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FAMILY PLANNING DEVELOPMENT AND SERVICES II PROJECT (398-0249): INDONESIA: AN URBAN SECTOR STRATEGY

by

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PREFACE

This report was commissioned by the United States Agency for International Development (USAID) mission in Indonesia as part of the preparatory work for an amendment to USAID's Family Planning Development and Services II Project No. 398-0249. The consultant spent just over a month in Washington and Indonesia carrying out the scope of work. This included a review of urban sector family planning activities, especially as they related to the private sector, specifically to fee-for-services and to the contraceptive social marketing project. The scope of work called for recommendations to USAID regarding strategy and components for a project amendment. Lists of person and institutions contacted and documents reviewed are contained in Appendices A and B.

GLOSSARY

AVSC	Association for Voluntary Surgical Contraception
BKKBN	National Family Planning Coordination Board (Indonesia)
CDC	Centers for Disease Control
CPS	Contraceptive Prevalence Survey
DEPNAKER	Ministry of Manpower
DGI	Council of Churches
ELCO	Eligible couple for family planning
FPIA	Family Planning International Assistance
FPFW	Family planning field worker
GOI	Government of Indonesia
IBI	Indonesian Association of Midwives
IDI	Indonesian Association of Doctors
ILO	International Labour Organisation
IMR	Infant mortality rate
IPPF	International Planned Parenthood Federation
ISFI	Indonesian Association of Pharmacists
JHPIEGO	Johns Hopkins Program for International Education and Obstetrics
JHU/PCS	Johns Hopkins University/Population Communication Service Project
MCH	Maternal and child health
MOH	Ministry of Health
MWIFA	Married women in fertile age
NFP	Natural family planning

NGO	Non-governmental organization
NUCD	Neighborhood contraceptive distribution personnel
PERDHAKI	Indonesian Catholic Health Council
PKBI	Indonesian Planned Parenthood Association (Perkumpulan Keluarga Berencana Indonesia)
PKMI	Indonesian Association for Secure Contraception (Perkumpulan Kontrasepsi Mantap Indonesia)
PIACT	Program for Introduction and Adaptation of Contraception
POGI	Indonesian Association of Gynecologists
SOMARC	Social Marketing for Change
SPSI	All Indonesian Workers Association
SRI	Survey Research Indonesia
SUPAS	Indonesian Fertility Survey
SRI	Survey Research Indonesia
TIPPS	Technical Information on Population for the Private Sector
UNFPA	United Nations Fund for Population Activities
URC	University Research Corporation
VSC	Voluntary surgical contraception
WIFA	Women in fertile age
YIS	Foundation for Prosperity (Yayasan Indonesia Sejahtera)
YKB	Yayasan Kusuma Buana (Family Planning Foundation)

EXECUTIVE SUMMARY

1. Background

Unlike most successful family planning efforts, the excellent program in Indonesia has registered its greatest successes in rural, not urban, areas. Although it is difficult to establish definitive figures, the 1983 Contraceptive Prevalence Survey suggests that the use of modern contraceptive methods among urban women may be 15-25 percent below that of rural women (36 percent compared to 50-60 percent). Although the urban population is small (perhaps 15 percent of the total), it is growing fast and with it, the need for an effective program to meet the need for family planning.

The reason for the discrepancy between the two programs may be that the very approach that has made for success in rural areas is not equally suitable for cities. The Indonesian National Family Planning Coordinating Board (BKKBN), working with the Ministry of Health, uses an intensive, personalized approach at the village level, characterized by volunteer efforts to exert peer pressure. In cities, where there is more exposure to the media, higher educational levels, and more disposable income, this approach may not be equally appropriate.

BKKBN has decided that a new approach in cities is needed and has developed a strategy that focuses on increasing and improving the level of services provided by the private sector. The new approach acknowledges the ability of the urban population to pay for services and emphasizes the voluntary nature of family planning.

The United States Agency for International Development (USAID) commissioned the consultancy on which this report is based as part of the preparatory work for an amendment to its Family Planning Development and Services II Project. Specifically, the scope of work calls for a review of urban sector family planning activities, especially as they relate to the private sector, including fees for services and contraceptive social marketing.

2. Overview of Private Sector Family Planning Activities

At least a dozen organizations in the private sector might be enlisted in any effort to increase the availability of family planning services in urban areas. Four professional organizations (doctors, obstetricians/gynecologists, midwives, and pharmacists) are already involved in one way or another in delivery of family planning services. Protestants, Catholics,

and Muslims all have organizations that provide some family planning services. Non-sectarian organizations are also involved, in particular the important Indonesian Planned Parenthood Association supported by the International Planned Parenthood Federation. International funds have also supported three specialized activities, one to provide family planning at the factory site, a second that carries out research and a third that offers voluntary surgical contraception. Finally, commercial sales of pills, condoms, and injectables are growing in importance, particularly in urban areas.

3. New Public and Private Sector Initiatives in Urban Areas

Considerable outside support, particularly from USAID, is helping launch several new efforts to improve public and private sector program performance and increase client satisfaction in urban areas. Operations research directed specifically to how the rural delivery system might more effectively be applied in the cities should provide enough information to allow the BKKBN to achieve its target of improving delivery in 11 major cities. Research is also under way on the injectable NORPLANT, which appears to have a particularly promising future in Indonesia. USAID-funded block grants are assisting the private sector medical organizations of doctors and nurse-midwives to increase their family planning client load, while other USAID funds are supporting a social marketing effort to increase sales of condoms.

4. Recommendations for Future USAID Strategy

USAID strategy should focu in the near future on implementing the most promising of the many good initiatives already under way in urban areas. This strategy is the basis for the recommendations that follow, including the carry-over of funds from and an amendment to the current project and as a bridge to the new project design being considered by USAID (Private Sector Family Planning Project FY 1989).

4.1 Activities to be funded with carry-over project funds and/or under a project amendment and incorporated in future project

o Operations research that would explore introducing fee for service in the public sector.

o Contraceptive social marketing that would aim to expand the current market and add other products. This would be a major component of a new project.

o Urban block grants with emphasis on institution building and strengthening service delivery capability of organizations of commercial providers.

o Continued support of the Indonesian research organization YKB in efforts to improve the institutional and service delivery capability of organizations comprised of private sector providers.

o Information, education and communication (IEC) activities to guide advertising related to specific products.

o Technical Assistance.

4.2 New Activities to be Included in Future Project

o Operations research on the level of community involvement in health centers and the introduction of fee for service by NGOs.

o Review of full spectrum of issue of viability of introduction of fee for service.

o Exploration of other ways to include family planning in the private sector including prepayment of family planning services in health insurance or health maintenance organization plans.

o Contraceptive Prevalence Surveys.

o Support to efforts to coordinate non-governmental organization initiatives to provide family planning.

o Review of degree to which urban fee for service emphasis can be spread to rural areas.

4.3 Other Funding Sources

USAID should support a reasonably strong centrally funded portfolio to complement its bilateral funding and should encourage appropriate Indonesian organizations to play a role in provision of technical assistance and training.

4.4 Non-Family Planning Influences on Fertility

While focusing on service delivery, USAID should continue to take cognizance of such non-family planning influences on fertility as breastfeeding, women's role in development, age of marriage and infant mortality.

Funding for the amendment is recommended at $1 million: $400,000 for technical assistance and $600,000 for social marketing. This would be added to a carry over of $2.36 million in current project funds, which is designated to cover an IEC campaign, research, urban block grants, and technical assistance.

I. BACKGROUND: INDONESIA'S URBAN FAMILY PLANNING PROGRAM

I.1 Urban Population Contraceptive Prevalence

The Indonesia family planning program, world-renowned for its many successes, has one characteristic that sets it apart from other national programs, namely: it has been more successful in rural areas than in the cities. A 1983 Contraceptive Prevalence Survey (CPS) carried out in five major cities showed that the use of modern contraceptive methods among married women in fertile age (MWIFA) averaged 36 percent (ranging from 27 percent and 28 percent in Medan and Ujung Pandang to 45 percent in Semarang with Jakarta and Surabaya 39 and 37 percent respectively). The 36 percent figure compared to a use level reported in rural areas of 50-60 percent.

There are indications that contraceptive prevalence is on the rise nationwide (the Indonesian National Family Planning Coordinating Board [BKKBN] reported recently that contraceptive prevalence had reached 58 percent nationally), with the urban population keeping pace (modern contraceptive prevalence was reported to exceed 45-50 percent in Jakarta in 1986, with similar levels in other major cities). In a 15-month period (April 1985-July 1986) in 30 cities with populations over 100,000, BKKBN reports indicate that total active users had increased from 1,974,000 to 2,040,000 (an increase of 66,000) and new acceptors had increased from 34,000 to 40,000 (an increase of 6,000). Nonetheless, the urban sector still lags behind the rural. In light of the high contraceptive prevalence rates (CPR),[1] Indonesia's program has not had the demographic impact that might be expected. Preliminary results of the Indonesian Fertility Survey (SUPAS 1985) suggest that, although down from 2.32 percent in 1971-80, the population growth rate is still above 2 percent nationally (2.13 percent). As of 1982 the crude birth rate was still 34 per 1,000,[2] at least 10 births above the level (the mid-twenties) that will be needed to achieve demographic goals.

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1 The BKKBN's estimates of the CPR is higher than the level of 38 percent found by the Indonesian Fertility Survey (SUPAS) which was carried out by the National Bureau of Statistics, using male interviewers to question heads of households.

2 World Development Report 1984. The World Bank. Table 20.

Different methodologies and definitions were used in all the surveys and calculations cited above. Thus, it is not surprising there are differences in results. Suffice it to say here that some in-depth review will be required to provide a consolidated estimate of prevalence. It is not within the scope of this report to attempt to reconcile possible differences. The 1987 CPS and other review studies, however, will be important.

I.2 Size of Urban Population

The urban population, while still a small proportion of the country's total, is growing fast. A conservative estimate is that the urban populace represents about 15 percent, or some 26 million, out of Indonesia's total population of 170 million. This estimate is based on the most recent figures from the National Bureau of Statistics (which showed a total of some 20 million inhabitants in Indonesia's 30 largest cities in 1980 and suggested an annual growth rate of 3.5 percent [see Table 1]--plus BKKBN statistics that suggest that another six cities should be added to the list of cities over 100,000, with a total population of another one million). Urban growth beyond the geographic city limits is not counted in these estimates, however, (e.g. Jakarta's population is stated to be 6.5 million, while in fact, it is probably closer to 10 million). Therefore, it is safe to assume that the size in the urban population and its rate of growth are both considerably above the estimates. If cities under 100,000 are also included in the count (the 1980 Census identifies 24 of these), estimates of the total urban population increase again to over 30 million.

A recent survey of five cities indicates considerable unmet need for contraception; the proportion of women who are at immediate risk of unwanted pregnancy (want no more children but are not currently contracepting) is estimated to range from 30-35 percent. Other findings from this survey are that

- -- From 50 to 60 percent of respondents who never used contraception and 65-70 percent of past users did not want additional children;
- -- From 15 to 30 percent of the women reported that their previous pregnancy was unwanted;

Table I

CITIES OF INDONESIA WITH POPULATION OVER 100,000 in 1980

	1971	1980	Rate of Growth 1971/1980
1. Jakarta	4,628	6,481	3.8
2. Surabaya, Jawa Timur	1,567	2,017	2.8
3. Bandung, Jawa Barat	1,209	1,461	2.1
4. Medan, Sumatra Utara	642	1,374	8.8
5. Semarang, Jawa Tengah	651	1,025	5.2
6. Palembang, Sumatra Selatan	589	787	3.3
7. Ujung Pandang, Sulawesi Selatan	438	708	5.5
8. Malang, Jawa Timur	425	511	2.1
9. Padang, Sumatra Barat	198	481	10.4
10. Solo, Jawa Tengah	417	470	1.3
11. Yogyakarta	345	398	1.6
12. Banjarmasin, Kalimantan Selatan	284	381	3.3
13. Pontianak, Kalimantan Barat	219	304	3.7
14. Tanjung Karang, Lampung	219	304	3.9
15. Balikpapan, Kalimantan Timur	138	280	8.2
16. Samarinda, kalimantan Timur	139	264	7.4
17. Bogor, Jawa Barat	197	247	2.5
18. Jambi	160	230	4.1
19. Cirebon, Jawa Barat	180	224	2.5
20. Kediri, Jawa Timur	180	222	2.4
21. Manado, Sulawesi Utara	170	217	2.7
22. Ambon, Maluku	80	208	11.2
23. Pakanbaru, Riau	147	186	2.6
24. Madiun, jawa Timur	137	150	1.0
25. Pematang Siantar, Sumatera Utara	129	150	1.7
26. Pekalongan, jawa Tengah	112	132	1.8
27. Tegal, Jawa Tengah	106	131	2.4
28. Magelang, Jawa Tengah	123	123	-
29. Sukabumi, Jawa Barat	97	110	1.4
30. Probolinggo, Jawa Timur	100	100	-
Total	14,008	19,656	

Source: Central Bureau of Statistics
by Survey Research Indonesia

-- From 70 to 75 percent of contraceptive users want no more births while the remaining used contraceptives for spacing or delaying births.[3]

Inevitably the momentum created by past high rates of population growth and the large numbers entering the reproductive age, both urban and nationwide, will substantially increase the numbers of new acceptors to be served. This increased population at risk will need to achieve higher levels of contraceptive prevalence to secure the desired reductions in the crude birth rate (see Section I.1).

I.3 Characteristics of the Urban Population with Relevance to Family Planning

I.3.1 Summary

It is generally concluded from world-wide experience that several factors, in addition to the availability of family planning information and services, influence fertility patterns and demand for family planning.

These include the general level of socio-economic development, closely correlated to which are the level of women's education and their role and status in society; time spent breastfeeding; the age at marriage; and the level of maternal and child health (MCH) and infant mortality. The situation in urban Indonesia is mixed, with the relatively high socio-economic indicators and long-term breastfeeding auguring well for population control and the MCH and age at marriage acting as brakes on progress in this area.

I.3.2 Positive Factors

I.3.2.1 Income Levels. Indonesia's urban population is relatively affluent compared with its rural population. Thirty percent of urban households have expenditures of

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3 From a Johns Hopkins University/Population Communication Services Project (JHU/PCS) report of August 1986, which provides a summary of characteristics of the urban population, identified from the 1983 CPS and Focus Group Discussions carried out recently by Survey Research Indonesia (SRI) in five cities. The report is entitled "Summary of Attitudes towards Family Planning and Family Planning Information Sources."

$150/month, 40 percent between $75 and $150, and 30 percent less than $75/month (see Table 2).

It is arguable whether higher levels of income will be converted into purchases of family planning services. While income elasticity for health expenditures in Indonesia is relatively high,[4] worldwide experience[5] indicates a reluctance to pay for preventive services, presumably including family planning. On the other hand, family planning services are not inordinately costly. Given the growth of worldwide production capacity, the highest price contraceptives, condoms, could be retailed for less than U.S. $8.00 for a year's supply. This has implications for individuals who are being asked to assume more responsibility in financing their fertility. It also has implications for government planners. Planners are faced with a growing demand for family planning as the number of users and potential users increases. However, the growth has some limits. It is not the potentially spiraling pattern where more and more sophisticated curative services bring major increases to health care costs, as for example, in the United States. Family planning is likely to remain a simple, more affordable intervention.

At any rate, the outlook in Indonesia's cities is favorable in regard to income levels. A 1984-85 CPS in Jakarta showed that 74 percent of the eligible couples at the upper end of the economic scale were using contraceptives compared with 29 percent at the lower end (see Table 3).

Furthermore, 80 percent of respondents to an August 1986 urban survey indicated a willingness to pay for a good, convenient family planning service.[6]

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4 According to a recent study conducted by REACH.

5 Johns Hopkins University, May 1986 Population Reports.

6 JHU/PCS August 1986. "Summary of Attitudes Towards Family Planning and Family Planning Information Sources."

Table 2

HOUSEHOLD EXPENDITURE/MONTH 1985

Adults Living in Households of Total Monthly Expenditure of	Medan %	Jakarta %	Semarang %	Surabaya %	Ujung Pandang %
a. US$250 and over*	11	13	10	8	13
b. US$150 to 250	17	17	17	19	20
c. US$100 to 150	19	19	19	24	19
d. US$75 to 100	19	18	21	22	16
e1. US$50 to 75	18	17	19	18	17
e2. US$30 to 50	11	9	12	7	11
e3. US$30 to below	5	6	4	2	3

* For ease of calculation and understanding, the 1985 household expenditures quoted by SRI in Rupiahs were converted to US dollars @ 1:1000.

Source: 1985 Media Index General Report which is based on interviews of 6,761 adults (15 years or older) in eight cities, five of which are the same as the CPS.

Table 3

URBAN POPULATION BY ECONOMIC LEVEL AND
USE OF CONTRACEPTIVE

Economic Levels	Total Number In Cities Over 100,000		Number of ELCOs*		Percent of ELCOs Using (Contraception)		Number of ELCOs Using (Contraception)	
	1986	1989	1986	1989	1986	1989	1986	1989
	(000)	(000)	(000)	(000)	(%)	(%)	(000)	(000)
1. A + B	3,787	4,040	58	620	29	35	169	217
2. C, D + E	15,620	16,664	2,397	2;557	61	70	1,455	1,790
3. F	4,260	4,545	654	697	74	74	485	516
TOTAL	23,667	25,248	3,631	3,874	58	66	2,109	2,523

Notes

Level of Economy	% of POP	% of Users
A = Rp. 30,000	2	1
B = Rp. 30,000 - Rp. 50,000	14	7
C = Rp. 51,000 - Rp. 75,000	9	7
D = Rp. 76,000 - Rp. 100,000	36	39
E = Rp. 100,000 - Rp. 150,000	21	23
F = Rp. 150,000	18	23

Source: Study monitor Prevalensi Kontrasepsi di Jakarta, 1984/85 oleh Survey Research Indonesia (1984-85 Contraceptive Prevalence Survey in Jakarta), from BKKBN.

* Eligible couple for family planning.

I.3.2.2 Educational Levels. Generally, an improvement in socio-economic levels is accompanied by an increase in educational levels, and with a few exceptions, educational levels, especially those of women, are postively correlated with levels of contraceptive use. Indonesia has made considerable progress in recent years providing education to the urban population. Currently, according to the 1983 CPS, a substantial percent of the women in fertile age (WIFA) have some elementary education (45 to 50 percent), and a significant number have also received high school education (25 to 30 percent). This contrasts with the 10 to 15 percent who have received no formal education (see Table 4).

The correlation between education and contraceptive use is amply demonstrated in Table 5, which shows a considerably higher level of contraceptive use (49-68 percent) among MWIFA with higher education than among those who have not finished elementary school (19-40 percent).

I.3.2.3 Women's Role and Status in Society. Although no special studies have been made in urban Indonesia to correlate women's role in society with contraceptive use, an increasingly professional role of women (other than as child bearer and domestic worker) is generally associated with fertility reduction. In Indonesia, women are breaking out of traditional roles. Nearly 70 percent of the urban respondents of the 1983 CPS were working outside the home. Of the working women, 20 to 30 percent were in administrative staff work and 3 to 4 percent in managerial positions. It is, however, a slow process. Even in organizations such as BKKBN, the number of women in leadership positions is limited.

I.3.2.4 Breastfeeding. Traditionally, breastfeeding has been one of the more effective means of child spacing, especially when associated with cultural practices leading to extended post-partum sexual abstinence. According to the results of the 1983 CPS, urban Indonesian women continue to breastfeed their children; only 6 to 10 percent do not. On the average, full breastfeeding is continued for 3 to 4 months and partial breastfeeding for 1 1/2 years to 2 years. These responses suggest that the early introduction of other foods may be lessening the frequency of nursing, however, limiting the fertility control aspect of breastfeeding.

Table 4

EDUCATIONAL STATUS OF WOMEN RESPONDENTS CPS 1983

	Medan %	Jakarta %	Semarang %	Surabaya %	Ujung Pandang %
No education	7	13	20	14	17
Some elementary	64	45	42	50	53
Some high school	27	29	25	33	26
Academy/university	2	3	3	3	3

Source: 1983 CPS

Table 5

PERCENT OF MWIFA USING MODERN CONTRACEPTIVES BY LEVELS OF EDUCATION AND CITY

Education	Medan	Jakarta	Semarang	Surabaya	Ujung Pandang
	Percent Using Contraceptives				
Elementary unfinished or less	27	19	40	27	20
Finished Elementary and Junior High	38	41	58	51	39
Senior High or University	51	57	68	62	49

Source: CPS 1983

I.3.3 Negative Factors

I.3.3.1 Early Age at Marriage. Indonesia has had a pattern of marriage at an early age and early onset of first pregnancy. Apparently this has largely continued, although the 1983 CPS gave some indication of slight delay. The survey reports the age of first marriage in Medan, Surabaya, and Ujung Pandang has remained fairly constant at around 19 for the last 20 years. During these 20 years, the mean age of marriage for Jakarta and Semarang has increased slightly from 18 to 19 years.

I.3.3.2 Maternal and Child Health. Improvements in MCH and infant mortality are often associated with decreases in fertility. Indonesia's experience has not been as positive in this regard as that of many of its neighboring countries. Nutrition programs, diarrhea control, immunization, and family planning are beginning to make a favorable impact on infant mortality. However, according to USAID's child survival strategy, "The Infant Mortality Rate (IMR) in 1980 was 98/1000 live births, registering a 3.2 percent annual reduction during the 1971-1980 period. Indonesia's IMR is the highest in Southeast Asia and approximates rates in South Asia and African countries."

I.4 Effectiveness of Urban Family Planning Services

I.4.1 Quality of Service Providers

Despite the predominance of favorable factors, the typical new urban acceptor of family planning waits until she is 25.28 (the median age) with two (1.87) children before seeking family planning assistance. Indeed, only 1.53 percent of new acceptors are nulliparous.[7]

Given the receptive urban setting, there is considerable debate why a highly respected organization like the BKKBN has not been more effective in attracting younger women with fewer children. The most commonly accepted theory, as expressed in the August 1986 JHU/PCS report, is that rural areas offer a more congenial setting for BKKBN's approach to family planning than do the urban areas. The approach involves a joint effort by fieldworkers, village leaders, and users, who together exert peer pressure on their fellow villagers. This pressure translates into higher levels of contraceptive usage. The theory is that

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7 BKKBN figures.

this approach does not work so well in an urban setting traditionally where there is less homogeneity and less structure and where people generally have higher educational levels, more exposure to the media and more disposable income.

To quote the JHU/PCS report: "The strategy (in the rural areas) of enlisting village and religious leaders' support, the establishment of a network of fieldworkers, volunteer cadres, family planning posts and mothers and satisfied users clubs all these in a culturally homogenous compact setting has produced an outstanding success. Social and peer pressure against family planning have been turned around in favor of family planning.

"This village-oriented approach, however, has not worked as well in the urban areas where the socio-political environment is less structured, where there is less homogeneity and community control and where people have generally higher education level, more exposure to media, more disposable income, more busy time schedule and different lifestyle aspirations and information needs."

Another theory relates to the performance of urban providers and holds that these fieldworkers do not carry out their promotional/distribution tasks as well as their rural counterparts.

I.4.2 Other Constraints to Family Planning Service Delivery

This debate, while focusing on a major problem--quality of service delivery--omits two other crucial factors: the method mix and the need to publicize further and develop yet more favorable public attitudes towards family planning.

- <u>Contraceptive Mix</u>. Another constraint is that there is insufficient use of longer-lasting, more effective methods. The current mix in urban areas is shown in Table 6, as well as the projected trends towards longer lasting methods.

- <u>Attitudes</u>. The 1983 CPS and follow-up client surveys taken by SRI suggest that both rumors and misinformation about contraceptives as well as a continued desire for large families tend to inhibit contraceptive use, both in urban areas and nationally. Knowledge is also limited about the various contraceptives, their method of use, relative effectiveness and a proper understanding of side effects.

Taken together, the three factors (quality of service, method mix and negative public attitudes) go a long way in explaining the major constraints affecting the service delivery system.

Table 6

CONTRACEPTIVE MIX IN URBAN AREAS
(In order of effectiveness)

Types of Contraceptives	1986 Percent	1989 Percent
1. Female sterilization)		
2. Male sterilization)	11.0	13.0
3. Norplant	1.0	1.5
4. Injectable	20.0	20.0
5. IUD	28.0	31.5
6. Oral	32.0	24.0
7. Condom *)	8.0	10.0
8. Other (e.g. Rhythm, withdrawal**)	N.A.	N.A.

* Condoms + vaginal tablets
** N.A. (BKKBN figures are based on reported users--users of these other methods are not recorded)

Source: BKKBN

A particular constraint has been in relation to voluntary surgical contraception (VSC), which, for sensitivity reasons, has not been made part of the official family planning program. The lack of access to this important permanent method is one of the contributing factors to Indonesia's program not having had the demographic impact one might have expected in light of the reported high level of prevalence. These constraints appears to be lifting at present. Over the next three years, the BKKBN also hopes to increase the use of IUDs and decrease the use of oral pills.

I.5 Description of Government Family Planning Service Delivery

As in the rest of the country, the bulk of family planning services are provided in the urban areas under the

direction of the BKKBN with much of the actual service delivery being carried out by the Ministry of Health. USAID bilateral assistance has been provided to this effort since 1969. An operations research proposal by the University Research Corporation (URC), the BKKBN and a private family planning foundation, YKB, describes this activity in a succinct fashion:

"BKKBN and MOH provide complementary services. The responsibility of providing medical services and contraceptives to clients is assumed by the MOH. Family planning information, education and communication (IEC), training and motivation are largely the responsibility of BKKBN. BKKBN provides the training of MOH staff, and the necessary instruments and contraceptive supplies as well as subsidy needed by the latter to effectively perform its family planning functions. On the other hand, MOH assists BKKBN in undertaking some of the latter's IEC and motivational activities.

"At the field level, BKKBN maintains its line of family planning field workers (FPFWs) and supervisors, whereas MOH operates its own health centers for family planning service and follow-up. Health center staff also motivate walk-in clients to become new acceptors. Assisting the BKKBN FPFWs are volunteers known as VCDC. The VCDC gets the supply of contraceptives from the MOH health center, and is responsible for it to the health center. In turn, VCDCs report the number of methods distributed and new acceptors. BKKBN provides VCDCs with Rp. 200-300 per month to cover transportation costs. The activities of VCDCs are directly supervised by the FPFW."

While volunteers are the motivators, the MOH medical/paramedical group is perceived by the local populace to be their best source of information on family planning. The JHU/PCS August 1986 survey also found that

-- Main sources of awareness of family planning are puskesmas (health centers) (19 percent), TV (16 percent), friends and neighbors (13 percent) and doctors (10 percent). When a follow-up question on "other sources" of information was asked, midwife increased from 5 to 18 percent, radio from 3 to 16 percent, and friends/neighbors from 13 to 28 percent.

-- The most reliable sources of information come from the medical/paramedical group: doctor (57 percent), puskesmas (47 percent), midwife (45 percent) and friends/neighbors (37 percent).

-- Preferred sources of reliable, non-embarrassing information are also the medical group: doctor

(13 percent), midwife (16 percent), and puskesmas (14 percent).

The program, in general, has a high level of contact with the populace; about 94-98 percent of persons interviewed stated that sources were conveniently located (65 percent used a vehicle and 34 percent walked). Furthermore, the level of satisfaction was higher than that generally found in relation to public programs. It bears repeating here that this approach has achieved contraceptive prevalence levels that exceed 45-50 percent in Jakarta and other major cities (see Section I.1).

There were problems, however. In this country of noteworthy community cooperation, for example, one might have expected to see more community involvement in the management and maintenance of the health centers. This is said to be a service provided for the community by the MOH and the local government; there was, however, little involvement except as recipients of the service. Apparently there is more community involvement with sub-centers and posts (posyandu).

Discussions with program leaders and site visits indicate physical conditions and hours of service, among other things at the puskesmas, leave something to be desired in terms of attractiveness and client convenience. Other problems are the lack of aggressive outreach by some field workers, the limited involvement of private doctors and midwives, and shortcomings of the client information system.

I.6 BKKBN Strategy

For the remainder of the decade, a major BKKBN goal will be to increase the percentage of the urban population who are contracepting.

The major new thrusts of BKKBN policy are toward

(a) increased privatization of family planning service delivery, giving more emphasis to private practitioners (doctors and midwives), pharmacies and private voluntary organization hospitals, clinics and volunteers.

(b) increased emphasis on program self-sufficiency and fee for service by those who can afford to pay.[8]

While the new thrusts are aimed at increasing prevalence, they are also to introduce a greater emphasis on the voluntary nature of family planning and a shift toward more private and individual responsibility for fertility control. The government will continue to take a strong role in urging fertility restraint but seeks to encourage individuals to take a more active part in pursuing these objectives.

The objectives of BKKBN policy could be stated in more detail as follows:

(1) To improve the quality of service, especially offering alternatives in service delivery points and contraceptives.

(2) To increase the percentage of the urban population contracepting and the percentage of those who are demonstrating their individual responsibility by paying for part of the service.

(3) To encourage a shift away from the use of less effective contraceptives among all users and to encourage a shift to more long lasting, more secure contraceptives among the older, higher parity users.

(4) To increase numbers of users who wish to postpone the first birth and those who wish to achieve a small family norm.

(5) To increase knowledge about contraceptives, their method of use, relative effectiveness, proper understanding of side effects and knowledge of all the alternative sources of supply. This includes increased attention to male responsibility.

(6) To increase the number and type of service providers and service delivery points, emphasizing ease of access for the lower economic level and use of subsidized private or full commercial channels for those who can pay for part or all of their ser-

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8 The JHU/PCS survey found that 38 percent of those questioned know they must pay for a service and 35 percent know they must pay for supplies.

vice. This implies a substantial shift from free public sector services to relatively more use of private fee-charging services.

(7) To strengthen the capacities of such private organizations as the Indonesian Association of Doctors (IDI), the Indonesian Association of Midwives (IBI), the private research organization (YKB), and the Indonesian Association for Secure Contraception (PKMI), to organize networks of family planning delivery in urban areas.

(8) To strengthen the commercial sector as a means for users to exercise greater freedom in choosing their method of contraception and in sharing the cost.

These policy thrusts and objectives are to be carried out under the overall guidance of BKKBN. The BKKBN Chairman is forceful in articulating these policies and has taken a personal role, especially in the contraceptive social marketing program, in pursuing them. There are positive elements of this new thrust being integrated into the responsibility of several BKKBN Bureaus. However, there is some confusion as both the Bureaus of Planning and Operations are involved as well as Divisions of Contraceptive Service and Integrated Programs.

BKKBN's initial programming thrust is to target the country's 11 largest cities, which have an estimated population of from three to four-and-one half million. Table 7 shows the targets for changes in the characteristics of new acceptors in urban areas (see Section I.4.1).

Table 7
Characteristics of New Acceptors in Urban Areas

		1986	1989
(1)	Average Age (Median)	25.28	24.25
(2)	Average Parity of new acceptor (Median)	1.87	1.5

BKKBN projects that between 1986 and 1989 the semi-commercial (i.e., subsidized, generally with government-supplied contraceptives) and commercial providers of family planning will have increased their share of users of family planning from 20 to 30 percent of the total, with public sector hospitals, clinics

and field worker volunteers dropping correspondingly from 80-70 percent of the total. BKKBN projects a modest rise in the number of service points providing family planning services, except for hospitals which are expected to increase dramatically from 102-600. Numbers of commercial and semi-commercial doctors and midwives are expected to increase more rapidly, however. By 1989, it is anticipated that 70 percent of all commercial doctors in urban areas will be providing family planning services (compared with 60 percent in 1986) and that 60 percent of commercial nurse-midwives will provide services (compared with 50 percent in 1986). The high percentage of semi-commercial midwives now providing services will remain the same--80 percent in both 1986 and 1989. The strategy would be to move users at the upper end of the low-income group (those whose incomes are at $50-100 a month) from the public sector to the semi-commercial and commercial sectors (see Appendix C).[9]

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9 While BKKBN keeps excellent records, the projections made above and in Appendix C required BKKBN to manipulate in new ways its existing data on users and providers. Some of the data needed for the analysis were not available and much had to be developed on the basis of estimates from samples. Nonetheless, the results, produced under considerable time constraints, proved very useful for this report.

II. PRIVATE SECTOR FAMILY PLANNING ACTIVITIES

There are a dozen or more organizations and activities in the private sector that might be enlisted in efforts to increase the availability of family planning services in urban areas. These include professional medical organizations, religious organizations, non-sectarian membership organizations that deliver family planning services, specialized activities, and commercial sales.

II.1 Professional Organizations

II.1.1 Indonesian Doctors Association (IDI)

IDI is a professional association representing Indonesia's 21,000 doctors. It is the only recognized medical association in Indonesia and has 16,000 general practitioners and 5,000 specialists representing 20 different specialty areas (including 600 in ob/gyn). Most of the doctors practice in the public sector a half day (2-5 years of public service is required). Most also have a private practice in the afternoon and evening.

IDI has a central office in Jakarta, 11 provincial offices and 160 branches. Its staff is small, with six persons in Jakarta and usually one person in each of the other locations. Dues are 1,500 R/month/member, an amount that does not allow for program expansion.

Present emphases of the IDI are

- -- Professional development, associated with specialization,
- -- Continuing medical education, and
- -- Community action programs (family planning, drug education, etc.).

The second and third emphases are related to the BKKBN family planning program.

The organization has a positive view of involvement in family planning. While generally favoring increasing the access to contraceptive services, the IDI board has taken a relatively conservative position toward midwife involvement, confirming the requirement that doctors must supervises nurse-midwives providing family planning and that an examination by a doctor is necessary before oral contraceptives can be provided.

While wishing to be more involved in family planning, IDI wants more authority from BKKBN to manage its own actions and more support to strengthen this capacity.

II.1.2 Indonesian Association of Gynecologists (POGI)

POGI is supported by Family Planning International Assistance (FPIA). It has become an outspoken ally of YKB (see Section II.4.2) and BKKBN in support of more aggressive approaches to family planning service delivery. Its extended medical supervision of the Indonesian Midwives Association (IBI) has made it possible for midwives to have more flexibility in providing family planning services. On the other hand, it had some difficulties in its administrative relationship with FPIA and it is not clear what service has been provided in university clinics.

II.1.3 Indonesian Midwives Association (IBI)

IBI's executive board is fully supportive of USAID-funded efforts to enable midwives to provide family planning services (see Section II.4.2) and is developing plans to expand this activity.

IBI recognizes a need for assistance to grow, to manage more of its own affairs and to have a more direct relationship with support agencies but sees the solution primarily in financial terms. The primary source of funds is membership fees. IBI has chapters in each of the 27 provinces as well as 260 branches. It has 13,000 members, not all of whom are active in family planning.

II.1.4 Indonesian Pharmacists Association (ISFI)

This organization is relevant to the project primarily because it currently has control over distribution of contraceptives in the private sector. An important issue is whether it would be willing to relinquish this control and permit doctors and nurse-midwives to dispense contraceptives from their offices.

II.2 Religious Organizations

II.2.1 Indonesian Christian Association for Health Services (BELKASI), Council of Churches (DGI), Department of Community Development

BELKASI has its roots in the Protestant church; it is assisted by Church World Service and unites the Council of Churches, the Evangelical Council and the Pentecostal Council. In keeping with Indonesian legal requirements, however, BELKASI emphasizes its health program rather than its religious affiliation. Said to be open to all, BELKASI appears to have good relations with Catholic-affiliated PERDHAKI (see Section II.2.2) for which Church World Service gets duty-free imports at times, and BKKBN, which provides commodity support. Its director is a female physician.

BELKASI has a network of 30 hospitals, most of which are urban and all of which provide family planning, including 19 which offer VSC. There are an additional 120 health centers and maternity clinics, 103 of which provide family planning. About half of these are urban. These institutions are located nationwide, some clustered around important missionary hospitals.

BELKASI is funded largely through individual and institutional membership contributions, which run as high as $500/month for large institutions. It is not clear what service the member institutions get that encourage this large a contribution, since BELKASI does only limited central purchase and/or distribution of supplies. BELKASI also receives German and Netherlands government aid through their respective national church agencies.

BELKASI reports that in 1985 its facilities provided service to 36,500 new acceptors and 158,000 revisits, which may mean about 40,000 continuing users. This was down about 10 percent from 1984, largely because of phase-out of FPIA support for small clinics and motivator/fieldworkers. The rate for various services is as follows:

Rp. 100 for a clinic visit and Rp. 1,500 for Depo-Provera (if client can pay).

BKKBN pill: free -- Schering pill: 2500 R/cycle.

Lippes Loop IUD: free -- FPIA CuT: 500 R to 1000 R.

II.2.2 Association of Voluntary Health Services of Indonesia (PERDHAKI or Indonesian Catholic Health Council)

PERDHAKI is a non-governmental organization (NGO) closely allied with the Catholic church. It has served as the grantee for FPIA funding for the Association of Voluntary Health Services for the past 8-9 years. Current FPIA funding is about $150,000 annually. PERDHAKI provides contraceptives to a network of 350 health institutions and training to nurse-midwives (a total of 400) and natural family planning (NFP) counselors (200-300).

In keeping with Indonesian law, PERDHAKI is not primarily religious in its affiliation, although its member health institutions are almost all run by Catholic orders or congregations. PERDHAKI headquarters is housed in facilities made available by the church but not under the direct supervision of the diocese. It has a Board of Directors elected by the member units and an Executive Staff of 25 professionals and support personnel. In addition to providing technical assistance, PERDHAKI purchases standardized essential drugs that it supplies to its members at enough savings to be attractive and enough markup to make the institution largely self-sufficient. Most of PERDHAKI's 120 affiliated hospitals are in urban areas, and almost all provide family planning services. About half the 230 health clinics are in urban areas, with approximately 80 providing family planning. Relations are said to be good with BKKBN, which provides commodity support but no financial assistance.

The method mix is about

40 percent injectables	- PERDHAKI, central purchase for 800 R.
40 percent pill	- mostly from BKKBN
20 percent IUD	- mostly from BKKBN
2 percent condoms	- mostly from BKKBN
2 percent NFP	

PERDHAKI expects to have no trouble reaching its current user target of 30,000 new acceptors and 50,000 continuing users.

Although provision is made for those who cannot pay, there is a significant fee for service.

Injectables: 800 R/dose plus 100-200 R service

Pill: 1000 R to 1500/cycle

IUD: 1000 R Lippes to 10,000 R CuT

PERDHAKI and FPIA have developed a system of financing subprojects (about $5,000 each) with member units, an approach that might have merit for the future. However, the administrative requirements are a constraint for project development (only five subprojects so far) and it may cost more to manage them than the amount distributed. An FPIA team is presently evaluating this approach.

II.2.3 Muhammadiyah

Muhammadiyah, an established federation of several Muslin women's, youth and welfare organizations, was founded in 1912. It has a central board and several councils in Jakarta, 25 Provincial boards, 300 Regencies, and 2,000 branches. To be a branch, a group must either run a school or a maternity hospital. There are approximately one million registered members and considerably more non-registered interested supporters. In addition to some 10,000 schools and 50 colleges, Muhammadiyah maintains eight hospitals, 125 maternity hospitals, 500 MCH clinics, eight schools for paramedical personnel, and 120 orphanages. Muhammadiyah considers its major contribution to family planning to be in the areas of policy support and informational programs rather than in service delivery. Initially it received assistance from The Pathfinder Fund, more recently from FPIA.

To the degree possible, Muhammadiyah asks fees for services including family planning. The family planning service delivery activity may reach as many as 20,000 new acceptors/year.

The director of Muhhamadiyah's social welfare council says the organization played an influential role in gaining Muslim leader and popular acceptance of family planning when the government intitiated its family planning policy in 1965. The organization considers its involvement in family planning important for its policy support, informational programs and somewhat less for service delivery.

II.3 Non-Sectarian Organizations

II.3.1 Indonesian Planned Parenthood Association (PKBI)

Founded in 1957 as an affiliate of the International Planned Parenthood Federation (IPPF), the PKBI continues to play a pioneering role in family planning in Indonesia and is recognized as one of the leading NGOs in the family planning movement in Indonesia. It does not receive any U.S. Government assistance due to AID's policies on means of fertility regulation. It has 19 active chapters at the Province level, 16 comprehensive family planning clinics and a number of small projects (community-based distribution in the transmigration areas and income generative activities in various locations). PKBI helps to develop a sense of volunteer leadership participation and self-reliance in family planning. About half of its $1.5 million annual budget comes from international sources and half from fees for clinic services, training programs and local contributions. PKBI has good working relations with BKKBN but would like to see BKKBN's privatization efforts move faster.

The comprehensive clinics provide counseling, training, pre-natal exercise classes and a full range of fertility management services, most with a fee for service to a middle and upper class clientele. Most of the clinics are self-supporting. Fees for service are as follows:

Counseling: 2,500 R/hr. or 25,000 for two-hour group session for 20

Prenatal exercise classes: 10,000 R/month

Sterilization: 10 to 15,000 R

IUD: 5 to 7,000 R

Injectables: 5,000 R

Pills: 1,500 to 2,000 R/cycle

Family Planning clients include about 35,000 new acceptors per year.

II.3.2 Indonesian Forum for Population and Family Planning NGOs (FISKA)

This organization, supported by PKBI and the Ministry of Environment and Population and housed in the PKBI headquarters, arranges annual meetings for participating NGOs to

share information and engage in coordinated planning. It reports membership growth from 20 NGOs in 1983 to 300 in 1986 and three plenary sessions annually.

The organization expects to provide some management training to its member organizations and assistance with developing proposals for national or external funding. To date, however, its small executive staff appears primarily to have been engaged in organizing the annual meetings and in providing information. If it were to take a more aggressive role in coordinating NGO activities, it would need considerable internal strengthening.

II.3.3 All Indonesian Workers Association (SPSI)

FPIA supports this effort to introduce family planning at the factory site. Union leaders are trained and motivated to promote provision of family planning in factory clinics. The current target is coverage for 15-20,000 new acceptors. While the effort is as yet fairly small, it can be credited with having laid the groundwork for the factory site family planning project described immediately below.

II.4 Specialized Activities

II.4.1 Factory Site Family Planning

Building on work of the International Labour Organisation (ILO) and that of SPSI, UNFPA has developed a substantial project with the Ministry of Manpower (DEPNAKER) and the BKKBN. This $2 million project ($1.5 million from UNFPA and the rest from the GOI) will provide funds to enable 1,200 plants to increase the level of family planning services in their health units. Much of the program involves training and motivation, with the main responsibility for clinical services resting with the factories.

BKKBN is expected to provide initial supplies of contraceptives (as it has been doing for many industrial clinics in the past). Project assistance will be provided for equipping 120 clinics. It is estimated that in excess of 1.2 million workers are employed by these factories, some of which have as many as 9,500 laborers.

The AID-centrally funded Technical Information on Population for Private Sector (TIPPS) and ENTERPRISE projects have been cooperating in this effort, providing technical assistance in reviewing the cost benefit to industry of providing family planning services to its workers. Several clinic demon-

stration projects in selected industries may be funded by the ENTERPRISE project, working closely with UNFPA and DEPNAKER.

The UNFPA project got under way in September with the arrival of a consultant and the official inauguration of the project by the Minister of Labor.

II.4.2 Yayasan Kusuma Buana (YKB)

YKB is a private non-profit corporation founded to do research and experimentation in family planning delivery. It has made noteworthy contributions in Norplant research in conjunction with The Population Council (see Section III.1.3) and in the development of non-literate communication materials with the Program for the Introduction and Adaptation of Contraceptive Technology (PIACT) and will be an important participant in an operations research activities to test ways to improve the BKKBN MOH delivery system (see Section III.1.1).

Since 1981, the YKB has been engaged with BKKBN and USAID (initially with FPIA assistance) in several experimental activities aimed at development of greater involvement of the private sector in family planning. YKB is conducting research to determine whether eight private clinics it manages could become self-sufficient through charging fees for service and offering a better quality of service, more convenient hours, and more contraceptive alternatives, all of which might attract an upper lower class and middle class clientele. Several of the clinics have become relatively self-sufficient. The clinics are each handling 1,200 to 1,500 continuing users at a recurrent cost to YKB of about $5,500/month. This works out to about $55/continuing user/year. Obviously some of this high cost per user is related to the start-up costs and requirements of close monitoring as a study area. Nevertheless, this approach does not appear to be sustainable.

Another area of the YKB work may be more promising. As part of a USAID-supported grant from BKKBN, YKB has been working with nurse-midwives, training them in family planning, securing medical supervision through POGI, providing IUD kits and an initial supply of contraceptives, and resupplying contraceptives at wholesale prices. Organizational problems and medical restrictions delayed initiation of this activity, but it appears now to have been successfully launched. Four hundred and six Jakarta-based midwives have been trained and supplied and have been providing service for six months. Some 25,000 "new" acceptors have been registered (at least "new" to this delivery approach), according to reports from 55 percent of the trainees. If the midwives are servicing an average of 900 clients at a start-up cost roughly estimated at less than $800 per midwife

(including IUD kits and contraceptives), costs will be at a very respectable level in a short time.

YKB has also assisted BKKBN in making a needs assessment and an inventory of potential private service providers in Jakarta and nine other cities. These are reported to have resulted in the formation of "YKB-like" counterpart organizations (not branches) in seven cities and leadership identification in others. YKB does not see itself as a leader of a national organization, but as a catalyst to help local leadership, working with BKKBN, to form local organizations, meeting local needs and dealing with local problems. There is much to be said for this approach as it stimulates local initiative. It may not be sufficiently direct, however, to respond to the rapidly changing role expected of the private sector in Indonesia.

II.4.3 Indonesian Association for Secure Contraception (PKMI)[10]

PKMI, with a specialized program providing VSC, is supported by the Association for Voluntary Surgical Contraception (AVSC), FPIA, USAID through BKKBN, as well as by The Pathfinder Fund and Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO). PKMI has demonstrated the capability of the private sector to organize and broadly and effectively to deliver a quality service. The service is largely, but not exclusively, delivered in public sector facilities. By carrying out needs assessments, training the surgical teams, providing equipment, and assisting in the organization of services, PKMI has helped to secure the availability of VSC in 2,157 clinical settings. These had provided service to 660,906 clients by January 1986 (84,000 between March 1985 and January 1986). While PKMI is largely supported by external sources, it is considering developing means of self-support, including patient fees and the distribution of products of such firms as KLI and FEMCARE.

II.5 Commercial Sales

A limited growth in the commercial sale of various contraceptive methods, largely through the country's 2,000 pharmacies, has accompanied the development of private and public sector family planning services. Condoms are also available

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10 The following treatment of this important organization is brief, in view of the availability of extended coverage in other reports.

through a wide variety of other outlets. A rough estimate of the volume of sales through commercial outlets is as follows:

Pills	-	One-and-one half to 2 million cycles (based on IMS audit of the wholesale value of sales to pharmacies and estimated wholesale price as paid by YKB. PT MECOSIN [see Section III.3] estimates of the commercial market are considerably smaller).
Condoms	-	116,000 gross (estimated by SRI as part as part of the Social Marketing for Change [SOMARC] project marketing plan study--sales to the "reputable" market).
Injectables	-	125,000 doses (estimated by BKKBN division of contraceptive supply).

This would suggest that on an annual basis, 250,000 to 300,000 persons are purchasing their contraceptive supplies from the regular commercial channels--largely in the urban areas.

III. NEW PUBLIC AND PRIVATE SECTOR INITIATIVES IN URBAN AREAS

Considerable outside support, particularly from USAID, is helping launch new initiatives to improve both public and private program performance and client satisfaction in urban areas. The initiatives are primarily in the areas of research, service delivery, commercial sales and IEC.

III.1 Research

III.1.1 Operations Research

BKKBN, YKB and the University Research Corporation (URC) are jointly developing an operations research project to test methods to improve the BKKBN/MOH delivery system in urban areas. This involves creation of a new cadre of Neighborhood Contraceptive Distribution Personnel (NUCD), similar to the urban volunteers in the MOH/BKKBN delivery system. The NUCD role will be to visit urban households and aggressively to offer contraceptive information and supplies. Modest fees for service will provide the basic remuneration and incentive for the NUCDs and their supervisors, who will be similar to the FPFWs (see Section I.4). Free contraceptives will be provided by BKKBN. A referral system will be improved which can steer clients to the local MOH health center or to participating private midwives or doctors. This three-year project will operate in selected areas of three cities. Within 18 months, it should provide enough information to permit decisions on the expected expansion to 11 cities.

III.1.2 Patient Flow Analysis

Plans are being developed to work with the CDC in a client flow analysis of various MOH facilities to improve the efficiency of the service and its convenience to the client.

III.1.3 NORPLANT

Indonesia is the site of one of the world's most extensive field trials of NORPLANT, an encouraging new long-acting (five-year) contraceptive developed by The Population Council. NORPLANT has proven to be a very acceptable contraceptive under Indonesian conditions.

Initial testing of 1,000 implants by YKB in two clinics in Jakarta and Bandung was followed by a 10,000-client test in 40 centers. Initially, specialists were used to do the implants, then general practitioners, and finally midwives. Medical

faculty involvement provided additional supervision and training. BKKBN purchased the first 34,000 implants needed for the expanded field trials. UNFPA and the Asian Development Bank participated with BKKBN in a second purchase of 94,000 implants. To date approximately 40,000 implants have been made. This method is not inexpensive, costing $11 per implant as delivered, with import costs through Kimia Farma (see Chapter IV) reportedly adding an additional $8. It is, however, a safe, long-lasting and effective contraceptive that will quite likely take an increasing role (probably among the fee for service clientele) for those who want to limit their fertility but are not yet ready for sterilization.

III.1.4 Contraceptive Prevalence Survey

The nationwide CPS planned for 1987 will help to verify user levels and provide additional information on knowledge levels and perception of accessibility of services. Technical support is provided by Westinghouse, financed by AID central funds, while local costs are covered by bilateral funds.

III.2 Urban Block Grant

As part of the present USAID bilateral project, urban block grants are provided to fund urban projects, primarily those supporting new initiatives in the private sector. After some delay, 11 such block grants have been approved since August 1, 1986, ranging from $15,000 to $50,000. Much of the initial support went to professional organizations (IBI, IDI, and ISFI) in the belief that it was important to involve their members in policy-setting, communication and service delivery. IDI's direct involvement in planning and management of family planning represents a significant qualitative change in BKKBN's relationship with the private sector. Some clinics are experimenting with such changes as evening hours and some media and promotional campaigns are being organized. According to BKKBN, IBI gained over 51,000 new acceptors during the first six months of 1986 and IDI claimed nearly 79,000 new acceptors, both as the result of the block grant. This, therefore, appears a promising approach to decentralizing planning and helping BKKBN improve its private sector relationship and involvement. Appendix D provides a six-month report from participating midwives and doctors on new acceptors.

III.3 Contraceptive Social Marketing

The BKKBN has taken a leading role in assisting the development of a contraceptive social marketing project that was inaugurated in April 1986 with funding from the SOMARC project,

an AID centrally funded activity. The project has a well-funded promotion/advertisement component and has benefited from 10 years of AID experience with social marketing. Expectations are that this project will fare better than its predecessor, a mid-1970s experiment selling condoms through "jamu" (herbal medicine) sellers. This project had mixed reviews. One report was encouraging, pointing out that with a limited ($10,000) promotional budget spent with a private advertising firm, the project had some initial success, reaching levels of sales of 90,000 condoms ondoms per month.[11] Others have not judged this level of sales so positively. The project nacewas listed among the CSM failures in AID's evaluation special study no. 40 "AID's Experience with Contraceptive Social Marketing April, 1986." That report does not give any reason for the failure. The general consensus seems to be that in the 1970s, the time was not ripe for the necessary government support for an aggressive promotional campaign advertising the commercial sale of contraceptives. There are still some constraints on advertising (cannot use TV) and commercial distribution of ethical products (orals, IUDs, injectables); however, the issue of lack of government support seems nearly to have evaporated in 1986.

Initially the project was launched with sales of Dualima condoms in three cities: Bandung, Medan and Surabaya. Following the launch, a private firm, Survey Research Indonesia (SRI), surveyed the target audience response to advertising (by a private firm, FORTUNE). SRI also carried out a sales outlet audit to review stocking performance by the commercial distributor (PT MECOSIN) and reviewed product performance in relation to other condom brands. These surveys indicated excellent performance by both the advertising and distribution firms, though actual sales of the product have not yet reached adequate levels (six-month sales figures in test market area are about 6,000 gross against a 100,000 gross first-year target). Although sales figures were lower than hoped for, the small overall market of condoms increased significantly in this period (28 percent) and Dualima attracted approximately 3 percent of the previous non-condom users to Dualima (in actual numbers this 3 percent is probably about as many as the previous condom users who tried Dualima). The initial performance was sufficiently encouraging that the review committee (BKKBN, PT MECOSIN, FORTUNE, SRI, SOMARC, and USAID) enthusiastically endorsed an October launch in Jakarta.

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11 Previous experimentation in the mid-1970's with social marketing of condoms by "jamu" sellers is described in encouraging terms by Dr. L. Hendrata in a publication of the East-West Center, "IEC Strategies: Their role in Promoting Behaviour Change in Family and Population Planning."

Examples follow of survey findings related to the promotional campaign, stocking of product, and sales.

-- Unaided awareness of condom as family planning method: 77 percent of respondents as compared to 72 percent pill and 63 percent IUD (an increase of 9 percentage points for condom following the campaign).

-- Total unaided awareness of Dualima brand: 55 percent as compared to 12 to 15 percent for others.

-- Awareness of condom brand advertising: Dualima 78 percent compared to 2 to 9 percent for others.

-- From Dualima launch until August, sales of all condoms increased by 28 percent and Dualima achieved 16 percent of the market.

-- 73 percent of the market are premium (priced) 3/$.40 or more; Dualima competes in the standard (priced) market (25 percent); Dualima has 62 percent share of the standard market.

-- Dualima has achieved a high spread of distribution. By the end of the test period 82 percent of the outlets sampled stocked Dualima as compared to 94 percent and 83 percent for traditional brands. (Fifty percent is considered high for new commercial products.)

-- Of those who tried Dualima, 85 percent said they definitely or probably would buy it again; only 4 percent said they probably or definitely would not.

-- During this period 33 percent of the sample who were previous condom users tried Dualima; of the non-contraceptors, 3 percent tried Dualima.

PT MECOSIN is considered to be a medium-sized pharmaceutical manufacturing and marketing company. The owner reports a 100 percent increase in the last two years, bringing the company's business level to $7 million annually. Its distribution network includes eight area managers, each with seven detail men who together contact up to 10,000 doctors per month, 2,000 apotiks (pharmacies) and several thousand other shops. There are also 60 merchandisers who are involved in the supply/promotion function.

In a way that is not completely clear, this system uses a "sole distributor," PT Sawah Besar, to supply stores with more that 40 pharmaceutical products, one of which, the cough syrup LASERIN manufactured by MECOSIN, is the nationally leading product in its field. PT MECOSIN is housed in modest but functional offices in Jakarta and gives the impression of an active, forward looking firm. It is difficult to say the same of the regional offices in Bandung, small operations in rented quarters.

PT MECOSIN's management expresses enthusiasm about the SOMARC project which derives in large part from the opportunity it gives MECOSIN to build relationships with the government and to project a good public image. MECOSIN, however, does not consider the project viable based on sales of condoms alone. Given the small size of the current condom market (116,000 gross annually), this conclusion is correct. The official prohibition on sales of ethical products, particularly of pills, however, currently makes it impossible for MECOSIN to add other contraceptives to its product line. A challenge to the project is to find ways to resolve these constraints.

A second challenge is to expand the overall market for condoms. MECOSIN sees no problem in adding doctors, midwives, factory sites and NGOs to the current marketing system. To serve these new outlets effectively, however, MECOSIN would have to offer a full product line, not just condoms. To meet these related challenges--expansion of product line and increasing number of outlets--MECOSIN will need to review ways to strengthen its marketing/distribution system.

The addition of other products is part of the step-by-step approach of the CSM project. The essential market research for adding oral contraceptives is expected to be carried out in October. How long SOMARC's available $2.5 to $3 million for advertising and promotion will carry this project will depend on how soon the condom market is expanded and when oral contraceptives are added.

A number of the private sector organizations reviewed in Chapter II have expressed an interest in receiving contraceptives through the CSM project. BELKASI's director stated that clinics would purchase from the project if offered Depo-Provera and IUDs. If BELKASI clinics, however, had to buy and sell pills and condoms, he believes they would lose clients. Muhammadiyah's secretary of the Social Welfare Council said that the CSM project would be consistent with the organization's interest in people relying on themselves. IDI indicated it would welcome the CSM project as a way to handle logistics for itself and other NGOs, but questioned ISFI's reaction (see Section II.1.4). IBI, on the other hand, had not heard of the CSM project.

III.4 Information, Education and Communication

Johns Hopkins University/Population Communication Service (JHU/PCS) has assisted USAID and BKKBN in developing a strategy for a widespread communication campaign based on the results of the 1983 CPS and the follow-up client surveys of the SRI.

An advertising brief and contracting procedures have been developed to enable USAID/BKKBN to secure a private public relations firm to carry out the campaign. The major objectives are to

a) provide more accurate information about contraceptives, dispelling rumors and misinformation;

b) disseminate information regarding the increased availability of contraceptive service providers, especially in the private sector; and

c) promote concepts of family size limitation.

This campaign, together with the CSM promotional campaign, should substantially improve the quality of information and knowledge of access to additional suppliers.

III.5 Increased Technical Assistance

Based on the positive results of one-person technical assistance being shared between the urban program and the sterilization activity, plans have been developed to split this assignment to allow more time for each. Possibly with the assistance of ENTERPRISE, an additional two years of TA will be secured specifically to assist the urban sector programs.

IV. IN-COUNTRY PRODUCTION OF CONTRACEPTIVES

A government-owned corporation, Kimia Farma, which has been exporting quinine since 1960, began to produce oral contraceptives in 1980. Different from other programs where women were conspicuous in their absence from leadership roles, this plant is managed by a competent and experienced woman. Raw materials (both for pill and package) are imported. The only pill presently being produced is the Syntex Noriday 1/50 formulation with BKKBN the sole outlet. The plant expects to produce a low dose pill next year. UNFPA is reported to have made inquiries leading to possible purchase for other Asian country programs. Most of the difficulties encountered early in the process have been resolved and this modern, clean and spacious factory (financed with AID, UNFPA and World Bank assistance) seems to be operating with little production problems. An exception is that of fluctuating production schedules since the only purchaser is a government agency which buys as money becomes available. Apparently last year's 40 million cycle production was crowded into about 6 months (although Kimia Farma considers its capacity about 50 million/year). There has been little production since March and it is just beginning to manufacture the pill again--not yet in packaging. Quality control procedures were set up by Syntex; presently they are all handled internally. The package is simple and attractive in appearance, the three pack in an aluminum foil pouch, much the same as AID supplied pills, complete with the Blue Lady symbol. Cost of production is estimated at 12 to 13 cents U.S. per cycle which at present does not represent much saving over world market prices. There is a foreign exchange savings since about one half the cost is local production cost, including employment of about 100.

Another building houses the IUD plant, a clean and spacious facility with modern equipment. The Population Council has assisted in establishing this facility which last year produced 1.3 million Lippes Loops. This year, the company expect the BKKBN order to be only 1 million. Last year, using equipment provided by The Population Council and adapted to its needs, it made 100,000 copper Ts--no order yet this year. It is making multi-load IUDs on a trial basis. The plant is presently only employing five persons in the period when lack of orders and shortage of raw materials has halted production. All the IUDs produced are sold to BKKBN. Production costs of Lippes are reported to be about 5 cents U.S. with price to BKKBN of 10 cents. Copper Ts are reported to cost 50 cents to produce with cost to BKKBN about $1.00.

The new venture in this contraceptive production complex is the installation of a very sizeable condom factor (with Japanese loan and technical assistance). The plant, which

is scheduled to start trial production October, has the appearance of being ready. A problem related to the quality of locally produced latex is said to be resolved and the hope is to be in actual production in January, 1987.

A major concern is to secure an adequate market to keep production costs within reason. The plant has a total production capacity of approximately 900,000 gross annually from its three parallel lines. At 500,000 gross production, the cost (including amortization of the factory) is estimated at around 4 cents U.S. per condom, a price scarcely competitive on the world market. At present, total condom use (program and commercial) in the country is estimated at around 300 to 400,000 gross per year. This suggests the requirement for considerable promotion to take advantage of this large production facility. Employment is estimated at 150 persons.

V. RECOMMENDATIONS FOR FUTURE USAID STRATEGY FOR URBAN FAMILY PLANNING

V.1 Overall Strategy

The amendment to USAID's Family Planning Development and Services II Project and thereafter the new project (Private Sector Family Planning Project FY 1989) should aim to build on the successful urban family planning activities USAID has supported to date. The goal now should be to implement these good initiatives, which are supportive of BKKBN interests and which cover areas important to privatization objectives and improved performance. The following components are recommended for continued emphasis, either as part of the current project, its amendment, or as a bridge to the new proposed project (see Table 8).

V.2 Activities with Carry-over or Amendment Funding Project

The following activities, funded under the current project, either should be continued under carry-over funding (totaling $2.4 million) through March 1989 or are recommended for possible funding under a project amendment (or both).

V.2.1 Operations Research

While increased emphasis should be placed on the private sector, the importance of a continued role for the public sector should not be underestimated. The private, fee for service sector is still comparatively small and there is some limit to its immediate potential. Improvements in outreach can be achieved in the public sector; fees for services can be introduced and more popular involvement in health center management and maintenance may be developed.

USAID's involvement should be through operations research on use of fee for service by field workers and neighborhood contraceptive distributors. There is more work to be done developing the proposal, but it is assumed it will be implemented. This activity will be funded from the present project with some provision for expansion if feasible to 11 cities--December 1986 through March 1989. Requirements for expansion of operations research of the operational elements should be included as a major component in the new project design.

Table 8

Summary Schedule for Financing Actions Relevant to Urban Sector Family Planning

ACTIVITIES	9/30/86 Commitment Urban Component	Carry-over March-1989	Amendment $1,000,000 until March '89	As part of New Project Design	Private Service FP Project March 1989 - March 1994
1. IEC Campaign.	$ 312,500	$ 700,000			X
2. YKB pilot activit.	439,000	300,000			X
3. Urban block grant.	409,000	1,000,000			(1)X
4. Operation Research and Studies.	293,500				Especially with NGOS.
5. Technical Assist.	32,738	363,262	400,000		X
6. CSM	(+/- 2.8 million SOMARC)		600,000		X
7. Study of degree of community involvement in service delivery.				X	
8. Review of fee for service experience and potential.				X	
9. Norplant expansion					X
10. Family Planning in prepaid health plans.				X	X
11. Contraceptive Prevalence Survey.	(2)X			X	X
12. Possible Support to FISKA.				X	
13. Review of degree urban private/fee for service emphasis can be spread to rural program.				X	X
Totals:	$1,486,738	$2,363,262	$1,000,000		

(1) Expanded to include NGOS and results of operations research
(2) Project 327 - Research Budget & AID/W ST-DHS Project

V.2.2 Strengthening and Expansion of the Contraceptive SOMARC Project

Emphasis must be placed both on extending the variety and number of locations where condoms are sold and on adding products. Further review must be made of the requirements for sale of ethical products and the procedures for discount sale to doctors, midwives, NGOs and factory clinics. In reviewing ways to increase outlets, attention must be given to requirements for building MECOSIN capacity. The possibility has been raised of using several distributors rather than only one. This is questionable in the light of the requirement to have a large enough market to make the project commercially viable and attractive for the distributor.

The AID centrally funded SOMARC project will carry this activity until sometime in mid- or late CY 1988. The project amendment will add additional funds and this will be a major component of the new project.

The objective should remain to expand the present commercial market, not to interfere with it. Other activities such as the urban block grant and the IEC campaign should assist non-CSM sales of contraceptives.

V.2.3 Strengthening Private Initiatives Through Block Grant

The urban block grant mechanism should be continued as a means to stimulate decentralized planning and implementation and to support private initiatives at the local level. USAID/BKKBN management procedures should be reviewed. The labor-intensive involvement of USAID, appropriate initially, may no longer be as suitable as BKKBN matures and USAID staff decreases.

Institution building support will likely be necessary for IDI, IBI, and ISFI, as well as assistance with specific service delivery activities. The block grant mechanism might encourage BKKBN to provide support to other private organizations such as PERDHAKI, PGI, and Muhammadiyah.

Funds from the present project can carry this activity through March, 1989. It should be expanded in the new project to include additional cities and provide for research and technical assistance in mechanisms for government funding of private services such as U.S. Government Title IX, which provides government funds for private voluntary organizations.

V.2.4 Continued Support to YKB

USAID should continue its support to the YKB as it grows in institutional and management capacity to provide leadership in the private sector for family planning. A challenging role for YKB will be to accomplish service delivery objectives (as it has with midwives) while finding ways to assist parent organizations (like IBI) develop the capacity to manage activities independently. While YKB appears to have some reluctance in taking a national role, it can help some of its counterparts assume a regional role. YKB and its counterparts should be encouraged to review ways to strengthen their nationwide impact, perhaps through a federation (similar to that of the Mexican Federation of Private Associations for Family Planning [FEMAP] in Mexico). While YKB's experiment with urban clinics should be phased out, the experiment with private midwives has been sufficiently successful to warrant widespread replication. Support to YKB can be provided through the present grant plus the operations research project. The amendment can provide a bridge to the new project, which should include a component for support to YKB on a project-by-project fee for services basis.

V.2.5 IEC

Experience with the IEC contract being developed in the present project will guide development of this activity as a significant component of the new project. Advertising related to specific products and locations of service providers will be continued under the CSM project. The public information campaign should increasingly emphasize the benefits (health and family economics) of a smaller family and popularize family planning and the small family as a social norm.

V.2.6 Technical Assistance

Technical assistance to the urban sector program should be increased. Two person years will be provided through funds presently available and two person years should be provided through the amendment.

V.3 New Activities to be Included in Future Project Design or Future Project

V.3.1 Operations Research on Community Involvement in Health Centers and Fee for Service for NGOs

Either YKB or the Foundation for Prosperity (Yayasan Indonesia Sejahtera or YIS) should undertake operations research to determine the degree of community involvement in puskesmas maintenance and management and the potential for the use of volunteer help and service fees for improvement in conditions. The study could be funded as part of development for the new project. This would be a minor component. Operations research should also be undertaken to explore the effect of introducing fee for service among NGOs (perhaps PERDHAKI or DGI fixed facilities). This would be similar to operations research described in Section V.2.1 and should be included in the new project design as a minor component.

V.3.2 Review of Fee for Service

The focus on the private sector is premised on the assumption that a substantial portion of the urban population (maybe as high as 40 to 50 percent) can and will pay a fee for family planning services, particularly if this payment results in more attractive, more convenient service. The economic level of the population and household expenditure patterns support this assumption as well as the indications that a growing number are now paying private providers. However, this assumption will be tested by operations research results and by experience with CSM and IBI/IDI activities.

V.3.3 NORPLANT Expansion

At this time, modest support for training and some study of the requirements for training, equipment and supervision in a rapidly expanding program can be provided under the existing project. By the time of the next project, AID may be in a position to assist with substantially expanded contraceptive requirements, as appropriate. By then, U.S. FDA approval is expected.

V.3.4 Prepayment Plans

Other ways to include family planning in the private sector should be explored. A study should be commissioned as part of project design for the new project to review the feasi-

bility of support (research, training, or technical assistance) to activities leading toward the inclusion of prepayment of family planning services in health insurance or health maintenance organization plans.

V.3.5 Contraceptive Prevalence Survey

USAID should support BKKBN efforts to improve its evaluation of service statistics and contraceptive prevalence. This concern is supported by the World Bank, which has made overtures to the GOI that independent surveys will be required as the basis of future planning. A major AID-supported action will be the contraceptive prevalence survey of 1987, which will be funded by AID/W and the present project. Preliminary data should be available to assist project design for the new project. Nevertheless, a special study should be commissioned as part of new project design to assist BKKBN review its service statistics, contraceptive logistics information and various indications of contraceptive prevalence to produce a more precise estimate of contraceptive use. Provision for additional contraceptive prevalence surveys should be included in the new project.

V.3.6 Possible Support to FISKA

Contact with FISKA should be maintained. Further review is needed on its potential for growth. This might warrant inclusion in new project design.

V.3.7 Review of Degree Urban Private Fee for Service Emphasis Can be Spread to Rural Areas

Although the project's efforts should largely be directed to the urban population, many of them will have relevance for large portions of the densely populated rural areas. The fee for service concept, CSM approach, and use of private doctors and midwives will likely spread to much of the semi-urban population. Ways to enhance this spread should be reviewed as part of new project design.

V.4 Other Funding Sources

V.4.1 Increased Attention to Private Providers

While the urban block grant will assist IDI, IBI, and ISFI by supplying contraceptives and training information materials, additional assistance can come from other sources.

Technical assistance can be provided as needed through YKB and/or its counterpart organizations in other cities. Training of other health providers (private hospitals and maternities, NGOs) can be provided by DGI, PERDHAKI, YKB or others. Factory worksite training and motivation should be provided by UNFPA/DEPNAKER.

Contraceptive supply, following initial BKKBN input, should be directed toward the YKB/SOMARC channel.

Financing for these actions can be included as part of the present project (urban block grant), by SOMARC and by additional funds in the amendment. This will become a major component of the new project.

V.4.2 Factory Site Provision of Family Planning

The growth in factory site family planning delivery should be supported through complementary actions to the UNFPA/DEPNAKER project, i.e., the TIPPS project could be encouraged to do limited research on the cost benefits to Indonesian factories of providing family planning services; ENTERPRISE might support several pilot demonstration projects or work site family planning; and discount price contraceptives might be made available to factory clinics through the CSM project. No additional bilateral funds are likely to be needed.

V.4.3 Role of Other Centrally Funded Organizations

USAID should encourage a reasonably strong centrally funded portfolio to complement bilateral efforts, i.e., FPIA to continue innovative work with such organizations as PERDHAKI and DGI; AVSC with PKMI; JHPIEGO with medical faculties; JHU/PCS for IEC and URC for research with YKB and others. In addition to financial resources, these organization bring a worldwide experience in grassroots private sector programming (FPIA), particular expertise in technical fields (JHU/PCS and URC) or status and reliability in medical areas (JHPIEGO and AVSC). However, with the increased attention of BKKBN and the USAID bilateral to the private sector, the financial inputs of these organizations should be phased down substantially in the next project design.

V.5 Non-Family Planning Influences on Fertility

USAID should continue to take cognizance of such non-family planning influences on fertility as breastfeeding, women's role in development, age of marriage, and infant mortality. In

the light of attention to these issues by other sections of AID, other development agencies and other GOI institutions, the USAID population assistance should continue to focus most of its attention on family planning information and services. These other themes, however, can be dealt with from time to time in IEC campaigns. Suggestions to BKKBN to increase the number of leadership positions held by women might also be in order.

VI. AMENDMENT COMPONENTS

VI.1 Funding

The amendment should be funded at the level of $1 million and include two components: technical assistance ($400,000) and contraceptive social marketing ($600,000). The amendment components recommended below are built on the objectives of BKKBN, expenditure patterns of the current project and USAID's urban family planning assistance strategy. The amendment will be obligated in the second quarter of 1987 and will bridge program needs until the new project is developed for FY 1989. The technical assistance component would include the following:

VI.2 Technical Assistance

o Long-Term

With the growing emphasis on the urban and private sector program, it is expected that an additional two years of U.S. technical assistance will be required as an extension of the two-year technical assistance contract to be initiated January 1986. This person will assist the BKKBN in further developing its urban strategy, working with a larger group of cities to develop plans for the block grant activity including private sector NGO support, expanding the BKKBN neighborhood contraceptive distribution activity to more cities and to provide institutional networks, working with the contraceptive social marketing project to extend its spread and effectiveness, working with JHU/PCS and private firms in the IEC campaign, and reviewing ways to include family planning in private insurance schemes. A key role in this period will be to assist BKKBN in evaluating the cost effectiveness of these several approaches toward shifting more of the family planning program to privatization and fee for service emphasis.

o Short-Term

As various private sector institutions organize and begin to provide family planning services, they will require technical assistance in organization and management, training for service providers and evaluation. YKB is becoming one of the more effective organizations to provide this kind of assistance, and along with other groups, will be called upon to continue this role.

o Cost

(a)	Long-term: 2 person years @ $150,000	300,000
(b)	Short-term local assistance: personnel and management costs 50 person months @ $2,000	100,000
		$400,000

VI.3 Contraceptive Social Marketing (CSM)

The shift in CSM strategy to move more quickly to a full product line and to focus more attention to servicing such semi-commercial outlets as doctors, midwives, factory site clinics, private clinics, hospitals and maternities will require additional resources (see Section III.3). It is expected that by the end of the project, a full line of contraceptives (condoms, pills, IUDs, injectables) will be available at subsidized (but commercial) prices to the general public. This system will also provide access to discount priced contraceptives to approximately 5,000 private doctors, 8,000 private midwives, 130 factory clinics and 350 private hospitals, maternities and clinics. Additionally, this system will extend condom sales through patent medicine stores and a variety of other outlets totaling more than 20,000.

AID support will be required for additional promotional activities and advertising messages as well as market studies to implement and evaluate these new approaches:

1.	Promotional Activities	
(a)	short-term contracts for special detail personnel	US$ 80,000
(b)	informational materials	120,000
2.	Advertising	
(a)	media campaign	180,000
(b)	point of purchase materials	100,000
3.	Market, media and evaluation research	
(a)	market studies 3 @ 20,000	60,000
(b)	media impact 1 @ 20,000	20,000
(c)	sales audit 2 @ 20,000	40,000
		$600,000

APPENDIX A

PERSONS AND INSTITUTIONS CONTACTED

Appendix A

PERSONS AND INSTITUTIONS CONTACTED

A. Washington

1. Neil Woodward -- AID Project Manager for Association for Voluntary Surgical Contraception (AVSC)

2. Terry Jesowski -- (by phone) Program Director, AVSC

3. Tom Harriman -- AID Project Manager for Contraceptive Social Marketing (CSM)

4. James Shelton -- AID Physician responsible for contraceptive development and research

5. Alan Getson -- AID Project Manager for Family Planning International Assistance (FPIA)

6. Elizabeth Maguire -- S&T/POP Policy

7. Anne Aarnes and Marilyn Schmidt -- S&T/POP Training

8. Charles Johnson and Nick Studzinski -- AID ASIA/NE Bureau

9. Betty Ravenholt and Don Ruschman -- The Futures Group-- SOMARC

10. Jim Jeffers -- John Snow, Inc. -- Enterprise Project

11. Dene McGriff -- John Short, Inc. -- TIPPS Project

B. Indonesia

Persons Contacted

1. Dr. Emmanuel Voulgaropoulos -- Chief of Population and Health Office, USAID

2. David C. Denman -- Population Officer, USAID

3. Carol E. Carpenter-Yaman -- Population Officer, USAID

4. Russ Vogel -- AVSC Contractor

5. Gani Perla -- SOMARC Contractor

6. Dene McGriffs -- TIPPS

7. Gary Safitz -- JH/PCS

8. Bruce Carlson -- World Bank

9. John McWilliam and Kasuko Kano -- UNFPA

10. Gary Lewis -- Columbia University

11. Paul Richardson -- University Research Corporation

Institutions Contacted

1. BKKBN -- National Family Planning Coordinating Board

2. PKMI -- Perkumpulan Kontrasepsi Mantap Indonesia (Indonesian Association for Secure Contraception)

3. IDI -- Indonesian Doctors Association

4. SRI -- Survey Research Indonesia

5. Kimia Farma -- Government Pharmaceutical Production Corporation

6. PKBI -- Perkumpulan Keluarga Berencana Indonesia (Indonesian Plan Parenthood Federation [IPPF])

7. FISKA -- Forum for Indonesian Family Planning Non-Governmental Organizations (NGOs)

8. YKB -- Yayasan Kusuma Buana (Family Planning Foundation [NGO])

9. PT MECOSIN -- Private Sector Pharmaceutical Manufacturing and Distribution Firm

10. Fortune -- Private Sector Advertising Firm

11. DGI/BELKASI -- Indonesian Council of Churches Health Council

12. PERDHAKI -- Indonesian Catholic Health Council

13. Pill, IUD and condom factories, Bandung

14. Contraceptive Distributing firms -- Bandung

15. Puskesmas (Health Center) and private midwives-- Jakarta

16. YIS -- Yayasan Indonesia Sejahtera -- Foundation for Prosperity -- Community development NGO with interest in family planning

17. Health Insurance Agency for government workers

18. IBI -- Indonesian Midwives Association

19. Muhammadiyah -- Muslim social welfare organization

APPENDIX B

DOCUMENTS REVIEWED

Appendix B

DOCUMENTS REVIEWED

A. USAID Project Paper -- Indonesia -- Family Planning Development and Services II 497-0327

B. SOMARC -- Strategy for the Indonesian CSM Project -- Trip Reports

C. Enterprise -- Trip Reports

D. The Indonesian Association for Secure Contraception Program to Strengthen and Support VSC in Indonesia, January 1986

E. Success, Challenge and Future Prospect of National Family Planning Program in Indonesia, Haryono Suyono Ph.D., Chairman, BKKBN

F. Various SRI Research Reports on IEC Requirements and CSM Project Tracking

G. Johns Hopkins -- Population Communications Services (JHU/PCS) Strategy for IEC Campaign

H. IKB -- SOMARC -- Final Marketing Plan

I. USAID program documents related to Urban Block Grant, YKB grant and FPIA projects

J. The Indonesian Contraceptive Prevalence Survey Report, 1983 -- Jakarta, December 1984

APPENDIX C

BKKBN SUMMARY OF USERS AND PROVIDERS
1986 AND 1989

Appendix C

BKKBN SUMMARY OF USERS AND PROVIDERS
1986 AND 1989 (PROJECTED)

TYPE OF FAMILY PLANNING SERVICE PROVIDER IN URBAN AREA	TOTAL NUMBER OF URBAN FAMILY PLANNING SERVICE POINTS		NUMBER OF SERVICE POINTS ACTUALLY PROVIDING OR PROJECTED TO PROVIDE FAMILY PLANNING SERVICES		NUMBER OF USERS		ECONOMIC LEVEL OF POPULATION MOST LIKELY TO BE SERVED (A, B, C, D, E, or F)[1]	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
	1986	1989	1986	1989	1986	1989	1986	1989
1. PUBLIC SERVICE PROGRAM								
a. MOH Hospitals	154	600	102	600			A B C D	A B C
b. MOH Clinics	900[2] (15% tota)	1,080[2] (15% total)	867	1,000	1,687,481 (80%)	1,765,836 (70%)	A B C	A B C
c. Armed Forces Clinics	196	200	196	200			A B C	A B C
d. Field Workers and Volunteers	1,690	1,690	1,690	1,690			A B C	A B C
2. SEMI-COMMERCIAL								
a. Doctors	2,692[9]	3,657[11]	1,600	1,690			A B C D	A B C
b. Midwives	16,791[12]	17,721[14]	13,434[3]	14,177[4]	210,935	378,393	B C D	B C D
c. Private Clinics/ Hospitals	327	350	327	350	(10%)	(15%)	B C D	B C D
3. COMMERCIAL								
a. Pharmacies	1,136	1,486	1,067	1,200			D E F	C D E F
b. Factory Clinics	120	170	106	130			D E F	C D E F
c. Doctors	1,794[10]	3,657[11]	1,076[5]	2,560[6]	210,935	378,393	D E F	C D E F
d. Midwives	11,194[13]	14,499[15]	5,597[7] (50% of Total Points)	8,699[8] (60% of Total Points)	(10%)	(15%)	C D E	C D E
				[T O T A L	2,109,351	2,522,622]		

1. See Table 3 in Text
2. See Supplemental Table C-1
3. 80 Percent of midwives in column 2)
4. 80 percent of midwives in column (3)
5. 60 percent of commercial doctors in column (2)
6. 70 percent of commercial doctors in column (3)
7. 50 percent of commercial midwives in column (2)
8. 60 percent of commercial midwives in column (3)
9. 60 percent of all urban private doctors*
10. 40 percent of all urban private doctors*
11. 50 percent of all urban private doctors*
12. 60 percent of all urban private nurse-midwives*
13. 40 percent of all urban private nurse-midwives*
14. 55 percent of all urban private nurse-midwives*
15. 45 percent of all urban private nurse-midwives*

* See Supplemental Table C-2

SUPPLEMENTAL TABLES[1]

Table C-1

TOTAL NUMBER OF HEALTH PROVIDERS, NATIONALLY

Type	1986	1989
Hospitals	1,356(?)	800
Health Centers	3,000	5,500
Doctors	9,963	13,614
Pharmacies	1,894	2,123
Nurse-midwives	50,000	60,000

Table C-2

HEALTH PERSONNEL IN PRIVATE PRACTICE IN URBAN AREAS

	1986		1989	
Type	Total Private	Urban Private	Total Private	Urban Private
Doctors	5,607	4,486 (80%)*		7,314
Nurse-midwives	46,640	27,986 (60%)*	53,700	32,220 (60%)*

* Of total private

1 These tables were prepared by the POPTECH editor from BKKBN "notes".

APPENDIX D

NEW ACCEPTORS REPORTED BY DOCTORS AND MIDWIVES PARTICIPATING IN URBAN BLOCK GRANT (JANUARY TO JULY 1986)

APPENDIX D

NEW ACCEPTORS REPORTED BY DOCTORS AND MIDWIVES
PARTICIPATING IN URBAN BLOCK GRANT
(JANUARY TO JULY 1986)

Table D-1

I.B.I. * (MIDWIVES)

Jan - July, 1986

NO.	PROVINCE	IUD	PILL	CONDOM	VAGINAL	INJECTABLE	NORPLANT
1.	DKI JAKARTA	1.643	5.040	198	2	7.590	-
2.	JAWA BARAT	1.624	2.708	302	-	8.671	-
3.	JAWA TENGAH	520	256	46	-	6.612	-
4.	DI YOGYAKARTA	68	13	10	1	324	-
5.	JAWA TIMUR	448	376	66	-	2.305	-
6.	B A L I	271	23	1	-	100	-
7.	DI ACEH	32	75	10	-	129	-
8.	SUMATRA UTARA	250	1.045	248	-	2.593	-
9	SUMATRA BARAT	187	144	28	-	575	-
10	SUMATRA SELATAN	32	110	19	-	150	-
11	LAMPUNG	28	61	2	-	614	-
12	N. T. B.	126	33	3	-	292	-
13	KAL. BARAT	98	206	38	-	213	-
14	KAL. SELATAN	-	63	1	-	1.096	-
15	SUL. UTARA	41	34	-	-	913	-
16	SUL. SELATAN	3	8	-	-	204	-
17	RIAU	54	192	44	-	342	-
18	JAMBI	32	72	7	-	73	-
19	BENGKULU	14	72	3	-	50	-
20	KAL. TIMUR	89	145	39	-	300	-
21	KAL. TENGAH	10	45	7	-	395	-
22	N. T . T.	27	3	6	-	4	-
23	SUL. TENGAH	40	22	1	-	97	-
24	SUL. TENGGARA	19	46	1	-	5	-
25	MALUKU	24	17	2	-	53	-
26	IRIAN JAYA	-	-	-	-	-	-
27	TIMOR TIMUR	-	-	-	-	-	-
	Total 51,274	5,680	10,809	1,082	3	33,700	-
	Percent	11%	21%	2%	-	66%	-

JAKARTA, 22 SEPTEMBER 1986

Source BKKBN

There are 18,000 midwives in the country
400 are in the program to date in Jakarta
(There is probably some overlapping with YKB reporting)

Table D-2

I.D.I. * (Doctors)
JAN - JULY 1986

NO.	PROVINCE	IUD	PILL	CONDOM	VAGINAL	INJECTABLE	NORPLANT
1.	DKI JAKARTA	3.024	7.538	660	6	10.985	7
2.	JAWA BARAT	4.488	2.136	436	2	9.432	28
3.	JAWA TENGAH	919	1.801	405	-	8.040	81
4.	DI YOGYAKARTA	114	31	11	-	374	-
5.	JAWA TIMUR	1.635	2.273	578	-	8.560	35
6.	B A L I	140	9	-	-	100	-
7.	DI ACEH	38	8	1	-	129	-
8.	SUMATRA UTARA	879	1.203	461	-	2.593	16
9.	SUMATRA BARAT	380	46	37	-	575	-
10.	SUMATRA SELATAN	30	35	13	-	150	-
11.	LAMPUNG	48	62	6	-	614	-
12.	N. T. B.	12	22	3	-	292	-
13.	KAL. BARAT	59	400	26	-	213	-
14.	KAL. SELATAN	46	783	130	-	1.096	-
15.	SUL. UTARA	186	554	32	-	913	2
16.	SUL. SELATAN	40	48	6	-	204	-
17.	RIAU	125	166	11	-	342	3
18.	JAMBI	64	23	4	-	73	-
19.	BENGKULU	9	16	2	-	50	-
20.	KAL. TIMUR	182	150	12	-	300	-
21.	KAL. TENGAH	19	69	4	-	395	-
22.	N. T . T.	5	12	1	1	4	-
23.	SUL. TENGAH	30	27	3	-	97	-
24.	SUL. TENGGARA	6	20	4	-	5	-
25.	MALUKU	16	29	4	-	53	-
26.	IRIAN JAYA	6	14	3	-	50	-
27.	TIMOR TIMUR	-	-	-	-	2	-
	Total: 78,650	12,500	17,475	2,853	9	45,641	172
	Percent	16%	22%	4%	-	58%	-

JAKARTA, 22 SEPTEMBER 1986

Source: BKKBN

* There are 15,000 doctors who could be involved
3,000 doctors reported the above numbers.