

One response to these problems is greater decentralization to recognize different program needs. But this is difficult due to horizontal linkages with government structures where political will may be lacking and bureaucratic structures are highly centralized. Realistically speaking, the BKKBN is far more decentralized than most Indonesian agencies and continues to be committed to this pattern. This commitment is crucial for continued program success but can only go so far, especially outside of government channels.

Another way to address constraints to innovation and strategy development is through the use of operational task forces that cut matrix-style across a functional organization. As noted previously, this may be particularly appropriate as a vehicle to address the problem of effective urban strategy development. While some BKKBN offices do have "urban teams", these have no budget and often no leadership. An effective urban task force must have both, as well as direct responsibility to the organizational head, be it at the central or provincial level. With the credibility provided by the

three factors of leadership, budget, and access to the top, such a team can secure commitment from key "players", in and out of the BKKBN itself (for example, the private sector) and can develop, test, and eventually implement integrated approaches to reaching urban target audiences with family planning information and services. A model for such a team is provided by the BKKBN itself within the national government. It has budget, leadership, and access to the president. It coordinates a variety of established implementing units within a functionally organized government. It facilitates the actions of these units in the context of a wholistic strategy that is oriented to goals that transcend the functions of any of the individual component units. Such should be the role of an urban task force within the BKKBN, both at the center and in provinces where there are major urban centers. These task forces should work closely with outside leaders from the private sector, representatives of relevant professional organizations, actual or potential service providers, and universities capable of performing program-related research.

Crossroads:

In a real sense, the BKKBN is at a crossroads as an organization. Success extracts two severe costs. First, as discussed above, organizational growth threatens creativity, flexibility, and innovation. Signs of this are already present. Second, the immediate "reward" of visible statistical progress in target achievement diminishes as prevalence rises and reaches a certain "ceiling" level. The challenge of simply maintaining prevalence rates in the wake of a rapid increase in MWRAs is much less exciting. Maintaining the now clearly visible level of staff motivation and commitment will represent a growing challenge to BKKBN management under these circumstances.

Program Planning:

Over the last 15 years, but especially since 1980, USAID and the BKKBN have worked closely to create responsive, flexible, and innovative province-specific planning and implementation processes. A major objective of USAID support has been to institutionalize these functions within the provincial and central BKKBN.

The BKKBN describes its planning system as multidirectional: top-down, bottom-up, and horizontal. These perspectives indeed provide a useful way to observe how the planning system serves the needs of the BKKBN.

Top-down Planning

Like every Government of Indonesia program, the BKKBN operates within an annual planning and budgeting process that is largely top-down and standardized for all agencies. Guidelines, targets, and budgets are determined by the center for the provinces, by the provinces for the regencies, and by the regencies for the sub-districts, the lowest level of formal planning and implementation. Two basic realities underly this system. First, the entire local government apparatus is responsible to the central Department of Internal Affairs. Second, the great majority of development funds are provided from the central government with local revenue generation and management very limited.

As noted above, this system limits opportunities for specific variations from general planning parameters, a problem that has constrained progress in urban and outer island family planning programs where social and political infrastructure are out of the ordinary.

Within these limits, the BKKBN has effectively delegated authority for program management to provincial staff and, to varying degrees to regency-level offices. The ability of provincial and sub-provincial staff to obtain supplemental funding for specific

field initiatives is a key aspect of this decentralization. Again, USAID assistance has played a major facilitating role. Systems and procedures for obtaining USAID local cost funding are described in Indonesian language manuals available to all public and private agencies receiving funding from USAID through the BKKBN. Briefly, the system works as follows: first, a proposal goes to the provincial BKKBN office (the key implementation level). If accepted (and consistent with the provincial annual plan), the proposal is sent to the central BKKBN with a copy to USAID. After joint review (usually involving a field visit to work with local staff to review activities in the field and to strengthen the proposal), the proposal is formally submitted to BKKBN. After central BKKBN review, submission is made to USAID for funding. USAID then prepares a Project Implementation Letter (PIL) describing the activity, its time frame, budget, and disbursement schedule. Project funds are then released in phases based on scheduled project reviews and financial reports. The entire process has now been synchronized with BKKBN's annual planning cycle to permit one-time administration of both DIPs and Supplemental funding.

Perhaps the most problematical aspect of top down program management is the setting of targets for contraceptive prevalence. Based on an annual national target, the central BKKBN specifies a target for each province. Provinces, in turn, set targets for regencies and regencies for sub-districts. While there is some multi-level discussion of these targets before they are finalized, adjustments are minimal at best. To the extent political or promotional considerations influence the setting of the national target (the variance between BKKBN and KLI targets suggests this risk is real), all lower targets will be affected as the allocation process proceeds. Unrealistic targets encourage special promotions (called Safaris) and other gimmicks that probably contribute more to temporary statistical bumps than to genuine contraceptive prevalence. One way to enhance the quality of management decentralization would be to start the target setting process from both top and bottom and seriously negotiate the differences. The

process would help raise issues affecting particular area programs, especially when local and higher level perceptions of reasonable targets differed.

Bottom-up Planning

At levels below the national BKKBN, there is more focus on implementation than on planning, at least at the point of final decision making. This is particularly true for longer-term planning since sub-national control over funding is so limited. The primary mechanism for bottom-up planning in the family planning program is an extensive process of information exchange through meetings in which ideas from one level are discussed with higher decision making levels. This process functions more effectively in the family planning program than in most Government of Indonesia sectors where the process often is too formalized to permit optimal give-and-take. Frequent meetings among and at all levels for this kind of information exchange, negotiation, planning, and problem-solving may be described as the grease that oils the wheels of program planning and implementation. USAID supplemental funding has had a particularly beneficial impact on this process over the years, especially as a push for the extension of the program into new geographical areas. As the program matures in each province, the pattern has been for the BKKBN to institutionalize the consultative process as a recurrent cost.

The importance of these meetings cannot be overemphasized. At an informal level, sub-village meetings of acceptor groups start the process. Information from these discussions is fed up the system through the village worker network, the family planning field staff, and the village government structure. At the sub-district level, Camat (who themselves are likely to have received family planning training and motivation from the BKKBN), meet with regency officials to pass on recommendations for future development funding. And the process continues up through the province to the center. Thus, although decisions are essentially top-down, they are informed by a wide net of information gathering from below.

One constraint to subnational planning is dependence on the central BKKBN for computerized analysis of field program data and a general lack of analysis capability at lower program levels. Existing plans to enlarge the role of provincial BKKBNs in data analysis deserve higher priority. This matter is discussed in greater detail in a subsequent section of this report.

Horizontal-Planning

The small, happy, and prosperous family is an Indonesian national goal. Virtually every sector of the government has a role in this endeavor. At the level of local service points in which the BKKBN is involved, elements usually include family planning, immunization, maternal-child health, and other health and nutrition-related services. Frequently, local village workers share responsibility for several of these components in their role as interfaces with village families. The family planning link to health is formalized in the role of the sub-district health clinic as the focal point of family planning reporting, logistics, and medically administered contraceptive services.

Beyond the link to health, the family planning program has an integral link to local government structures as has been described elsewhere in this report. With USAID support, the BKKBN has worked hard to secure the informed support of local leaders and even their wives, who often hold an important place of influence in the community. In areas where the program is relatively new, it is not uncommon to find the wife of a village chief serving as the head of a local family planning post. Informal leaders such as Islamic Ulama and others with local influence are also incorporated into the network through training and motivational activities. These program initiatives, particularly appropriate in the Indonesian socio-cultural context, have had a clearly visible impact on the program in terms both of legitimizing family planning and spreading the network of information and motivation to the level of the individual couples who make the ultimate contraceptive decision.

Although this is a very successful aspect of the family planning program, most BKKBN personnel at all levels emphasize the importance of improving the net of horizontal relationships even further. This is a reflection of some remaining problems of coordination with the health service system and of the importance attached to horizontal links in an agency that implements through the coordination of units outside its direct supervision.

An area of horizontal linkage less well developed is that with the Indonesian private sector. Particularly important in urban areas, these links require more serious attention in the context of a comprehensive urban strategy. The private sector has an important role both in service provision (physicians and midwives) and in information and communications (media and advertisers).

Monthly Service Statistics:

The monthly service statistics system of the BKKBN is the basis for performance measurement, service delivery, and logistics. It is a comprehensive, multi-level management information system carefully designed to meet the specific information needs of program planning and implementation. The system is capable of handling a large quantity of data through procedures that are entirely manual up through the provincial level. While its outputs are in some ways flawed, BKKBN recognition of these weaknesses is leading to modifications that are expected to improve data accuracy and completeness. USAID has played a major role in system development and continues to support improvements with funding and technical assistance.

How the System Works

The basic reporting system is keyed to sub-district clinic-level reports (Form F/II/KB) that include information on contraceptive acceptance (by type and provider), contraceptive distribution, and contraceptive supply. Information sources for this monthly report include the clinic itself, village family planning posts and sub-posts, and private service providers. Most

important are the village posts since the majority of acceptors are pill users who receive their monthly supplies through this outlet. A supplementary local report (Form F/I/PLKB) from family planning fieldworkers contains data about local extension activities and the status of acceptor groups.

The clinic report is sent to the central BKKBN office with a copy to the regency BKKBN. The fieldworker report is routed to the center, also with a copy to the regency office. The regency office recapitulates the data and forwards a report to the provincial BKKBN. This process takes place within two or three weeks after month end. Meanwhile, the central office processes the reports it has received directly into a set of computer analyses which are returned to provincial and regency offices with a lag of six-weeks to three months. Provincial offices then reconcile differences in the two sets of summary data. Since the source is the same for both, differences at this point are usually inconsequential.

Management Use of Data

The most obvious uses of the processed information produced by this system are to track progress and to control contraceptive supply. These operational uses of the information proceed routinely and effectively within the BKKBN and are processes that have now been thoroughly institutionalized as an important component of information management.

The situation with regard to analytical use of the data is mixed. In East Java, service statistics are analyzed at the provincial BKKBN to check service points against performance by sub-district and type of provider. This analysis helps pinpoint the most effective service provision strategies for different income groups and geographical areas. This analysis was part of the exemplary Surabaya urban program strategy development cited above and is not necessarily typical. In many cases, the computerized central report is used as is. There is little evidence that provincial or other subnational suggestions have influenced the content of this analysis.

There are indications of limited capacity to understand the meaning of source data at lower levels of the program, even though collection of that data proceeds with remarkable efficiency in most places. Although local statistical summaries are often available and even posted on the walls of homes serving as village family planning posts, obvious errors such as inverted prevalence fractions typically go unnoticed until corrected at higher levels of the data flow. This suggests an agenda for BKKBN training, especially for fieldworkers and local volunteers involved in managing or supervising village posts.

Data Accuracy

The BKKBN has come under considerable criticism lately for alleged inaccuracies in the performance data that it collects and reports. Much of this criticism was triggered by the 1980 national census which included questions regarding family planning acceptance. In some areas, especially East and Central Java, embarrassing discrepancies between BKKBN prevalence claims and census indications appeared.

The issue has been the subject of much study and analysis, with a rough consensus that the difference is a combination of BKKBN overcounting and census undercounting of acceptors plus various definitional issues affecting comparability of results.

There is no evidence of any deliberate BKKBN "conspiracy" to over report prevalence gains. On the contrary, there are extensive indications that, in response to the census findings, the BKKBN is moving to further improve its reporting system (see below). Our best estimate (based largely on secondary sources) is that BKKBN prevalence overcounting has been in the range of 6-10 percent. Given certain structural flaws in the system primarily the fact that it is distribution based, we believe that much of the criticism directed toward the BKKBN is undeserved.

BKKBN reporting must overcome a number of systemic constraints. Many reports come (or sometimes fail to come) from volunteers in remote areas who have limited supervision and no vested interest in maintaining accurate and comprehensive records. Data collection has expanded rapidly, often faster than the capacity of people to handle it. It is not surprising that, for example, some method changers get counted twice as new acceptors or that the occasional woman who receives, but does not use, her pills is counted as an acceptor. A tendency to hold special end-of-year promotions (Safaris) also can lead to unsustainable spikes in reported annual prevalence rates.

In sum, the overall evidence is reassuring as to the accuracy of BKKBN service statistics for methods distributed by the program and as to BKKBN seriousness about publicizing accurate performance claims.

System Modifications

In response to its awareness of constraints to the accuracy of service statistics, the BKKBN has introduced two innovations, both well conceived. The first is the conduct of an annual "mini-census" by its own field staff but with certain crosschecks to improve the quality of results. The mini-census directly counts MWRAs and acceptors, avoiding the service statistics problem of being distribution based. This was first done in early 1985 and, as the results are compiled, local performance statistics and targets are being adjusted downward (and, in some urban areas upward) by 5-10 percent. The ability of the BKKBN system to perform this mini-census in a short time and with minimal disruption to its normal activities is a tribute to its operational field network.

A second modification involves the method of obtaining source data at the field level. This innovation has just been introduced but feedback from test areas is very positive as to its improved simplicity and accuracy. Under this system, village posts

receive a set of stickers (coupons) with their monthly package of supplies. Stickers are placed in a register for each pill or condom recipient. No writing is required and the family planning fieldworker can count acceptance by tallying stickers and count dropouts by blank spaces next to a previous sticker. There are special stickers used to specifically indicate dropouts, IUD users, women leaving the MWRA category as a result of age, and other special categories.

In addition to improving accuracy, this system frees village workers from administrative toil to focus on motivational tasks. It is a thoughtful organizational response to a recognized problem.

Computerization

Purchase and installation of microcomputers in provincial offices was planned for 1984 but has been delayed. In large part the delay represents appropriate concern for careful planning and preparation before introducing a new technology. In part, also, the delay is due to bureaucratic lags in USAID which has budgeted funding for this innovation.

Computers will help move processing and analysis of data to the provincial level which then would provide processed information to regencies in tabular form and to the center on diskettes. This will be an important step in management decentralization if introduced carefully and with appropriate training and guidance in the management and analytical skills that are necessary for effective use of automation.

There is a further opportunity to use the onset of new provincial analytical systems to encourage bottom-up identification of appropriate variables for inclusion in reports and analyses. This opportunity should be grasped by the BKKBN and USAID in planning introduction of computers.

Manpower Development:

One of the main concerns of BKKBN is the development of the knowledge and skills of family planning workers, both in and out of the BKKBN organization itself. Efforts to improve the quality of family planning workers has resulted in the development of the Center for Education and Training (Puskidlat) at the national level, and Provincial Education and Training Centers (Balai Diklat) at the provincial levels. Training has also been a major focus of USAID's local cost programming support. A review of Project Implementation Letters shows that often 50% of total activity budgets are used for this purpose.

The roles of Puskidlat and Balai Diklat are well-acknowledged. They conduct a wide range of training in the field of family planning, including, for example, training for medical workers who are operationally responsible for family planning services. It was observed that most medical workers at the Puskesmas (Health Clinics) are knowledgeable about their jobs and that, typically, medical doctors in the clinics are fully committed to the family planning program.

However, still needed is continuous support in the form of skill development among medical workers, especially paramedics, in order to increase the quality of family planning performance by these providers.

Training of persons involved in the family planning network in IE&C has been conducted with a strong impact on the knowledge and skill of these potential agents for change. BKKBN has conducted such training with a wide-range of participants from youth association members and students, to beauty salon owners; from personnel of government agencies to leaders of non-government organizations.

In general, the fieldworkers and fieldworker supervisors know their jobs well. However, outside of Java their responsibilities are different in geographic scope and socio-cultural milieu from their colleagues in Java and Bali. Therefore, standardized training that is not sensitive to local conditions is not appropriate for these fieldworkers. Since, the fieldworkers function as "managers" at the village level, additional managerial training is also advisable to improve their supervisory skills. They should also receive more training in techniques of motivating non-acceptors.

The training conducted by BKKBN for formal and informal community leaders has clearly helped enhance their knowledge and skills regarding family planning. It is evident that many of these community leaders are able to articulate family planning concepts and to help convert new acceptors. In the village of Sukamulya, West Java, for example, the success of the program is largely due to the dynamism of the sub-district chief and his wife. In some areas of South Sulawesi it appeared that the use of school teachers as motivators had been more successful than in other areas where this role was largely undertaken by the wives of village chiefs. This is indicative that regency and sub-district leaders are sensitive enough to identify the more effective motivators. The training of these formal and informal leaders should be planned so that efforts will be targeted to the potentially more effective groups in specific localities. As in other program elements, this requires sensitivity and adaption to local differences.

Overseas Training

Overseas training is another strategy to develop skills among middle and upper echelon personnel in the BKKBN and supporting units as well. Participation of key personnel in international meetings, workshops, seminars, and short-term training has been widely supported.

Moreover, BKKBN has been sending its staff members and personnel from implementing units for graduate training in the U.S. since 1972. The large majority of external assistance for such long-term training has come from USAID. Between 1972-1982, a total of 101 persons were sent abroad through BKKBN for masters and doctoral degrees using USAID funds. During that period only 14 of the participants were actually from the BKKBN staff itself. One positive observation is that Indonesian trainees have a proven record of nearly 100 percent return and retention rates in the program.

It has also been the desire of the government to develop core groups of population experts in domestic universities who could be delegated to help in strengthening the capability for in-country population research and training programs. This initiative has also built-up capabilities of local universities to offer degree programs in population. A number of fellows have been supported by USAID for in-country degree programs.

This strategy has supported the idea of "decentralized planning" where universities can become regional population research centers. To date, every state university has established a population studies center. The development of these research centers has benefited BKKBN and other related government agencies in supporting the need for policy research.

Rising costs for overseas training have led to strategies to conserve resources through direct BKKBN administration of overseas training. BKKBN started to self-administer this training in 1982. Under the expanded USAID loan 497-Q-069, funded under Project 0270, Pusdiklat adopted new procedures for overseas graduate training with the new procedures in 1983 and 1984, BKKBN emphasized the importance of strengthening its own middle and upper level personnel. In that period, more than half of the 59 persons sent for overseas training were from BKKBN itself. Not only has BKKBN successfully

institutionalized its ability to administer the overseas training program, it has done so with substantial savings on costs. This has allowed BKKBN to increase the number of persons sent abroad.

The primary area of concern in the manpower development strategy is the placement of the returnees. Those who complete their education do not have any guarantee of being returned to their previous posts or of catching-up with the promotion of peers who have stayed behind. Similarly, those who have completed their overseas training may be posted in a new area of responsibility which may not be in line with the field of specialization pursued in their training.

Another area of concern is that the criterion of seniority in the selection of candidates may create career interruption for senior staff for the duration of their long-term training. This career interruption may discourage potential candidates to avail themselves of training opportunity.

A major factor in the graduate overseas training strategy is the selection of potential candidates. The requirement for achievement in English is a barrier for many otherwise qualified staff. BKKBN attempts to help strengthen English language proficiency have contributed to the expanding pool of potential candidates.

In interviews with former overseas trainees, support allowances appear to be commensurate with their needs, except for the amount allotted for books. Considering the scarcity of recent texts and references in Indonesia, it would serve well to provide a more generous allowance for this purpose.

Procurement, Production and Logistics:

The availability of a cafeteria of contraceptive options throughout Indonesia is a remarkable achievement for which both USAID and the BKKBN deserve recognition and credit. Timely contraceptive availability is obviously a necessary condition of any successful family planning program. The BKKBN's system of production, procurement, and logistics has emerged from heavy dependence on external support, primarily USAID, for provision of commodities and logistics management to a status of almost total self-sufficiency. It represents a case study in effective institutionalization of critical management systems. In the last fiscal year, the BKKBN successfully procured and distributed 65 million pill cycles, 7.5 million injections and, 1.5 million IUDs.

Procurement and Production

BKKBN self-sufficiency in procurement and production of oral contraceptives is proceeding well. Local production is now providing the bulk of these contraceptives and in-country capacity to meet local demands has increased substantially. In 1980, the Kimia Farma pharmaceutical plant in Bandung began local production and packaging of pills under contract to the BKKBN. Production levels were 18 million cycles in 1980, 25 million in 1981 and 1982, 41.5 million in 1983 and nearly 40 million in 1984. USAID-funded deliveries of oral contraceptives were phased out in late 1984 as scheduled and other BKKBN procurement is expected to end in 1989.

The BKKBN is now considering contracting the production of low-dosage pills to Kimia Farma; USAID is assisting in field studies of various brands, types, and formulations. In the meantime, procurement of pills through foreign pharmaceutical companies is assuring the availability of a variety of oral contraceptives to meet local demand.

At present, production of the Kimia Farma pill is being carefully monitored and remains under maximum capacity levels. This is due to a number of factors including: 1) BKKBN's increased efforts to shift acceptors to IUD usage on continuation and cost-benefit grounds; 2) larger oral contraceptive stock levels than anticipated at provinces and below; 3) the desire to maintain a diverse array of pill types through procurement in anticipation of future low-dosage pill production; and 4) reductions in annual budgets for oral contraceptive production. New contract negotiations with Kimia Farma are currently underway.

With regard to the increasing role of Kimia Farma pills in the contraceptive mix, one area of concern requires further attention. In certain areas of Indonesia, distribution of the Kimia Farma pill has resulted in rumors and complaints of poor quality and various side-effects. In West Java, for example, a number of symptoms such as headache, nausea, and dizziness were attributed to the Kimia Farma pill when it replaced the imported Syntex pill. Chemical analyses and quality control checks show no difference in the composition of the two pills so it may be that general public distrust of domestically produced, non-traditional medicines is at the root of the complaints. To ensure a smooth transition to acceptance of the domestic pill with a minimum of acceptor drop-outs, more informational and educational efforts to dispel rumors and doubts about the new pill are needed. Indications are that the BKKBN has begun to take steps in this direction.

Logistics

The BKKBN contraceptive logistics system is keyed to local needs for contraceptives of each type and distribution and an inventory system that assures adequate levels of stock at each level from the center down to the village. Prior to 1980, the BKKBN used Ministry of Health facilities for storage and distribution but these have now come under its own management and control with training and operational assistance from USAID. The system's primary information

base derives from the monthly service statistics system described above and special logistics reports (Form F/V/KB) sent from the regency and provincial levels to the national BKKBN office.

Inventory

A stock policy described as the 3-3-6-6-3-1 system guides inventory policy for resupply of contraceptives (primarily pills and condoms). These numbers refer to the planned months of stock at the respective levels of center, province, regency, sub-district, village, and acceptor. Thus, for example, the sub-district health center, the focal point of local contraceptive supply, maintains a stock sufficient for six months. This system assures adequate cushions of supply under normal circumstances. The system is flexible enough to adjust for special influences such as the occasional Safari promotions that may lead to a short-term spike in demand for, say, IUDs. In the course of this evaluation, no case was found where a shortage of contraceptives of any type at any level had been experienced. (A frequent exception was a shortage of medicine at sub-district health clinics for treating side effects of IUD use. This is a Ministry of Health, not BKKBN, responsibility - another instance where coordination could be improved.)

Distribution

Distribution of stock from one level to another is based on two general systems, depending on contraceptive type. For those requiring continuous resupply (pills, condoms), a "non-request" system is used. This system is based entirely on monthly service statistic reports of remaining inventory; resupply occurs from each level down based on analysis of the reports. For clinic-based methods (IUD, injection), distribution is based on clinic requests for inventory addition.

A first-in, first-out (FIFO) system is the basis for distribution from warehouses or other storage points. FIFO is superseded in cases where stock with an older expiration date was not first-in. In most cases, storage conditions and management

permit adherence to these principles. Inventory and distribution management records appear generally well-maintained with adequate control. With reasonable precautions, well-packaged contraceptives have a long shelf-life and loss or wastage during storage and distribution does not now appear to be a significant problem.

The logistics system is not without problems, but none are crippling in their effect. From the standpoint of storage, warehouse space is limited, especially at many regency-level distribution points. Often contraceptives must be stored with an array of other gear ranging from typewriters to old tires. Often, too, the warehouse is little more than a small room in the regency BKKBN office.

This problem will grow as the program continues to expand and staff and storage needs compete for limited space. While not yet a serious issue in terms of consequences, the BKKBN may soon need to address the problem to avoid more serious losses in the future.

Contraceptive storage at sub-district clinics and village depots is usually in cabinets, drawers, or anywhere else that is available. At these levels, the attention of those responsible is more important than the physical facility, however, and this attention seems generally to be careful.

The routine reports on which the logistics system is based do not have a specific category for recording of inventory loss. This would be a useful addition and could prevent some loss being treated statistically as distribution. It would also draw the attention of local contraceptive posts to this issue and help assure that the loss problem remains minor.

Several persons responsible for logistics felt that it had received inadequate training attention, especially at lower levels. Most warehouse managers had been trained but some said there had been no follow-up for several years. Despite this, storage management appears generally good.

IV. LESSONS LEARNED:
SUMMARY OF FINDINGS AND RECOMMENDATIONS

The Family Planning Program in Indonesia:

- o The BKKBN has successfully institutionalized several critical management processes and procedures previously dependant to large degree on USAID initiative and technical support. These include contraceptive supply, logistics, information systems, and the management of its manpower development program.
- o Rapid growth of the BKKBN and the proliferation of local activities in which it is involved place the organizational attributes of flexibility, innovation, and its action-based goal orientation at severe risk.
- o The current village family planning model has continued to provide a successful and flexible framework for program extension in Java, Bali, and the more developed outer islands. In remote, thinly-populated outer island areas, the model is less successful, particularly on grounds of cost-effectiveness.
- o The BKKBN has been successful in building good working relationships with the local government apparatus, largely by incorporating them into its training and motivation agenda. These activities have helped legitimize family planning and spread the network of information and influence to the level of individual acceptor couples.
- o Quality of information and services at the local level are taking on added importance as the program matures, the number of acceptors to be maintained increases, and remaining non-acceptors become more difficult to reach.
- o Despite a number of innovative experiments and pilot tests in Jakarta and some other cities, the BKKBN has yet to clearly define a viable urban strategy or give adequate emphasis to this process at the level of individual city BKKBN offices.
- o The BKKBN is organized to deliver services efficiently. It does this well but the future will require a broader ability to address challenges of social marketing in areas less receptive to its traditional service delivery strategies.
- o Within the constraints of formal Indonesian planning and budget systems, the BKKBN has effectively delegated authority for program management to provincial staff and, to varying degree, to lower implementation levels.
- o The availability of a cafeteria of contraceptive options throughout Indonesia is a remarkable achievement of production, procurement, and distribution, reflecting BKKBN maturity and the impact of productive use of donor assistance.

- o The monthly service statistics of the BKKBN provide a reliable basis for performance measurement, service delivery, and logistics. While its output are in some ways flawed, BKKBN recognition of certain weaknesses has led to well-conceived modifications that should improve data accuracy and completeness.
- o Opportunities to use analysis of service statistics as a management tool are not fully utilized, especially at lower levels. An emphasis on improved understanding of the meaning of data to match the efficiency of its collection would facilitate management decentralization.
- o Strongly USAID-assisted manpower development programs, including both domestic training and overseas degree programs, have had a major impact on the quality of the BKKBN staff and on the implementation of field activities by both the BKKBN and other implementation units. This emphasis continues. The major concern with regard to this issue is the effective reassignment of returning degree candidates from abroad whose skills are not always put to effective use.

USAID Assistance:

- o By most indicators of success, the Family Planning Development and Services Project (0270) has met or, in many cases, exceeded stated project goals and objectives. This success applies both to measures of contraceptive availability and use and to the project's institutional impact on the BKKBN and related implementing units in the field.
- o The flexibility and timely local cost programming mechanism used for USAID funding of BKKBN activities remains the key factor supporting innovation, learning, local adaptation, and effective implementation of high priority local initiatives.
- o USAID plays a major facilitating role in BKKBN program decentralization by providing selective supplementary funding for local activities and by helping to finance meetings for coordination and information-sharing at early stages of program development in new areas. The investments establish productive management patterns that have been institutionalized with BKKBN procedures and funding.
- o USAID support to the village family planning program has clearly played a major facilitating role in the development and spread of this highly effective concept throughout the most populated areas of Indonesia. The USAID support has been strategically targeted, timely, and programmed in ways that facilitated institutionalization of successful innovations.

Recommendations for the Future:

- o High-level policy coordination is needed to assure that the BKKBN, the State Ministry for Population and Environment, the Ministry of Health, and other involved departments have a common view of shared goals and responsibilities for achieving Indonesia's small, prosperous, happy family concept. In this connection, the BKKBN's roles as coordinator and implementor need better clarification, especially for activities that are peripheral to the basic fertility reduction mandate.
- o USAID should continue give high priority to support of the Indonesia family planning program. Its strategy of selective supplemental advance funding has and should continue to have a significant impact on the critical task of addressing the demographic challenge in Indonesia.
- o USAID should review and expand its commitment to two key lessons from its effective support for Indonesian family planning: the contribution of local cost programming (advances of USAID grant and loan funds for specific local activities) and the importance of effective, collaborative staff relations with the counterpart agency (requiring a high level of technical competence and cultural sensitivity).
- o The BKKBN should create an urban task force with budget, leadership, and direct access to the Chairman. This task force should be charged with developing a comprehensive framework for urban strategy and facilitate the development of effective provincial task forces in areas with major cities. USAID should direct a significant portion of its future funding for the urban program to assist this process.
- o As reported in the recent Indonesia Contraceptive Prevalence Survey, the availability of permanent, non-resupply methods of contraception is a needed service for women who clearly wish to have no more children. Improving availability or and access to voluntary sterilization, especially in cities, should receive higher priority in the family planning program on both service and cost-effectiveness grounds.
- o A more collaborative bottom-up process of setting prevalence targets would enhance the quality of BKKBN decentralization. BKKBN should enlarge the role of lower-level implementation units in the discussions leading to target determination for those levels.
- o USAID and the BKKBN should give greater attention to analysis of the cost-effectiveness factor as it spreads the family planning program in the outer islands. This has implications for strategy development, information analysis capabilities, and planning.

- o Monthly service statistics reports should add a category for inventory loss due to waste or damage to prevent local losses being counted as distribution and to focus attention to the potentially growing problem of loss as stock levels increase.
- o Computerization of BKKBN provincial offices should be accompanied by an emphasis on training and guidance in the management and analytical skills that are necessary for effective use of automation. Development of new analytical formats should be accomplished with the participation of lower-level personnel to increase their interest and skills in the area of information as a management input.