

AUDIT OF
FAMILY PLANNING DEVELOPMENT AND
SERVICES II PROJECT
PROJECT NO. 497-0327

Audit Report No. 2-497-89-01
October 7, 1988

UNITED STATES OF AMERICA
AGENCY FOR INTERNATIONAL DEVELOPMENT
REGIONAL INSPECTOR GENERAL/AUDIT
MANILA

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MANILA, PHILIPPINES

DATE: October 7, 1988
RIG/EA-89-

MEMORANDUM

TO: David Merrill
Director, USAID/Indonesia

FROM: *William C. Montoney*
William C. Montoney, RIG/A/M

SUBJECT: Audit Report of Family Planning Development and
Services II, Project Number 497-0327
Audit Report No. 2-497-89-01

The Office of the Regional Inspector General for Audit/Manila has completed work on the audit of the Family Planning Development and Services II, Project Number 497-0327. Comments provided by the Mission on the draft audit report were considered and incorporated in this report as appropriate.

The Mission has taken actions to implement the four audit recommendations contained in this report. Therefore, the four audit recommendations were closed upon issuance of this audit report.

I appreciate the cooperation and courtesies extended to my staff during the audit.

EXECUTIVE SUMMARY

The Family Planning Development and Services II Project was initially implemented in 13 of Indonesia's 27 provinces. The project, initiated in June 1983, was authorized through December 1992 with total A.I.D. funding of \$36.4 million. Its overall goal was to reduce the annual birth rate in Indonesia to between 22 and 23 births for every 1,000 members of the population by 1990. The project sought to achieve this goal by increasing the use of contraceptive methods by married couples of reproductive age from 43 percent in December 1982 to 69 percent by December 1992.

The project consisted of six principle components. The Village Family Planning component increased the numbers of family planning posts in rural villages. The Urban Family Planning component sponsored contraceptive promotional activities in urban areas. The Voluntary Sterilization component upgraded hospitals and health clinics to do voluntary sterilization procedures in 13 Indonesian provinces with plans for expansion into the 14 other provinces. The Training component provided short-term and long-term degree training to officials of the Indonesian agency responsible for implementing the family planning program. The Modern Management Technology component sought to improve the computer capabilities of the family planning implementing agency. The Research and Development component sponsored family planning related research studies and workshops.

Audit results showed that improvements were needed in the management of project resources under the Voluntary Sterilization component of the project. It also demonstrated that USAID/Indonesia could not measure the impact of three project components - Training, Research and Development and Modern Management Technology - in meeting the project purpose.

Selection of hospitals and clinics upgraded under the Voluntary Sterilization component did not consider potential demand for voluntary sterilization as required by the project paper. Therefore, use of the upgraded facilities may be limited. As a result, USAID/Indonesia had no assurance that 470 facilities upgraded in 13 provinces to perform voluntary sterilization at a cost of \$3.2 million were needed or that plans to expand the program into the remaining 14 provinces at an additional cost of \$1 million were justified. This report recommended that criteria, including potential demand for services, be developed for selecting hospitals and clinics for upgrade in the 14 provinces included in Phase II of the Voluntary Sterilization program. In response, Mission officials said

that criteria, including potential demand for service, had been developed and that the number of facilities to be upgraded in Phase II had been reduced from 200 to 113 as a result of applying this criteria. The audit recommendation was closed upon issuance of the audit report based on the Mission response.

Renovations made to hospitals and clinics under the Voluntary Sterilization component were of poor quality and equipment and furniture supplied to hospitals and clinics were being used for other than intended purposes. This occurred because, contrary to Agency guidance: (1) site visits were not made while building renovations were in progress; (2) equipment and furniture needs of hospitals and clinics changed during the long delay between the needs assessments and delivery of the equipment and furniture, and (3) furniture specifications did not meet local needs. As a result, \$2.5 million was inefficiently used for poor quality building renovations and for equipment and furniture which did not promote family planning. This report recommended that USAID/Indonesia not fund building renovations and local purchase of equipment and furniture for hospitals and clinics during the second phase of the Voluntary Sterilization component unless: site visits are made while building renovations are in progress; delays in delivering equipment and furniture are avoided; and furniture specifications meet local needs. The report also recommended that USAID/Indonesia assess the quality and utilization of equipment and furniture provided to hospitals and clinics under Phase I, recover cost for furniture and equipment of poor quality and collect furniture and equipment in excess of needs for use in Phase II. The Mission responded that plans for monitoring the upgrades under Phase II included (1) monitoring the bidding and contract award processes for equipment, furniture and building renovations, (2) review of specifications for equipment, furniture and renovations, and (3) field inspections of all upgraded sites. Officials also said that site inspections were being made of facilities upgraded under Phase I to assess use of furniture and equipment provided and that excess materials would be collected for use in Phase II. Audit recommendations were closed upon issuance of this report.

Indicators did not measure the impact of the Modern Management Technology, Research and Development and Training components of the project as required by regulations. Therefore, USAID/Indonesia could not effectively determine contributions made by these three components in achieving the project purpose and goal. The Mission could not measure the impact of \$7 million spent on three project components in increasing the contraceptive use rate and reducing the

birth rate. This report recommended that a method be developed for assessing the effectiveness of the Modern Management Technology, Research and Development and Training components of the project. In response, officials said that the verifiable indicators for these three components were modified to establish indirect linkages between the component outputs and the project purpose and goal so that impact could be measured. The audit recommendation was closed upon issuance of this report.

Office of the Inspector General

Audit of the
Family Planning Development and
Services II Project

Indonesian Provinces Included in the
Voluntary Sterilization Component
of the Project



Provinces In
Phase I

Bali
Central Java
East Java
Lampung
DKI Jakarta
North Sulawesi
North Sumatra
South Sulawesi
South Sumatra
West Java
West Kalimantan
West Nusa Tenggara
West Sumatra

Provinces In
Phase II

Aceh
Bengkulu
Central Kalimantan
Central Sulawesi
East Kalimantan
East Nusa Tenggara
East Timor
Jambi
Maluku
Riau
South Kalimantan
Southeast Sulawesi
West Irian
Yogyakarta

AUDIT OF
THE FAMILY PLANNING DEVELOPMENT
AND SERVICES II PROJECT

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AUDIT OF THE
FAMILY PLANNING DEVELOPMENT
AND SERVICES II PROJECT

PART I - INTRODUCTION

A. Background

The Family Planning Development and Services II Project was initially implemented in 13 of Indonesia's 27 provinces. It was begun in June 1983 and authorized through December 1989. Through three project amendments, the authorization was extended through December 1992.

The overall goal of the project was to reduce the birth rate in Indonesia to between 22 and 23 births for every 1,000 members of the population by October 1990. The project sought to achieve this goal by increasing the contraceptive prevalence rate, the percentage of married women between 15 and 44 years of age using contraceptive methods, from 43 percent in December 1982 to 56 percent by March 1987. In June 1987, a project amendment raised this target to 65 percent by March 1989 and 69 percent by December 1992. These changes were made because according to statistics collected by the Indonesian National Family Planning Coordinating Board (BKKBN) the original project purpose was achieved in March 1986.

The project consisted of six output components with total A.I.D. funding of \$36.4 million, \$17.2 million in loans and \$19.2 million in grants. Three project components were service delivery oriented:

- The Urban Family Planning component, funded by A.I.D. at \$7.2 million, sponsored contraceptive promotional activities in 11 of Indonesia's larger cities. Activities included marketing low priced contraceptive supplies through drug stores and private doctors, training doctors and midwives in contraceptive methods and funding activities designed by participating cities to meet their own needs.
- The Village Family Planning component, funded by A.I.D. at \$7 million, assisted BKKBN in increasing the number of fully-functioning village and sub-village family planning posts and strengthened their information and service capacity.
- The Voluntary Sterilization component, funded at \$7.9 million, trained medical personnel and upgraded hospitals and health clinics to perform voluntary surgical sterilization procedures. Phase I of this

component included 13 of Indonesia's 27 provinces while Phase II was to include the other 14 provinces.

Three other project components were research and institution building oriented:

- The Modern Management Technology Component sought to improve the computer and word processing capacities of the BKKBN central offices and 16 provincial level offices at an A.I.D. cost of \$2 million.
- The Research and Development component obligated \$2.9 million to sponsor research studies, seminars and workshops on population related topics. One of these studies was a national contraceptive prevalence survey conducted by the Central Bureau of Statistics to validate contraceptive use data collected by the BKKBN data collection system. Data from this system was used by USAID/Indonesia to measure whether the project purpose was being achieved and to justify extending the project completion date from December 1989 to December 1992.
- The Training component obligated \$9.4 million to train BKKBN personnel through short-term in-service courses and through long-term masters and doctoral degree programs at universities in the United States and in Indonesia.

Evaluations had been conducted of the Training and Village Family Planning components. The training evaluation was a comprehensive assessment of the education and training program sponsored by BKKBN from 1972 through 1986. It assessed training activities funded under the current family planning project as well as prior projects. The Village Family Planning Evaluation was completed in 1987 and covered A.I.D. support to village family planning activities under the current and prior family planning projects.

B. Audit Objectives and Scope

This was primarily an audit of program results. The audit objectives were to determine whether: (1) the project goal and purpose were being achieved; (2) an effective system for measuring program results had been established; and (3) funds and other resources were being effectively managed. The audit was made at USAID/Indonesia and the BKKBN central offices in Jakarta and at provincial, district and village levels within four of the 13 participating provinces. These four provinces - Central Java, East Java, North Sumatra and South Sulawesi - were selected based on the amount of A.I.D. funds received under the project and the level of project

activity within the provinces. The audit included all six of the project components which represented \$12 million in A.I.D. funds expended under the project as of December 1987. The \$76.9 million in host country contributions was not reviewed. Audit work included reviews of project files, limited reviews of financial records for funds advanced to four provinces, interviews with USAID/Indonesia and Government of Indonesia officials and visits to selected hospitals and health clinics upgraded to perform voluntary sterilization. Most of the host country documentation was in the Indonesian language. The audit team, therefore, relied on translators, USAID/Indonesia officials and host country representatives for interpretations. The audit did not assess the validity or accuracy of data collected by BKKBN on the use of contraceptive methods in Indonesia.

Audit work also included reviewing funds advances made by USAID/Indonesia to BKKBN under three project components - Urban Family Planning, Village Family Planning and Voluntary Sterilization. The advances were traced down to the point where the funds were used within four participating provinces. In some cases, funds were traced from USAID/Indonesia through the central BKKBN, the provincial BKKBN office, through one district BKKBN office, one subdistrict office and to a village within the provinces.

The audit work was conducted from August 1987 through May 1988. It was made in accordance with generally accepted government auditing standards.

AUDIT OF THE
FAMILY PLANNING DEVELOPMENT
AND SERVICES II PROJECT

PART II - RESULTS OF AUDIT

Audit of the Family Planning Development and Services II Project showed that improvements were needed in the management of project resources under the Voluntary Sterilization component. It also demonstrated that USAID/Indonesia could not measure the impact of three project components - Training, Research and Development and Modern Management Technology - in meeting the project purpose.

The audit team traced advances made by USAID/Indonesia to the Provinces of Central Java, East Java, North Sumatra and South Sulawesi under the Diban Family Planning, Village Family Planning and Voluntary Sterilization components of the project. Documentation to support expenditure of these funds was reviewed at the provincial, district, subdistrict and, in some cases, village levels within the provinces. Nothing came to the auditor's attention while conducting this work that caused them to question other advances made under the project.

This report recommended that greater emphasis be placed on potential demand in selecting hospitals and health clinics for upgrade in the 14 provinces under Phase II of the Voluntary Sterilization component of the project. It also recommended that USAID/Indonesia not fund renovations and local purchase of furniture and equipment for hospitals and clinics during the second phase of the Voluntary Sterilization component unless specific actions were taken. Finally, this report recommended that a method be developed to assess the effectiveness of the Modern Management Technology, Research and Development and Training components of the Project.

A. Findings and Recommendations

1. Potential Demand for Services Was Not Considered in Selecting Hospitals and Clinics for Upgrade to Perform Voluntary Sterilization

Selection of hospitals and clinics upgraded under the Voluntary Sterilization component did not consider potential demand for voluntary sterilizations as required by the project paper. Therefore, use of the upgraded facilities may be limited. As a result, USAID/Indonesia had no assurance that 470 facilities upgraded in 13 provinces to perform voluntary sterilization at a cost of \$3.2 million were needed or that plans to expand the program into the remaining 14 provinces at an additional cost of \$1 million were justified.

Recommendation No. 1

We recommend that USAID/Indonesia develop criteria for selecting hospitals and health clinics in the 14 additional provinces for upgrade under Phase II of the Voluntary Sterilization component to include potential demand for voluntary sterilizations and distances between facilities to be upgraded.

Discussion

USAID/Indonesia had spent \$3.2 million to upgrade 201 hospitals and 269 health clinics in 13 Indonesian provinces to perform voluntary sterilization and planned to spend an additional \$1 million to expand the program into 14 additional provinces. However, the Mission had no assurance that these facilities were needed.

Phase I of the Voluntary Sterilization component upgraded hospitals and health clinics in 13 provinces to do voluntary sterilization by providing building renovations, medical equipment and facilities. The hospitals and clinics were to be selected by a private association of physicians, the Indonesian Secure Contraception Association (PKMI) under supervision of the Indonesian National Family Planning Board (BKKBN) which was responsible for implementing the family planning program in Indonesia and managing the data collection system on contraceptive use in Indonesia.

Selection of hospitals and health clinics for upgrade to do voluntary sterilization should have been based upon (1) the level of contraceptive use within the local community, (2) potential demand for voluntary sterilization, and (3) the degree of support for the program from local officials. These criteria were specified in the project paper for the Family Planning Development and Services II Project.

Only two of the three selection criteria specified in the project paper were used to select hospitals and clinics for upgrade. These were: the level of contraceptive use within the local community; and the degree of support for the program from local officials. The selection process did not consider potential demand for voluntary sterilization. In addition to the two project paper criteria, officials also sought to distribute facilities geographically throughout the 13 participating provinces.

Selections were made through two questionnaires. The first was submitted to 600 hospitals and the second to 350 health clinics located in the 13 participating provinces. The questionnaires (1) asked whether the hospitals and clinics were interested in participating in the program, (2) assessed the capabilities the hospitals and clinics in terms of equipment, furniture and renovations to perform voluntary sterilizations and (3) identified the types and quantities of equipment and furniture that could be provided. A total of 201 hospitals and 269 health clinics were selected for upgrading in Phase I.

Although contraceptive use rates were considered in selecting hospitals and clinics, these rates were not good indicators of potential demand for voluntary sterilization. Contraceptives are temporary birth control methods used primarily by couples who want to have additional children in the future. These methods include birth control pills, condoms, interuterine devices and spermicidal foams. Voluntary sterilization is a permanent method of birth control used primarily by couples who do not want additional children. In addition, couples using temporary birth control may be reluctant to accept voluntary sterilization because of cultural, social and religious beliefs. As a result, contraceptive use rates are not good indicators of potential demand for voluntary sterilization.

USAID/Indonesia planned to expand the Voluntary Sterilization component of the project nationwide. The Mission intended to resurvey 100 hospitals and 30 health clinics located in the 13 original provinces which did not participate in Phase I of the upgrades for participation in the second phase of the program. Under Phase II, the Mission also intended to expand the upgrades to include hospitals in the 14 Indonesian provinces which were not included in Phase I. BKKBN, working through PKMI, was also responsible for identifying hospitals for Phase II. The questionnaire approach used to choose hospitals and clinics for Phase I was the intended selection method for Phase II. The primary objective in making the selections was to ensure that services were distributed evenly throughout the provinces. A total of 200 hospitals located in the 14

provinces were surveyed. At the time of the audit, selection of hospitals for Phase II had not been completed.

Potential demand for voluntary sterilizations was not considered in selecting hospitals and health clinics for upgrade in Phase I. This was demonstrated through comparisons of data on the number of male versus female voluntary sterilization performed in the 13 provinces participating in Phase I to the number of facilities upgraded to perform these services. The number of male versus female voluntary sterilizations performed in the 13 provinces over the period 1974 to 1987 are presented in Exhibit I. The number of facilities upgraded in the 13 provinces to do male and female sterilizations are presented in Exhibit II.

Female sterilizations performed in the 13 participating provinces over the period 1974 through March 1987 outnumber male sterilizations by almost 7 to 1. Yet, the number of facilities upgraded under Phase I which could perform male sterilizations exceeded the number of facilities which could do female sterilizations by more than 2 to 1. As shown in Exhibit I, 600,425 female sterilizations were performed in the 13 provinces between 1974 and March 1987 while only 87,114 male sterilizations were performed during this period. For every male sterilization that was done, seven (7) female sterilizations were performed. Exhibit II shows that 201 hospitals were upgraded to do both male and female sterilizations while 269 clinics were upgraded to do only male sterilizations. Therefore, a total of 470 facilities were upgraded to do male sterilization while only 201 upgraded facilities could do female sterilization, for a ratio of more than 2 to 1.

Comparisons of similar figures for selected provinces also demonstrated that demand for service was not considered in selecting facilities for upgrade. For example, the ratio of female to male sterilizations performed in North Sulawesi over the comparison period was 195 to 1. Only 53 male sterilizations were done in this province between 1974 and 1987 while 9,614 female sterilizations were performed. Yet, the number of facilities upgraded to do male sterilizations outnumber facilities for female sterilizations by 2 to 1 in North Sulawesi. In West Nusa Tenggara, 152 female sterilizations were done for every 1 male sterilization.

Nineteen male sterilizations were performed in the province between 1974 and 1987 versus 2,894 female sterilizations. However, three (3) facilities in this province were upgraded to do male sterilizations for every one (1) facility upgraded to do female sterilization.

Visits by the audit team to facilities upgraded under the program confirmed that little consideration was given to demand in selecting hospitals and health clinics for upgrade. During visits to hospitals and health clinics in North Sumatra the audit team noted that three facilities, a hospital and two health clinics, located within a two mile radius were upgraded to do male sterilization. The three facilities were selected even though no male voluntary sterilizations had been done in the district. According to the Chairman of the local BKKBN, men in the area objected to the procedure because they associated it with a loss in sexual potency. In the same district, 400 female sterilizations had been done since 1979. Of these, 281 or 70 percent had been performed within the six month period April through September 1987. Yet, only one facility, the general hospital, had been upgraded to do female voluntary sterilization within the district. The local BKKBN Chairman said that there was at least one other hospital in the district which could have been upgraded for female sterilization.

Phase II of the Voluntary Sterilization component would expand the upgrades to hospitals in 14 additional Indonesian provinces. Statistics on the number of voluntary sterilizations performed in these 14 provinces raised questions concerning the need to expand the program. As shown in Exhibit III, the number of female and male sterilizations performed in the 14 provinces over the 13 year period 1974 through March 1987 were very low.

A total of 91,691 voluntary sterilizations were performed in the 14 provinces between 1974 and 1987. Women accounted for 80 percent, or 73,591 voluntary sterilizations, while voluntary sterilizations on males comprised the other 20 percent or 18,100 sterilizations. Totals by province ranged from 371 voluntary sterilizations in East Timor to 54,265 in Yogyakarta. In 13 of the 14 provinces, less than 10,000 voluntary sterilizations had been performed since 1974.

Although selections of hospitals for upgrade in Phase II had not been completed, a total of 200 hospitals in the 14 provinces had been surveyed for participation in the Phase II upgrades. USAID/Officials said that the primary objective in selecting hospitals for Phase II was to ensure that upgraded voluntary sterilization facilities were geographically distributed throughout the 14 provinces to provide easy access by the local population.

USAID/Indonesia officials said that their main concern in administering the Voluntary Sterilization component was to ensure that quality services were generally available throughout the participating provinces. They said that 13

provinces selected for Phase I were chosen based on high levels of contraceptive prevalence. Officials said that such high prevalence levels were indications of demand for voluntary sterilization. They also said that although past demand for voluntary sterilization in some provinces had been low, once quality services were available demand would increase. However, they could not supply factual evidence to support this contention.

USAID/Indonesia had not assessed the demand for voluntary sterilization in Indonesia's 27 provinces. As a result, the Mission could not be assured that hospitals and clinics upgraded in 13 provinces at an A.I.D. cost of \$3.2 million would be used or that expenditures of \$1 million to upgrade additional facilities in the 13 original provinces and expand the program into 14 other provinces were necessary.

Management Comments

In response to the draft audit report, USAID/Indonesia said that potential demand for voluntary sterilization has become an important criteria in selecting hospitals and clinics for upgrade in Phase II of the program. Officials said that potential demand could be measured by estimating the number of voluntary sterilizations which would occur if quality voluntary sterilization services were available. Officials developed these estimates by (1) assessing the number of fertile age couples who desired to stop having children, (2) determining the number of voluntary sterilizations which occurred in response to pilot activities which provided quality services and (3) identifying the number of long term birth control pill and interuterine device users.

Officials said that the number of facilities to be upgraded under Phase II had been reduced from 200 to 113 based on application of five selection criteria, including potential demand for voluntary sterilization services. Other selection criteria were: contraceptive prevalence; local leader support for the program; location and level of existing family planning services; and distances between facilities.

Office of the Inspector General Comments

Based on the USAID/Indonesia response to the draft audit report, Audit Report Recommendation No. 1 was closed upon issuance of this report.

2. Improvements Were Needed in Contracting Procedures Under the Voluntary Sterilization Component.

Renovations made to hospitals and clinics under the Voluntary Sterilization component were of poor quality and equipment and furniture supplied to hospitals and clinics were being used for other than intended purposes. This occurred because, contrary to Agency guidance: (1) site visits were not made while building renovations were in progress; (2) equipment and furniture needs of hospitals and clinics changed during the long delays between the needs assessments and delivery of the furniture and equipment; and (3) furniture specifications did not meet local needs. As a result, \$2.5 million was inefficiently used for poor quality building renovations and for equipment and furniture which did not promote family planning.

Recommendation No. 2

We recommend that USAID/Indonesia not fund building renovations and host country local purchase of furniture and equipment for hospitals and clinics to be upgraded during Phase II of the Voluntary Sterilization component unless the Mission ensures that:

- Site visits are made while building renovations are in progress to assess the quality of work being performed;
- Excessive delays between assessing the furniture equipment needs of hospitals and clinics and delivery of materials are avoided; and
- Furniture specifications meet the needs of local hospitals and clinics.

Recommendation No. 3

We recommend that USAID/Indonesia:

- Assess the quality and utilization of furniture and equipment provided to hospitals and health clinics under Phase I of the Voluntary Sterilization component;
- Recover costs for furniture and equipment of poor quality; and
- Collect furniture and equipment in excess of needs for redistribution during Phase II of the Voluntary Sterilization component.

Discussion

USAID/Indonesia spent \$2.5 million for building renovations, equipment and furniture to upgrade hospitals and health clinics in 13 Indonesian provinces to perform voluntary sterilization. In some locations, building renovations were of poor quality and furniture and equipment were used for purposes other than family planning.

Inspections and site visits by the project officer while work was in progress were important methods for monitoring host country contracting, according to Section N of Chapter VII to Supplement 3B, Project Officers' Guidebook on Host Country Contracting, to A.I.D. Handbook 3, Project Assistance. Inspections and site visits would also provide the project officer with firsthand impressions of the contractors' progress and identify problems which could adversely affect contractor performance.

Prompt procurement and proper utilization of project-related supplies and equipment were critical to the effective performance of the contractor and achievement of the project goals according to Section F of Chapter VII. Monitoring such procurements were an important aspect of project and contractor oversight which should be shared by the host country contracting agency and the A.I.D. project officer. The project officer should verify actual arrival and proper utilization of commodities during site visits.

Visits by the audit team to facilities upgraded to perform voluntary sterilizations demonstrated that building renovations were of poor quality and that equipment and furniture supplied to hospitals and clinics were being used for purpose other than family planning. The audit team visited 14 upgraded facilities, 8 hospitals and 6 health clinics, in the provinces of Central Java, East Java, North Sumatra and South Sulawesi.



The audit team found that the quality of renovations at a hospital in East Java was poor. The examination room for the voluntary sterilizations clinic had been renovated four months prior to the audit team visit at a cost of \$1,132. The work included replacing the ceiling and painting the walls. As demonstrated in the picture on the preceding page, the ceiling panels were falling and the paint was beginning to peel at the time of the audit team visit.



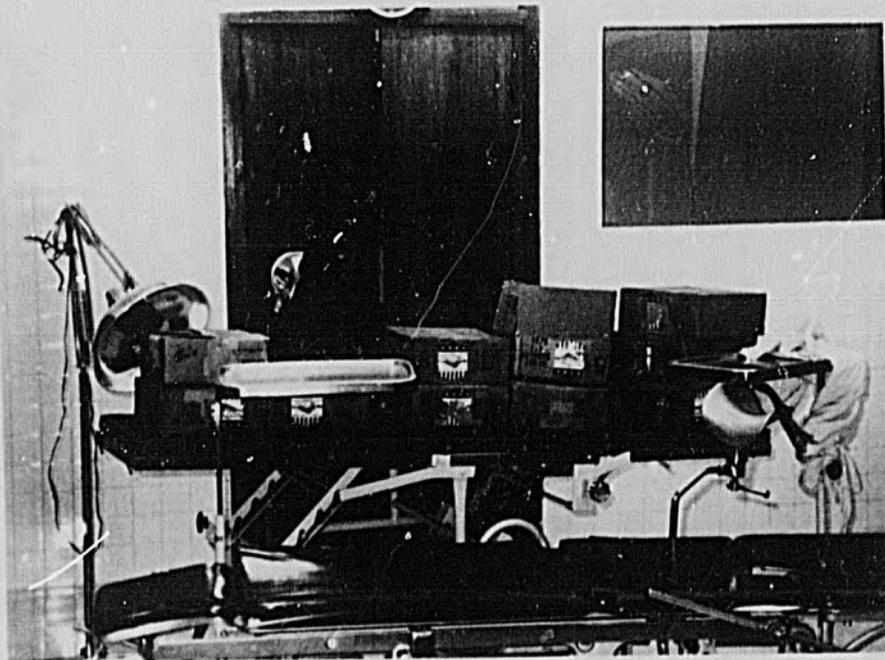
At a hospital in North Sumatra, the audit team found that renovations had not been done in accordance with approved plans. An examination room, a waiting room and a scrub room were planned for renovation. However, as the photograph above showed, a storage room was renovated instead. The hospital administrator said that funds had been received from the Indonesian Ministry of Health during the two-year period between selection of the hospital for upgrade and the beginning of the renovation work and the Government of Indonesia (GOI) funds were used to renovate the examination room, the scrub room and the waiting room. According to the administrator, the storage room renovations had been completed about six months earlier and the room had not been used since that time. The storage room was empty at the time of the audit team visit.



Three hospital beds supplied to a health clinic in Central Java were in storage at the time of the audit team visit. Hospital beds were in storage or were being used for other than family planning purposes at 4 of the 14 sites visited by the audit team. Under the budget for Phase I, 990 of these beds were purchased at a total cost of \$38,376.



A hospital in East Java received six desks for use in the voluntary sterilization clinic. At the time of the audit team visit, the desks were being used in the hospital laundry and the kitchen. Desks supplied under the project were not being used for family planning purposes at 8 of the 14 facilities visited by the audit team. Under the budget for Phase I, 1651 of these desks were purchased at total cost of \$55,369.



Equipment costing \$3,200 was supplied to hospital in East Java in March 1987. When the audit team visited the hospital six months later the equipment had not been used. Most of it was still in the original boxes.

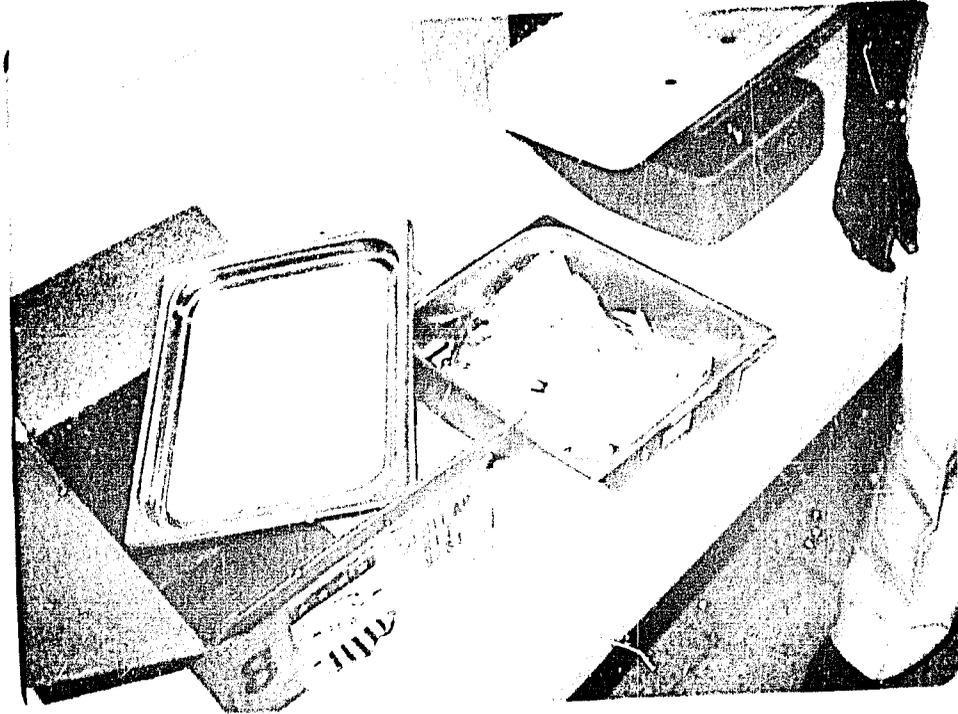


A hospital in East Java received a card file cabinet for storing voluntary sterilization records. The cabinet was being used to store dinner plates and a coat hanger. The hospital administrator said that the draws in the card file cabinet were too small to accommodate the voluntary sterilization record cards. A total of \$32,500 was budgeted for 40 of these cabinets which were not suited to their intended use.



A clothes cabinet supplied to a hospital in South Sulawesi was being used in a classroom for student nurses because the

cabinet would not fit through the doors leading into patient rooms. The budget for phase I called for purchasing 195 of these cabinets at a total cost of \$14,300.



Equipment sets for performing female sterilizations costing \$87 each were supplied to a hospital in North Sumatra. At the time of the audit team visit, the equipment sets were in storage and had not been used.

Inspection teams composed of representatives from USAID/Indonesia and the Indonesian National Family Planning Board (BKKBN) made visits to selected facilities upgraded under the voluntary Sterilization component. These visits, conducted from June to August 1987, were made to evaluate the quality of building renovations, equipment and furniture supplied to hospitals and clinics under Phase I of the upgrades. The two teams visited a total of 10% of the 470 facilities upgraded under Phase I, 56 hospitals and 52 health clinics.

Although the teams inspected nearly one-fourth of the facilities upgraded under Phase I of the Voluntary Sterilization component, the benefit of these inspections as a management tool was questionable. The inspections were done after the building renovations were completed, most of the furniture and equipment delivered and most of the costs reimbursed by USAID/Indonesia. In addition, the quality of reports resulting from these visits was poor. Although 108

facilities were inspected by the teams, reports contained comments about the quality of renovations, furniture and equipment at only selected facilities. For example, observations concerning the quality of building renovation were discussed in only 33 or 31 percent of the 108 facilities visited. Comments concerning furniture and equipment varied between reports. Some reports made general statements about quality at all facilities within a province. Others discussed selected hospitals and clinics. As a result, it was impossible to effectively evaluate the quality of renovations, furniture and equipment delivered to each facility visited by the inspection teams.

Renovations to the hospitals and clinics were of poor quality because neither BKKBN nor USAID/Indonesia made site visits to hospitals and clinics while renovation work was being done to inspect quality and identify problems. As a result, early opportunities to identify and correct quality related problems before payments were made to contractors were lost.

Equipment and furniture were in storage or were being used for purposes other than voluntary sterilization. This occurred because of the long delay between the assessment of hospitals and clinics for participation in the upgrade and delivery of regional equipment and furniture. The hospital and clinic assessments were done through two questionnaires administered in September and October 1984. In addition to determining whether the facilities desired to participate in the program, the questionnaires determined their equipment and furniture needs to perform voluntary sterilizations. The processes of selecting the hospitals and clinics, negotiating contracts for equipment and furniture and delivering the equipment and furniture took two years. Administrators at hospitals and clinics visited by the audit team said equipment and furniture were not delivered until early 1987. During this period the equipment and furniture needs of the hospitals and clinics charged.

A second reason that furniture was in storage or was being used for purposes other than voluntary sterilization was that the furniture items were not designed to meet the needs of the local hospitals and clinics. Specifications for local purchase furniture items identified the types of furniture and the size and types of materials for construction. Separate procurement contracts for the furniture were negotiated with local vendors by the provincial level BKKBN's in the 13 provinces participating in Phase I. However, the specifications did not always meet the needs of individual hospitals and clinics. For example, drawers in a card file cabinet intended to store voluntary sterilization records were too small to accommodate the

records. (See photograph on page 15) This occurred because the design specifications for the card file drawers did not specify the size of records for filing. The specifications identified only the desired height, width and depth of the overall file cabinet. A clothes cabinet observed by the audit team would not fit through the doors leading into patient rooms. (See photograph on page 15) The design specifications directed that the clothes cabinets be 6 feet high, 6 feet wide and 2 feet deep. The cabinet built to these specifications would not fit through the doors to patient rooms at a hospital in South Sulawesi.

Poor quality renovations were made to hospitals and clinics in some provinces. Equipment and furniture provided to some hospitals and clinics were in storage or were being used for other than intended purposes. As a result, the benefit in terms of increasing the contraceptive prevalence rate and reducing the Indonesian birth rate achieved through expenditures of \$2.5 million to upgrade hospitals and clinics for voluntary sterilization was doubtful.

Management Comments

In response to the draft audit report, USAID/Indonesia said that plans for monitoring the upgrade of hospitals and clinics under Phase II had been prepared. According to these plans, the district level BKKBN offices would be responsible for monitoring the development of specifications for building renovations, equipment and furniture purchased under the program. These specifications would be reviewed and approved by the central BKKBN office. Bids and contracts for non-medical equipment would also be reviewed by USAID/Indonesia. A final inspection team composed of representatives from BKKBN, PKMI and the Ministry of Health would visit each renovation site to ensure that specifications had been met prior to payment. The USAID/Indonesia project officer would review the activities of the BKKBN central office and make selected site visits during the implementation process.

USAID/Indonesia said that evaluation teams would visit each of the hospitals and clinics upgraded under Phase I. These teams would review the use of equipment and furniture provided, conduct training in equipment use and management, and identify excess equipment and furniture and problems with renovations. Excess equipment and furniture would be removed for use in the Phase II upgrades.

Office of the Inspector General Comments

Based on the USAID/Indonesia response to the draft audit report, Audit Report Recommendation Nos. 2 and 3 were closed upon issuance of this report.

3. Indicators Could Not Measure Impact of Three Project Components.

Indicators did not measure the impact of the Modern Management Technology, Research and Development and Training components of the project as required by regulations. Therefore, USAID/Indonesia could not effectively determine contributions made by these three components in achieving the project purpose and goal. The Mission could not measure the impact of \$7 million spent on three project components in increasing the contraceptive use rate and reducing the birth rate.

Recommendation No. 4

We recommend that a method be developed to assess the effectiveness of the Modern Management Technology, Research and Development and Training components of the Family Planning Development and Services II Project.

Discussion

USAID/Indonesia could not determine the benefit derived from \$7 million spent on the Modern Management Technology, Research and Development and Training components of the Family Planning Development and Services II Project in meeting the project purpose and goal.

The essential elements of successful project design were specified in Appendix 3K, titled Elements of an Evaluation Plan, to Chapter 3 of A.I.D. Handbook 3, Project Design. This Appendix required that targets be established at the project output, purpose and goal levels which had causative and verifiable relationships with each other. Such relationships were necessary to facilitate: (1) measurement of progress toward planned targets; (2) determination of why the project was or was not achieving its planned targets; and (3) determination of whether the project purpose continued to be relevant to the country's development needs.

USAID/Indonesia could not effectively measure the impact of the project's research and institution building components - Modern Management Technology, Research and Development and Training - in meeting the project purpose and goal of increasing contraceptive use and reducing the birth rate. This occurred because verifiable indicators included in the project logframe did not establish either direct or indirect linkages between the component outputs and the project purpose and goal.

Unlike the three service delivery components - Urban Family Planning, Village Family Planning and Voluntary Sterilization - the research and institution building components did not focus directly on increasing contraceptive use and reducing the birth rate. Therefore, verifiable indicators could not establish direct and quantifiable linkages between outputs of these three project components and the project purpose and goal. The Modern Management Technology component sought to improve the computer and word processing capabilities of the BKKBN. The Research and Development component sponsored family planning related research studies. The training component provided training to BKKBN personnel. None of these components had direct impact on the project purpose and goal.

Although the research and institution building components did not directly impact the contraceptive use rate and the birth rate, they could have indirect impact. However, verifiable indicators for these components did not establish indirect linkages between outputs and the project purpose and goal so that this impact could be measured. For example, the output target for the Training component was "GDI personnel trained to manage, implement and evaluate enlarged program." The verifiable indicator for measuring impact of the outputs simply listed the number of participants to be trained in-country and overseas. The indicators did not link the results of the training to the project purpose and goal so that impact could be measured. Such indirect linkages could have included improvements in BKKBN's abilities to plan, implement, manage and evaluate family planning activities resulting from the training. These improvements could impact the contraceptive use rate and the birth rate.

Verifiable indicators for the Modern Management Technology and Research and Development components did not establish indirect linkages between outputs and the project purposes and goal. The output target for the Modern Management Technology component was "Improvement through introduction of modern management technologies." The verifiable indicator was "Computer-Word Processing capacity at 16 provincial headquarters and central office." The output target for the Research and Development component was "Research and development studies for program improvement." The verifiable indicator was "25 operations research studies completed." In neither case did the verifiable indicators establish indirect linkages between outputs of the project components and the project purpose and goal. Therefore, the impact of these components could not be measured.

Verifiable indicators for the research and institution building components of the project did not establish linkages between outputs and the project purpose and goal. Therefore, USAID/Indonesia could not determine the impact of \$7 million spent on these components in increasing the contraceptive use rate and reducing the birth rate in Indonesia.

Management Comments

USAID/Indonesia said that they were revising the verifiable indicators for the Modern Management Technology, Research and Development and Training components of the project. The revised indicators establish indirect linkages between the component outputs and the project purpose and goal. Officials said that these revised indicators will be used to measure impact of these project components.

Office of Inspector General Comments

Based on the USAID/Indonesia response to the draft audit report, Audit Report Recommendation No. 4 was closed upon issuance of this audit report.

B. Compliance and Internal Controls

Compliance

As discussed in the report, the audit identified three instances of non-compliance. First, potential demand for service was not considered in selecting hospitals and health clinics for upgrade to perform voluntary sterilization as required by the Family Planning Development and Services II Project Paper. Second, site visits were not made while building renovations were being made to hospitals and health clinics upgraded to do voluntary sterilization as required by A.I.D. Handbook 3, Supplement 3B. Third, indicators did not measure progress of three of the six project components in achieving the project purpose and goal as required by A.I.D. Handbook 3, Appendix 3K. Nothing came to the auditor's attention as a result of specific procedures that caused them to believe untested items were not in compliance with applicable laws and regulations.

Internal Controls

The audit reviewed fund advances made by USAID/Indonesia to the BKKBN under three components of the project. The advances were traced down to the point where the funds were used within four participating provinces. Nothing came to the auditor's attention as a result of specific procedures that caused them to believe untested items were not in compliance with applicable laws and regulations.

AUDIT OF THE
FAMILY PLANNING DEVELOPMENT AND
SERVICES II PROJECT

PART III - EXHIBITS AND APPENDICES

EXHIBIT I

Voluntary Sterilizations Performed in 13 Provinces
Participating in Phase I of the Hospital and
Clinic Upgrades 1974 to 1987

<u>Province</u>	<u>Sterilizations</u>		<u>Ratio of</u> <u>Female to Male</u> <u>Sterilizations</u>
	<u>Female</u>	<u>Male</u>	
Bali	29,568	3,413	9 to 1
Central Java	137,397	41,107	3 to 1
East Java	173,801	3,202	54 to 1
Lampung	4,805	2,296	2 to 1
Metropolitan Jakarta	68,113	4,483	15 to 1
North Sulawesi	9,814	53	185 to 1
North Sumatra	61,593	1,885	33 to 1
South Sulawesi	10,581	500	21 to 1
South Sumatra	21,914	727	30 to 1
West Java	67,143	28,350	2 to 1
West Kalimantan	3,376	451	7 to 1
West Nusa Tenggara	2,894	19	152 to 1
West Sumatra	9,426	628	15 to 1
TOTALS	<u>600,425</u>	<u>87,114</u>	<u>7 to 1</u>

EXHIBIT II

Facilities Upgraded to Perform Voluntary Sterilizations
in 13 Provinces Participating in Phase I of
the Hospital and Clinic Upgrades

<u>Province</u>	<u>Facilities Upgraded</u>		<u>Ratio</u>
	<u>Female</u>	<u>Male a/</u>	<u>Facilities for Males to Female</u>
Bali	9	25	3 to 1
Central Java	38	99	3 to 1
East Java	41	95	2 to 1
Lampung	4	7	2 to 1
Metropolitan Jakarta	7	15	2 to 1
North Sulawesi	7	11	2 to 1
North Sumatra	17	37	2 to 1
South Sulawesi	21	51	2 to 1
South Sumatra	8	16	2 to 1
West Java	29	68	2 to 1
West Kalimantan	6	14	2 to 1
West Nusa Tenggara	4	12	3 to 1
West Sumatra	<u>10</u>	<u>20</u>	<u>2 to 1</u>
TOTALS	<u>201</u>	<u>470</u>	<u>2 to 1</u>

a/ Figures included hospitals upgraded to do both male and female sterilizations as well as health clinics upgraded to do only male sterilizations.

EXHIBIT IIIVoluntary Sterilizations Performed in 14 Provinces
Which Would Comprise Phase II of the Upgrades
1974 to March 1987

<u>Province</u>	<u>Sterilizations</u>		<u>Totals</u>	<u>Ratio of</u> <u>Female to Male</u> <u>Sterilizations</u>
	<u>Female</u>	<u>Male</u>		
Aceh	2,351	71	2,422	33 to 1
Bengkulu	1,979	270	2,249	7 to 1
Central Kalimantan	870	94	964	9 to 1
Central Sulawesi	1,997	24	2,021	83 to 1
East Kalimantan	4,787	284	5,071	17 to 1
East Nusa Tenggara	4,028	2,467	6,495	2 to 1
East Timor	350	21	371	17 to 1
Jambi	1,646	144	1,790	11 to 1
Maluku	2,124	36	2,160	59 to 1
Riau	5,097	344	5,441	15 to 1
South Kalimantan	3,744	163	3,907	23 to 1
Southeast Sulawesi	1,181	20	1,201	59 to 1
West Irian	3,186	148	3,334	22 to 1
Yogyakarta	40,251	14,014	54,265	3 to 1
TOTALS	<u>73,591</u>	<u>18,100</u>	<u>91,691</u>	<u>4 to 1</u>

UNITED STATES GOVERNMENT

memorandum

DATE:
REPLY TO:
ATTN OF:
SUBJECT:
TO:

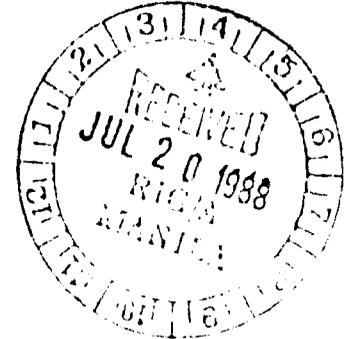
July 7, 1988

James M. Anderson, Acting Director

John M. Minerva

Response to Draft Report of the Family Planning Development and Services
II Project Number 497-0327

Mr. T. Montoney, RIG/A/M



This memo is submitted to be printed in connection with above report and to fulfill your request to provide information to allow closure of the Audit Recommendations at this time.

Summary: In response to the draft audit report, USAID has the following general comments: USAID believes that Recommendation No. 1 is being followed in the Phase I's Needs Assessment now underway and that indeed the criterion of potential demand has been an important part of our project site selection to date. In response to Recommendation No. 2, USAID will provide the plan for site visits during site upgrading and the plan for equipment purchase and delivery. Recommendation No. 3 asks for an assessment of the furniture and equipment utilization under Phase I and a plan to recover any items in excess to needs and use them in Phase II. USAID has such an assessment underway at this time and will put these audit requests into this effort. Recommendation No. 4 asks that a method be developed to assess the effectiveness of the Modern Management Technology, Research and Development and Training Components of the FPD's II Project. The USAID will revise the verifiable indicators for each of these components and indicate how we will assess their effectiveness.

A. Response to Recommendation No.1 which reads "We recommend that USAID/Indonesia develop criteria for selecting hospitals and clinics in the 14 additional provinces for upgrade to do voluntary sterilization to include potential demand for both male and female sterilization, location and level of family planning service of existing facilities and distances between facilities to be upgraded."

This response is in two parts: in the first part USAID will review the auditors' comments in regards to whether or not USAID considered potential demand in the implementation of Phase I upgrade of 470 hospitals and health centers and, in the second, how USAID is developing

criteria for the selecting the approximately 150 hospitals and health centers in Phase II. The RIG auditors indicated to USAID officials that they considered previous performance of VS to be the most significant indicator in determining potential demand. The USAID project officer stated that potential demand is indicated by the estimated number of VS cases which would occur if quality VS services were available to all potential clients at a reasonable cost. To assess this, measurements of the number of fertile age couples who desire to stop having children, responses to pilot activities that increase the supply of services, the number of long term contraceptive pill and IUD users as well as the current supply of VS services should all be considered when estimating amount of potential demand. These indicators are all being considered in the Phase Two planning as well as data on existing family planning prevalence, location and level of existing services and distances between facilities.

1. Determination of potential demand in Phase I:

USAID and the BKKBN had considered potential demand in selection of the hospitals and health posts for upgrade in the following ways:

a. Potential demand for VS is related to the desire to stop having children

An important factor in determining potential demand for VS is the number of couples who indicate that they desire no more children. Surveys completed in 1976, 1983, and 1987 have indicated that substantial numbers of Indonesian couples desire no additional children. In the most recent survey, the 1987 National Indonesian Contraceptive Prevalence Survey (NICPS), 55 percent of the currently married women in the reproductive age group stated they wanted no more children. When examined by the currently married women at risk of pregnancy (i.e., not currently pregnant, postpartum, or infertile) 45 percent indicated they wanted no more children. Twenty-six percent of the eligible couples are currently using effective methods properly and say they want no more children. However, only 3.3 percent of the couples have had a V.S. Table I examines the number of eligible couples (currently married in reproductive age) by Province in Phase I, lists current level of voluntary sterilization use, indicates the number of VS per province which would match the average prevalence of VS for ASEAN member states and shows a remainder of VS cases not yet done which should equate with potential demand. The final column indicates an average potential demand of 192 monthly case load over the next 4 years for each unit to be upgraded, a very significant number.

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TABLE I

POTENTIAL VS DEMAND IN INDONESIA USING ASEAN AVERAGE DATA FROM UNFPA

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Province	Eligible Couples (ELCO) (March'88)	Current User All methods (March'88)	Current User as Percent of ELCO	VS Current Users	VS User as % of All C.U.	(Col. 3*15%) Potential Demand - 15% of C.U. from ASEAN C.U. of VS (1987 UNFPA)	(Col. 7-5%) Potential Demand ASEAN Minus Current VS Users	(from Col. 8) ASEAN Estimated Monthly Case Load Over 4 Years	(from Col. 8) ASEAN Estimated Monthly Case Load Over 4 Years by UPGRD Hospt.	Number of Up Graded Hospitals or Planned Upgrade
DKI Jakarta	1,242,338	804,116	64.73%	45,655	5.68%	120,617	74,962	1,562	223	7
Jabar	5,361,339	3,995,977	74.53%	77,892	1.95%	599,397	521,505	10,865	375	29
Jateng	4,545,278	3,242,048	71.33%	127,036	5.34%	486,307	313,271	6,526	172	38
Jatim	5,449,271	3,804,458	69.82%	160,256	4.21%	570,669	410,413	8,550	214	40
Bali	427,714	335,342	68.40%	18,363	5.48%	50,301	31,938	665	74	9
NTB	449,508	279,409	62.16%	1,833	0.66%	41,911	40,078	835	209	4
SumUt	1,420,654	959,298	67.53%	54,286	5.66%	143,895	89,609	1,867	110	17
SumSel	817,971	575,349	70.34%	20,469	3.56%	85,302	65,833	1,372	171	8
SumBar	564,601	337,110	59.71%	6,948	2.06%	50,567	43,619	909	83	11
Lampung	919,233	601,280	65.41%	6,239	1.04%	90,192	83,953	1,749	437	4
KalBar	448,382	262,651	68.58%	3,261	1.24%	39,398	36,137	753	151	5
SulSel	953,837	632,418	66.30%	7,263	1.15%	94,863	87,600	1,823	91	20
SulUt	356,216	259,449	72.83%	6,495	2.20%	38,917	32,422	675	96	7
	22,956,342	16,080,905	70.08%	591,996	3.62%	2,413,336	1,831,340	38,153	192	199

CJ = Current User
ELCO = Eligible Couple

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b. Potential demand depends on the supply of services

It is increasingly clear that although large numbers of fertile Indonesian couples desire no more children and want a voluntary sterilization procedure, this service is not being offered by hospitals because of lack of operational supplies, staff interest and priority setting. BKKBN, during the last four months of GOI FY 1987/88, had a pilot project to provide additional funds to ten provinces to pay for these operational costs and prioritize VS service in the medical staff duties. Table II indicates that the number of cases performed by the last month in the study was 2.5 times greater than the average monthly cases performed in 1987/88.

TABLE II
GOI FY 1987/88

VOLUNTARY STERILIZATION CASES						
	Average Monthly Cases 1987/88	Dec '87	Jan '88	Feb '88	Mar '88	Total 4 Months
1. D.I. Jakarta	422	416	577	471	448	1,715
2. West Java	820	1,384	1,556	1,597	1,754	6,259
3. Central Java	1,587	2,875	4,192	3,761	6,150	16,794
4. East Java	1,766	2,595	3,116	3,342	3,207	12,260
5. North Sumatra	526	629	1,671	2,355	4,057	9,213
6. South Sumatra	282	898	383	316	192	1,989
7. Lampung	77	53	71	119	114	387
8. South Sulawesi	112	66	117	52	76	348
9. Riau	59	74	109	136	178	541
10. N.T.T.	101	116	121	266	236	696
Total	6,532	9,091	11,698	13,168	16,412	50,359

c. Demand for vasectomy services is low because of the lack of service facilities - Potential demand is high

BKKBN found that very few doctors were trained and few hospitals were offering outpatient vasectomy services. The assistance in Project No. 497-0527 was to address that problem as well as to improve overall quality of services provided. Table III below indicates the total BKKBN/AVSC/USAID efforts to date to upgrade the quality of voluntary sterilization services in Indonesia:

TABLE III
BKKBN/AVSC/USAID UPGRADATION PROGRAM
1986-1989

Types of Hospitals and Health Posts	Total Number 1986	Prior to Upgradation		AVSC Upgrade	Tubectomy & Vasectomy	Tubectomy & Vasectomy
		1985 Offering VS Services			Phase I	Phase II
		Tub	Vas		0327 (1986-87)	0327 (1988-89)
General Hospitals	688			50	266	150
Specialty Hospitals	679					
Puskesmas	5,009				271 (VAS)	0
Total Units	6,376	1,000	50	50	471	150

Note that of the 1,050 service points providing VS services before AVSC and Phase I upgradation, only 50 could provide vasectomy services. When all 671 facilities planned for upgradation are completed, 460 will provide the full range of male and female services and 271 vasectomy only.

In another pilot activity carried out in West Java during ODI FYs 1982/83 and 1983/84, mobile vasectomy services were set up throughout the province in an effort to determine the underlying demand for services. USAID did not support this effort because of the lack of good counseling, the lack of regular support procedures and the difficulties in follow up. Nevertheless, during those two years the level of vasectomy procedures in West Java came close to equalling those of tubectomies (see Table IV below):

Table IV

VS Procedures in West Java during Pilot Vasectomy Activity

	<u>FY 1982/83</u>	<u>FY 1983/84</u>	<u>Total</u>
Number Vasectomy	10,958	4,726	15,684
Number Tubectomy	7,460	10,630	18,090

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It is clear from the above Table that given a reasonable supply of services, males will accept vasectomy. One of the results of this BKKBN pilot was the interest by the BKKBN in putting quality vasectomy services in Health centers in the FPDS II Project.

2. Criteria for selection of hospitals for upgrade in the 14 Outer Island Provinces, including potential demand for male and female voluntary sterilization, location and level of family planning services of existing facilities, and distances between facilities:

The criteria being used for choosing health facilities to be included in the Phase II of the VS National Development program for upgradation are:

- a. Potential demand
- b. Contraceptive prevalence
- c. Local leader support
- d. Location and level of family planning services in existing facilities
- e. Distances between facilities

These criteria will be used initially in the selection of hospitals by the local VS development task force to determine which districts and then which hospitals in each district will be included in the upgradation. For the individual hospital, potential demand will basically be an estimation of the needs for VS in the community and the ability of the hospital staff to provide the service (once some training is provided). Each hospital will be prioritized and the situation carefully reviewed at the local level by the Department of Health, the Ministry of Interior, the local PKMI branch personnel and BKKBN. The local team will recommend the priority facilities to the Central BKKBN and PKMI. As a result of rigid application of these criteria and the urging of RIG/Manila, the list of hospitals to be upgraded in Phase II-in the Outer Island provinces has already been reduced from 200 to an estimated 113.

At the Central level, a very systematic approach will be used to determine whether the local recommendation is rational:

a. Each province will be mapped, to check geographic distribution of facilities.

b. Provincial and district VS and general family planning data will be analyzed and charted for each facility that is recommended for upgradation. Each provincial facility will be prioritized by this data. Also, certain low potential areas and/or facilities will be eliminated from the project. Initial estimates of potential demand were made as in Phase I (Table V). Although the potential monthly case load of the approximately 113 sites at 38 per month from the 4 year period is considerably lower than the Phase I demand estimate, it is still a significant number. In areas where we estimate a low monthly case load, there will be careful selection of sites to ensure maximum coverage.

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TABLE V
POTENTIAL VS DEMAND IN INDONESIA USING ASEAN AVERAGE DATA FROM (UNFPA)

Province	Eligible Couples (March '88)	Current User All methods (March '88)	EUD as Percent of C.U.	VS Current Users	VS User as % of All C.U.	Potential Demand - 15% of C.U. from ASEAN C.U. of VS (1987 UNFPA)	(Col. 5*15%) Potential Demand ASEAN Minus Current VS Users	(from Col.8) ASEAN Estimated Monthly Case Load Over 4 Years	(from Col.8) ASEAN Estimated Monthly Case 4 Years by UNFPA Hospt.	Number of Upgraded Hospitals or Planned Upgrade (Planned)
Java	386,744	246,614	63.77%	5,396	2.19%	36,992	31,596	658	66	10
Sumatra	279,044	201,025	72.04%	1,556	0.78%	30,154	28,588	596	54	11
Borneo	145,297	98,979	69.07%	2,742	2.78%	14,842	12,100	252	63	4
Sulawesi	408,564	152,008	37.21%	6,836	4.59%	22,801	15,965	333	22	15
Malaya	180,329	109,167	60.55%	1,051	1.05%	15,025	13,974	291	49	5
Java	230,714	147,526	63.94%	3,613	2.45%	22,129	18,516	386	26	15
Sumatra	378,447	256,537	67.79%	3,359	1.31%	38,481	35,131	732	73	10
Borneo	227,332	107,536	47.48%	2,379	2.15%	16,190	13,870	289	48	6
Sulawesi	144,072	61,214	42.43%	1,034	1.69%	9,182	8,148	170	34	5
Malaya	229,716	172,078	74.97%	1,626	1.35%	17,562	15,936	332	22	15
Java	215,415	89,280	41.44%	5,229	5.53%	8,392	5,613	117	39	3
Sumatra	63,852	9,594	11.45%	176	1.82%	1,441	1,265	26	5	5
Borneo	457,733	328,186	71.93%	47,615	13.29%	49,228	5,613	117	15	8
	3,345,259	1,989,153	59.36%	76,609	4.06%	282,923	206,314	4,298	38	113

U.C. = Eligible Couple

C.U. = Current User

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c. A financial estimation will be made of the cost of the upgradation, based on estimated cost of renovations and equipment purchase. Further reduction in the list of facilities for upgradation will depend on the funds available and requested inputs. Based on this data, the Central level task force will prepare a centrally approved list of facilities for upgradation, by province, for review by the provincial task force. The provincial team can suggest changes in this provincial list, if it is felt appropriate.

Summary:

This summary of the selection process in progress now for Phase II indicates that the criteria of contraceptive prevalence (56% average for the 14 provinces), potential demand (38 cases per month per unit upgraded) and the involvement of local leaders are being considered at this time. We request RIG/Manila to close this Recommendation No. 1.

B. USAID response to Recommendation No. 2 which reads "We recommend that USAID/Indonesia not fund building renovations and host country local purchase of furniture and equipment for hospitals and clinics to be upgraded during Phase II of the Voluntary Sterilization component unless the Mission ensures that:

- Site visits on building renovations are in progress to assess the quality of work being performed;
- Excessive delays between assessing the furniture equipment needs of hospitals and clinics and delivery of materials are avoided, and
- Furniture specifications meet the needs of local hospitals and clinics."

1. Plan for development of Phase II site visits and time schedule

The USAID has opted for dual-track II Host Country Contracting procedures again in Phase II and BKKBN and USAID have modified the site visits and contracting approach to consider RIG/Manila suggestions as follows:

The district BKKBN office will be responsible for monitoring the specification process, the actual bidding, and finally, the implementation of the upgradation. PKMI and the provincial PKMI office will supervise at the provincial level and provide technical assistance as needed. The BKKBN district office will make visits to the upgradation sites in that district to ensure the upgradation is proceeding as planned.

The BKKBN provincial office will work together with PKMI to finalize the list of sites that will be included, to supervise and to carry out and monitor the local equipment contracting. This office, along with PKMI and the Ministry of Health (Depkes), will visit the upgradation sites in the province from time to time, using funds mainly from the PKMI grant budget. The provincial task force will also form the final

inspection team that will inspect each renovation site and ensure that the agreed to specifications were met prior to payment.

The BKKBN central office, working closely with PKMI, will supervise the activities at the provincial level. This will include several visits to the all provinces to meet with the provincial task force and visit several representative upgradation facilities to check the process. Also, the specification and quality of the local purchase equipment will be reviewed. The central BKKBN office and PKMI will approve the submitted renovation specifications and the provincial bids and contracts for the non-medical equipment purchases. BKKBN will arrange for the non-medical equipment bids and contracts to be sent to USAID for review and processing.

USAID will review the activities of the BKKBN Central office, make selected visits by the project officer with the BKKBN/PKMI/DepKes teams and check independently in the provinces during the intensive upgradation period as often as is prudent in relation to OE fund availabilities. The AVSC consultant to the BKKBN will also conduct site visits. This whole process for Phase II should be completed in six to eight months.

It should be noted that since the audit visit, USAID staff have visited several additional upgraded facilities and have found renovations properly done and equipment in use. Pictorial examples are given in Attachment 1. USAID staff also participated in the first round of Phase II upgradation visits to the 27 provinces to review the questionnaire results and to give guidance in the selection criteria and provincial duties and responsibilities to the PKMI/BKKBN/MOH provincial teams.

2. USAID response to audit comments on Phase I

a. USAID project monitoring

The report lists several items which it says are contrary to Agency guidance. The first of these statements is in regard to site visits which the RIG auditors state are required by Agency guidance. Although site visits are one of four monitoring tools commonly used in AID projects, AID guidance in Handbook 3, Chapter 11 "Project Monitoring", Section 11E2 also includes borrower/grantee project reports, consultation with project participants, and review of project documents as also being useful in monitoring project progress. Handbook 11 indicates that when the Host Country entity has a generally good system for carrying out projects then that system should be used.

The Mission determined in view of the 470 sites and the amount of funds per renovation (under US\$2,000 per hospital, and \$1,000 per health post) that we would rely on host country reporting systems and meetings for the bulk of our monitoring effort. One AVSC consultant to the BKKBN made a limited number of field trips to review the sites while the work was in progress and it was felt that between those efforts and the BKKBN field staff administration site visits in the provinces that the project was well reviewed.

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We note that the Audit team found two sites out of the 12 they visited where it felt renovations were inappropriate in terms of quality or specifications. [The audit sample contained 5 health clinics (1.8 percent of the total) and 7 hospitals (3.5 percent).] USAID and BKKBN also reviewed about 100 sites earlier than the audit team and found that, in general, the renovations were done as described or were done in conjunction with GOI funds that were also made available to the project. Although some of the work might not pass inspection in the US, the work reflected provincial and regency contractor work in Indonesia and is generally considered acceptable under Indonesian standard. Therefore, we do not believe that the conclusions are correct. Some pictures of properly completed renovations are included in Attachment 1 of this report.

b. Delay between assessing the equipment and furniture needs of the hospitals and clinics and delivery of the materials

The delivery of the furniture was delayed by the rather lengthy administrative procedures required to have each province bid the furniture to their local manufacturers, produce and deliver the furniture to each site and a local currency devaluation during this time. Since the Mission followed Handbook 11, the project officer reviewed all the contract awards (based on the lowest bid) and required certification by the BKKBN that the furniture had been delivered to the site and made according to the specifications prior to releasing the funds. Before this stage was reached, both the Provincial and Central Steering Committees had to review the requests and determine that the equipment was required prior to BKKBN making its request for funding to USAID. We believe that from the experience gained in Phase I, Phase II can move at a faster pace.

The medical equipment was ordered through the AVSC Cooperative Agreement with AID/W. We determined at the outset to deliver this equipment in seven shipments over a two year period, so that the medical training could be completed before the medical equipment was delivered to the site. Some of the equipment is still in the BKKBN warehouses, because not all of the health centers have had their medical staff trained. This fact also accounts for some of the equipment the auditors found not yet in use at the site. USAID staff made this clear to the auditors during the review, so we disagree with the finding that the unused equipment represents wasted equipment purchases.

c. Furniture specifications did not meet local needs

BKKBN followed the specifications used by the Ministry of Health in purchase of hospital furniture. This seems to us to be by far the best way to make a large purchase of furniture for 470 different service sites, and, thus the audit statement is not correct. Although it is true some of the equipment may not have fit in every room of each voluntary sterilization unit, as far as we can determine the furniture is in general use at the sites. The principal problem was the clothing wardrobe and specifications are being modified for that item.

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Summary:

As a result of USAID plans in Phase II to carry out site visits, avoid delays and modify furniture specifications, we request RIG/Manila to close this Recommendation No. 2.

C. Recommendation No. 3 which reads "We recommend that USAID/Indonesia assess the quality and utilization of furniture and equipment provided to hospitals and clinics under Phase I of the Voluntary Sterilization component and recover furniture and equipment in excess of needs for use in Phase II."

BKKBN, USAID, and PMH have set up a monitoring and evaluation activity to send two person teams to visit each of the 470 upgraded facilities in Phase I. Training will be conducted in Jakarta in July and teams will visit all sites over the next 3 months. Their task is to review use of the equipment and furniture provided, provide training in both equipment use and management of a VS service site and to prepare lists for BKKBN and PMH of any excess equipment or furniture and any outstanding problems with the renovations. If sites are completely ready for service, certificates for service provision will be issued. Any sites with discrepancies in training or equipment will also be listed. All lists will be developed into a provincial tally.

In case of excess furniture and equipment, BKKBN will remove it from the service site and place it in the Provincial warehouse for use in Phase II. Any discrepancies in renovations will be noted to the BKKBN Regency offices and they will be requested to notify contractors to repair the problem by a certain date or face removal from local available contractors list for Phase II renovation procurement bidding.

The service site discrepancies in equipment may be made up from excess items in the Province. The medical training deficiencies will remain the focus of the remainder of this year and next year's training efforts.

Summary:

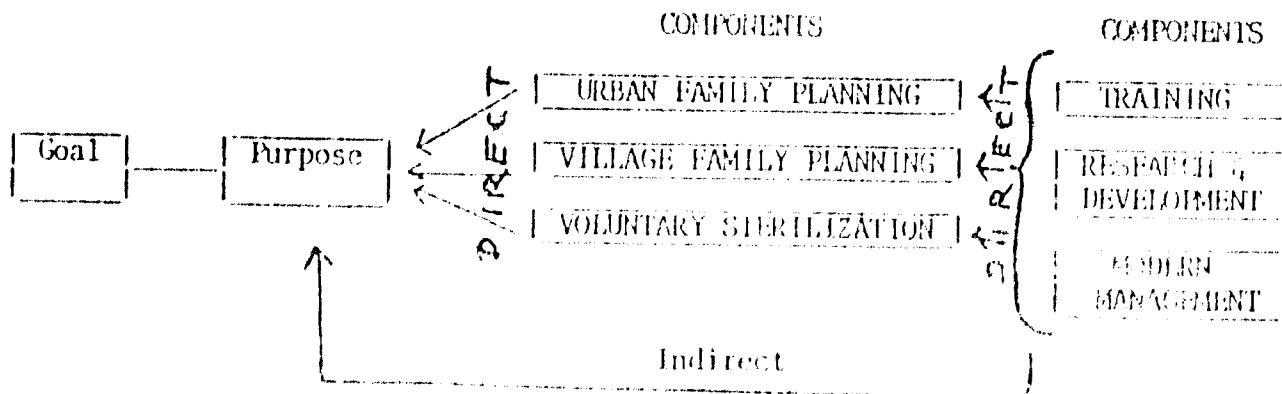
BKKBN has in operation a survey of all sites in Phase I which will allow recovery for use in Phase II of any excess furniture and equipment. We request that RIG/Manila close Recommendation No. 3.

D. Recommendation No. 4 which reads "We recommend that a method be developed to assess the effectiveness of the Modern Management Technology, Research and Development, and Training components of the Family Planning Development and Services II Project."

USAID has reviewed Recommendation No. 4, the accompanying narrative in the report, and Appendix 3 K, "Elements of an Evaluation Plan" which states:

"Targets at the output, project purpose, and sector/program goal levels are to have a hypothesized, causative relationship to each other which is susceptible to verification by systematic evaluation and which presents a strong probability of occurring."

We highlight the word hypothesized and note that indirect causative relationships are not excluded. We do not interpret this statement and the intention of the project design and evaluation sections of Handbook 3 to mean that each component must be related directly to achievement of the project purpose and goal, and that such a direct relationship must be quantitatively specified in the case of each project sub-component. Accomplishment of the tasks included in one component may be a necessary or essential part of accomplishing another which, in turn, will more directly and quantifiably contribute to accomplishments of the project goal. For example, if one component is to increase contraceptive use through an increase in service outlets, it will be necessary as part of increasing the number of outlets to have training to ensure that the quality of service is maintained and that sufficient personnel with the management skills required to increase the number of service points are available. Thus, provision of training in and of itself would not be linked directly to the project purpose or goal, but would be a pre-condition for achieving another component which is. Similarly, expanded computer facilities at the central and provincial levels will help program managers efficiently manage the expanded number of service points. Research and development efforts may be conducted to develop and test new approaches or evaluate on-going ones to give insights on how to expand and improve quality services. The extent to which such studies will result in recommendations which are useful and acceptable cannot be reasonably predicted or expressed usefully in advance in terms of quantifiable targets. We do know, from past experience on other projects, however, that such research studies can make valuable contributions to improving project management. In sum, then, three project activities (training, research and development, modern management technology) are sub-components of other activities which, if successfully completed, can be linked more directly with accomplishment of project goals and purpose. This is schematically presented below:



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We discussed our interpretation of Appendix 3 K with the auditors on June 9, 1988 and they agreed that indirect as well as direct linkages of outputs to the project goal and purpose are acceptable as long as they are measurable, and the wording in the draft report was changed accordingly. The auditors also agreed that qualitative as well as quantitative measures are acceptable.

Based on experience with family planning programs worldwide, the mission hypothesized in the design of the FPDS II project that soundly managed institutions were needed to deliver and expand family planning services, to monitor and evaluate the use of these services and to test new approaches to delivery in order to expand and offer better services. Therefore, the modern management, training and research components were included in addition to the three components more directly related to increased service delivery and accomplishment of the project goals and purpose. We have found over the project period, utilizing routine service statistics and the recently completed National Indonesian Contraceptive Prevalence Survey, that contraceptive prevalence has increased significantly and fertility has declined. It is not feasible or possible to determine how much contraceptive increase and how much fertility decline is attributable to which sub-component activity, e.g., whether for every \$10,000 spent in urban family planning or in training, one will get "x" percent increase in contraceptive prevalence. We do not agree with the implication of the audit report that the mission does not know and is unable to determine the value of the three institution building project components. In compliance with the audit recommendations, USAID will discuss below the indirect linkages of the three institution building components (research and development, training, modern management) to the project purpose and goal, revise the verifiable indicators, and discuss the method that has been developed to assess the effectiveness of these components.

Research and Development Component

The output specified in the Log Frame for this component was "research and development studies for program improvement" and the verifiable indicator was "25 operations research studies completed." The Project Paper text, pp 41-43, emphasized the importance of research and development for program improvement, specifically for program planning, implementation, and evaluation. Included in the text description was a preliminary list of studies/research projects such as testing new contraceptive technologies and examining the cost effectiveness and continuation rates of various contraceptive methods; operations research on new delivery systems (e.g. retail sales, private sector and urban approaches); program evaluation (including an independent measure of contraceptive prevalence in an intercensal survey). Also included in the text was the need for training in population research methodologies. In response to the Recommendation 4, USAID proposes that the following verifiable indicators be specified to measure accomplishment of the project component "research and development" towards achieving the project's purpose and goal:

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1. 25 bio-medical, operations, and social science research projects (including a nationwide intercensal survey) implemented to improve planning, implementation, and evaluation of the national family planning program.

2. 12 seminars and workshops on special population research methodology-related topics conducted to upgrade the research skills of BKKBN and implementing unit staff and 12 conferences and meeting held to disseminate research finding.

3. U.S. and local consultants provided to improve BKKBN research design, implementation and evaluation.

4. Institutionalization of research capacity at BKKBN, increase of Indonesian research capabilities, and improved utilization of research findings.

As discussed in the introductory section, these indicators work through "indirect" linkages to achieve the overall purpose and goal -- i.e., research and development can improve program management and the delivery of family planning services; these, in turn, affect increases in contraceptive use and subsequent fertility decrease.

To measure effectiveness, USAID conducted an evaluation of the research and development component in February 1988. The scope of work of the evaluation identified three major objectives:

1. to gauge the extent to which activities supported under this project have met the objectives of the project as indicated above, including quantitative measures as well as an assessment of quality of research and utilization of findings;

2. To examine the development of institutional capacity to manage research at BKKBN, and the effectiveness of AID's role in that process; and

3. To assess the contribution of international technical assistance to improving the quality of research and to developing BKKBN's research management and implementation capability.

Based on the findings, the evaluators were asked to provide recommendation in three areas: 1) how to improve further the institutional capacity at BKKBN to manage research; 2) how to utilize most effectively the remaining original and new resources planned for the final years of this project; 3) what role the Division could play in implementing the proposed new USAID project, "Private Sector Family Planning" planned for FY 89 obligation.

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The evaluation team consisted of one international consultant (a specialist in research management) and two local consultants (a medical doctor with research and public health experience, and a social scientist with program implementation, evaluation, and research experience). Prior to the arrival of the evaluation team, the Program Development Division (PDD) assembled and organized relevant documents (project papers, monthly/quarterly reports, annual plans and corresponding umbrella PILs, proposals and final reports of all research projects funded). The PDD prepared a list of all projects funded, by time period and institution, and a list of every seminar/workshop and training participant.

The team reviewed the documents assembled by the PDD and selected a sample of USAID-supported research projects to review in depth from proposal selection, field implementation to final report and dissemination of findings - in order to assess the PDD's research management system, the quality of work produced and the manner the findings are utilized to improve program planning and performance. The evaluators surveyed a number of outside institutions which have received project funding from BKKBN to learn their perceptions of BKKBN support. They also surveyed a sample of workshop/seminar participants to learn their views on the value of the experience.

The evaluators reviewed research management systems development by the Division and the degree to which they have been institutionalized. The quality and usefulness of the technical assistance, both long and short term was reviewed in terms of its contribution to the institutional development of the PDD and to improving the quality of the various subprojects. This evaluation was carried out during the period February 1-28, 1988.

The evaluation team concluded that:

"While the Program Development Division (PDD) must still be considered to be in very early stages of its institutional development, its accomplishments have been substantial: 25 research projects have been completed, numerous training courses for staff development have been held, seminars/workshops have been organized for outside researchers and staff, first steps have been taken toward computerization of project monitoring, and systems for research management are in place. One of the strongest aspects of research management at BKKBN is utilization of research findings: policy implications of recent research are presented regularly at two major policy and planning meetings. Research is considered a priority by the Chairman and there is considerable pressure for high quality, policy - relevant studies produced in a timely fashion. A recent major success in research management and implementation has been the collaboration between BKKBN, AID, UNFPA, Westinghouse, and the Central Bureau of Statistics to design and conduct the first National Contraceptive Prevalence Survey."

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This survey provided an independent measure of contraceptive prevalence and fertility as well as provided a wealth of information on family planning services which can be used to gauge progress (e.g., urban versus rural, method mix, age and parity of acceptors). Other examples of research findings which have been utilized by program staff include the continuation rate studies, where results are used for target setting in particular areas, the lippes loop quality study which supported the increased usage of locally produced IUDs, and the male involvement in family planning study after which the Chairman initiated an intensive effort to increase male participation in the program.

The team also concluded that:

"While improvements have been made over the project period in training, management, and research output, considerable opportunities exist for more progress in future. The PDD has been through a period of very rapid expansion and increasing demands for output. The evaluation team feels that the time is appropriate for tightening up the system and clarifying objectives and goals for the future. Concerns which should be addressed include development of concensus, consolidation of effort, improvements in quality, and longer range planning.

It is precisely because the BKKBN utilizes research findings so extensively, the evaluators stressed that the Program Development Division should reduce its large number of activities and research projects and consolidate or a limited number of topics to allow an increased emphasis on quality of output and on institutional development. The BKKBN has already incorporated the evaluation findings into its 1988/89 Annual Plan which has reduced the number of activities (research, training, seminars) and has consolidated activities into one priority area for each of the three research centers plus continued emphasis on improving research management.

Training Component

The output specified in the Log Frame, "GOI personnel trained to manage, implement, and evaluate enlarged program" had as a verifiable indicator "16 Ph.D.s and 56 MAs trained overseas, 90 MAs and 14 Ph.D.s trained in country". In the text, p.31, a more detailed listing of indicators is given:

1. 56 persons completing Master's degrees in U.S.
 2. 16 persons completing doctoral degrees in U.S.
 3. 90 persons completing Master's degrees in Indonesia
 4. 14 persons completing doctoral degrees in Indonesia
- 42

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5. development and adaptation of at least four specialized in-service training programs
6. a special program of management development training
7. plans for new schools of public health are completed, including identification of faculty members requiring additional academic training and specification of library and other reference requirements.

It was mentioned that long term goal of the assistance for overseas training is to institutionalize the capability within BKKBN to plan, place, monitor, and evaluate its overseas training program. The Comprehensive Training Assessment reviewed by the auditors paid special attention to the institutionalization aspect as well as the quantitative indicators mentioned above.

In the Project Paper Appendix B F.1, Technical Analysis, section (d) Training, there is a detailed description of the Training Needs Assessment undertaken prior to development of the project. This analysis stated that the aim of the graduate level training is twofold:

- 1) to strengthen management capability of staff of the BKKBN and other implementing units involved in the national family planning program;
- 2) to develop and strengthen institutional capability of Indonesian training and research organizations so that they can assume a greater role in providing trained manpower in the future.

The training needs were classified into six areas, listed below by BKKBN in order of priority:

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

As explained above, the linkages between training component activities and the project purpose and goal are indirect. Management training, including financial management, program planning

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administration, and economic assessment, should strengthen BKKBN and implementing unit capability to manage the enlarged national family planning program, thereby improving services and, consequently, increasing contraceptive prevalence and decreasing fertility. Likewise, training in technical areas (public health; population studies; sciences such as behavioral, computers, medical, education, and communication) will assist the technical staff of the BKKBN and implementing units improve their skills and competencies, and consequently their services (medical, IEC, research/evaluation). Technical training in family planning related areas for Indonesian university staff will improve their capability to offer in-country degree programs, thereby increasing the number of family-planning related programs for BKKBN and implementing unit personnel who cannot qualify for overseas training and, in consequence, expand the number of trained manpower available to implement the program (at less cost than overseas training).

In compliance with the audit recommendation and, incorporating the new training funds provided in Amendments II and III, USAID hereby revises the verifiable indicators of the training component:

1. Candidates selected for in-country or overseas training occupy managerial or technical positions in the BKKBN or its implementing units (including the universities) in the following composition:

a. Management training for program improvement:

Long Term:

- 27 Masters degrees in the U.S. for BKKBN and implementing unit staff
- 80 S₁ degrees in Indonesia for BKKBN staff

b. Technical Training for program improvement:

1) Long Term:

- 3 Ph.D. degrees in U.S. for BKKBN staff
- 13 Ph.D. degrees in US for School of Public Health and Demographic Institute Faculty
- 32 Masters degrees in U.S. for School of Public Health and Demographic Institute Faculty
- 27 Masters degrees in US for BKKBN staff
- 109 S₁ degrees in Indonesia for BKKBN staff
- 14 S₂ degrees in Indonesia for BKKBN staff
- 59 S₂ degrees for staff of Schools of Public Health, and interdisciplinary program of Ministry of Population and Environment
- 8 S₃ degree for staff of Schools of Public Health

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2) Short Term:

- Development of a "distance learning" (programmed packages for correspondence course) for family planning fieldworkers and supervisors for refresher training in technical areas to upgrade skills.
- Training of 2500 Ministry of Health midwives in new clinical contraceptive methods to improve clinical method service delivery
- Retraining of all village family planning (VFP) fieldworkers in: descriptions of fee-for-service delivery systems; role of VFP fieldworker in the Posyandu system; new contraceptive method descriptions; and appropriate referral procedures for voluntary sterilization services in order to improve the delivery of family planning at the village level, offer greater contraceptive method choice, and improve client selection.
- Special orientation for 500 village family planning fieldworkers for male contraception and responsibility to improve male participation in the family planning program, especially in relation to vasectomy acceptance.

2. Candidates selected for long-term training are placed in academic programs related to management and administration; population studies; public health; sciences (social, behavioral, medical library, economics, computer); education; communication/audio-visual;

3. Participants completing long-term training are expeditiously returned to their former position or are placed in a new position that is relevant to their training;

4. Management efficiency of the units receiving trained management personnel increases; the technical output of units receiving training technical personnel improves.

In order to measure the above indicators, the PKHRB will do a follow-up study of all participants trained under Project 497-0327 in 1990, prior to the overall evaluation of the project. The follow-up study will involve a desk review of all long term training participant statistics, questionnaires to the participants concerning their training and current functions, and interviews with supervisors and peers in a sample of the participant's current work situations to assess the participant's contribution to improved program performance (or, university teaching program). The study will also include a statistical sample of the participants in the short term technical training which should be completed by then in order to assess the effectiveness of the training in improving competencies.

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Modern Management

In the Log Frame, the modern management component output was stated as "improvement through the introduction of modern management technologies" and the verifiable indicator was "computer word processing capacity at 16 provincial headquarters and central office". The output as described in the project paper text was "to assist the BKKBN to develop computer and word processing capabilities in 16 provincial BKKBN offices, in headquarter offices, and in selected training and research institutions". The rationale given in the text and Technical Analysis Annex was that many of the offices at BKKBN headquarters and provincial level lack access to computers for data analysis useful for program planning, implementation, evaluation, and allocation of funds. Including the funds provided in Amendment III, the modified outputs should now include:

1. 27 Provincial Offices linked to Central BKKBN Bureaus via a micro computer network.
2. Mini Computer replaced and new applications packages in place.
3. Provincial and central secretarial, middle and upper level personnel trained in computer technology and use.
4. Provincial Pilot Study Tour conducted to equip and train Regency level personnel in computer use.
5. Enhanced software for logistics, financial and personnel in place.

Again, by "indirect" linkages, the supply of modern management technology and personnel trained by their use, will improve program efficiency and management of the expanded program and thereby help the program increase contraceptive prevalence and decrease fertility. Based on this rationale, and in compliance with the audit recommendation, we revise the verifiable indicators as follows:

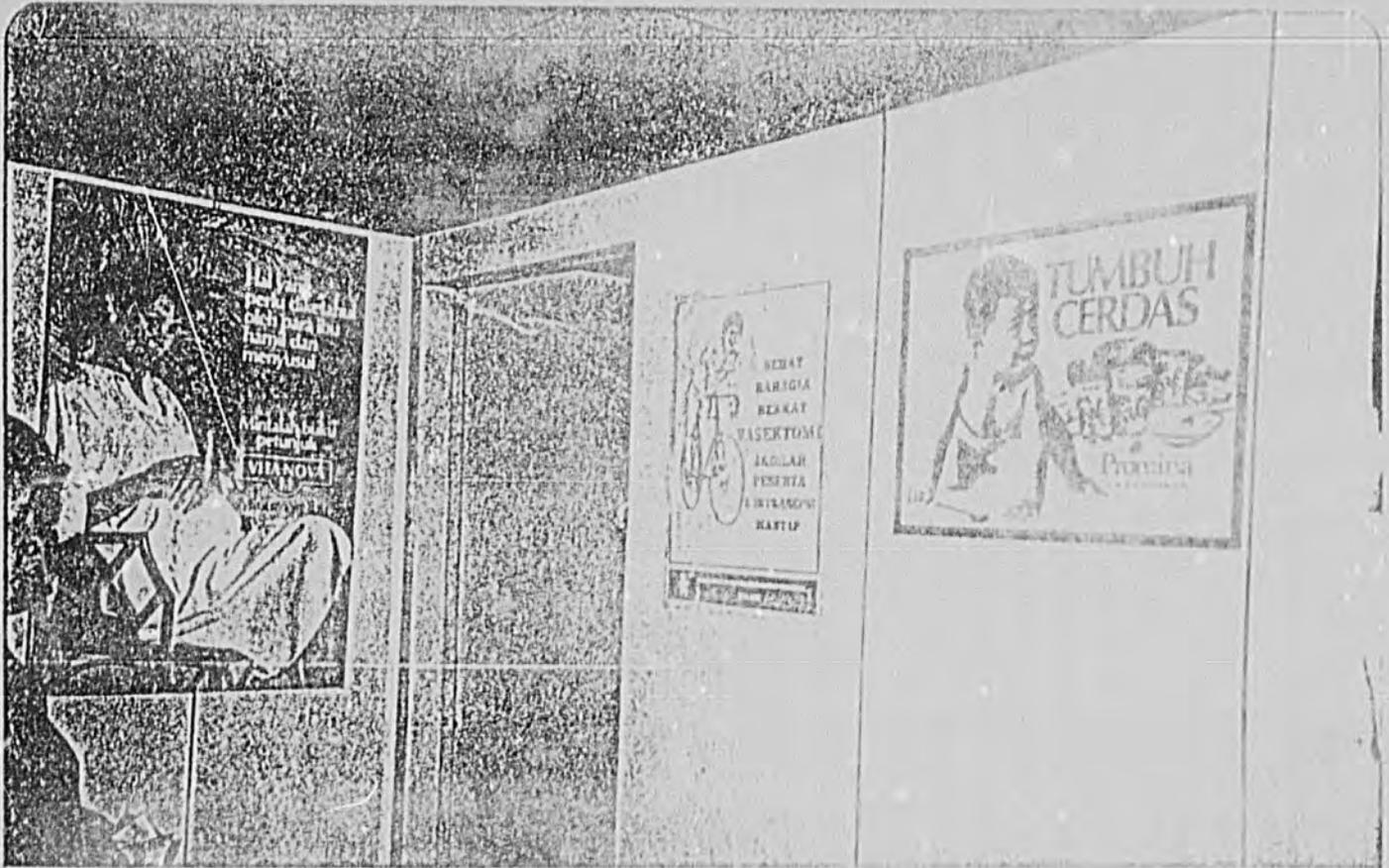
1. improved analysis of program performance;
2. improved rapid feedback of program performance data from central to provincial and lower levels;
3. improved access to program data for research and administrative purposes;
4. improved financial accounting, planning and budgeting;
5. improved personnel management (assignment, evaluation, training);
6. improved logistics.

Although we realize the above indicators are more qualitative than quantitative, we believe that the activities included in the Scope of Work of the evaluation to be conducted in August 1988 will be able to verify that this was an appropriate investment in support of the project's purpose and goal. We foresee the evaluation being structured as follows: the objectives are to evaluate whether the systems described above have improved on the basis of the introduction of the computer capabilities at central and provincial levels, and to evaluate the extent to which BKKBN has institutionalized the system in terms of training, development of hardware and software standards, appropriate acquisitions, monitoring network system, policy and practices for data security. To conduct the evaluation, an international expert from an existing IQC with a firm in the automation field will work in conjunction with an Indonesian computer consultant. The team will review the projects activities at the central, provincial and pilot kabupaten level. The final report will assess the extent to which the administrative and management systems have been improved based on the introduction of modern management technology, recommend refinements in the systems established to date, and make recommendations for future activities to include training support, locational placement, technical specifications, and management systems for additional computer technology.

Summary:

In compliance with this audit recommendation, USAID has discussed the methodology of measuring the effectiveness and has revised the verifiable indicators of the three institution building components. These indicators better reflect the "indirect" linkages between the outputs and purpose and goal and have been used or will be used in upcoming evaluations. We request RIG/Manila close this recommendation No. 4.

USAID PHOTOS OF LOCALLY PROCURED FURNITURE & RENOVATIONS



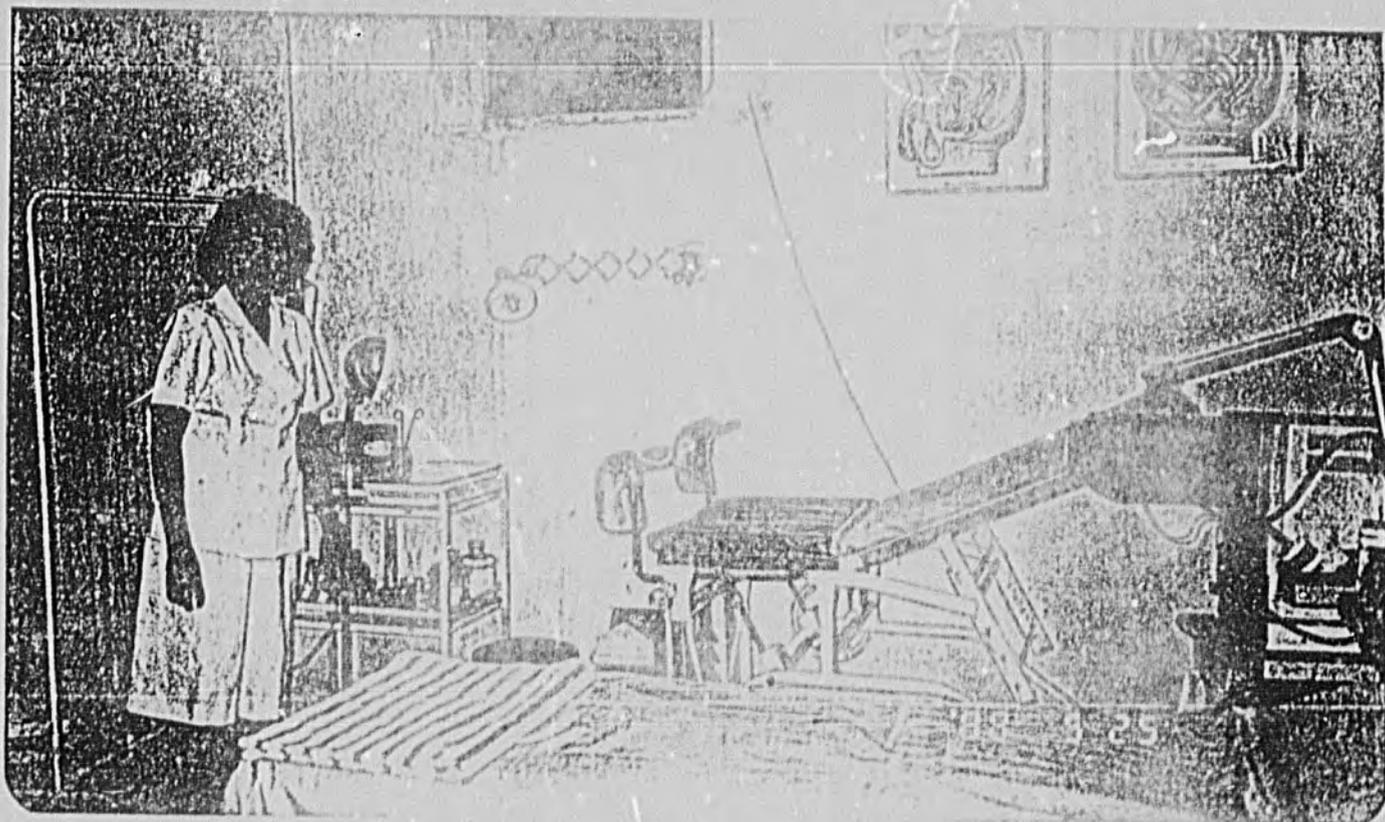
HOSPITAL PARTITION IN VS SERVICE AREA (PHOTO #1)



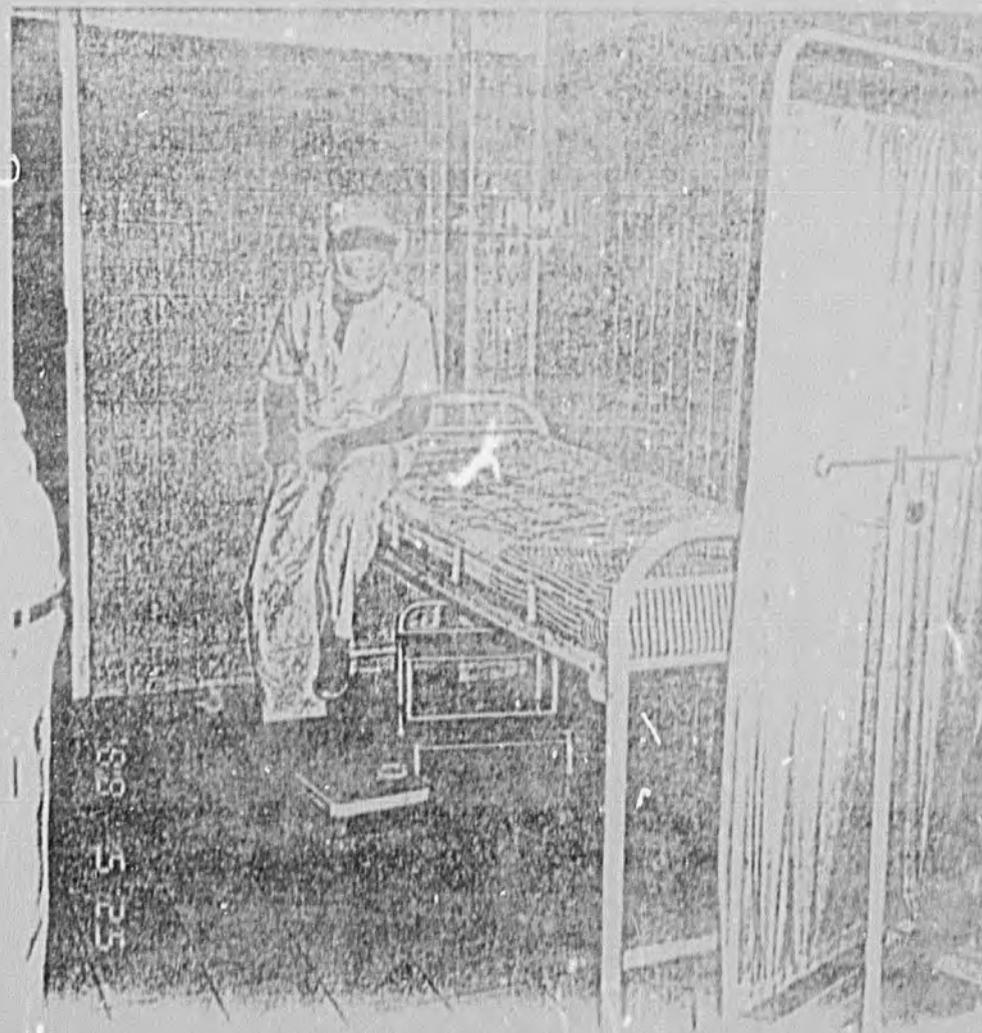
VS OPERATING ROOM SCRUB SINK (PHOTO #2)

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HOSPITAL BED READY FOR USE (PHOTO #3)

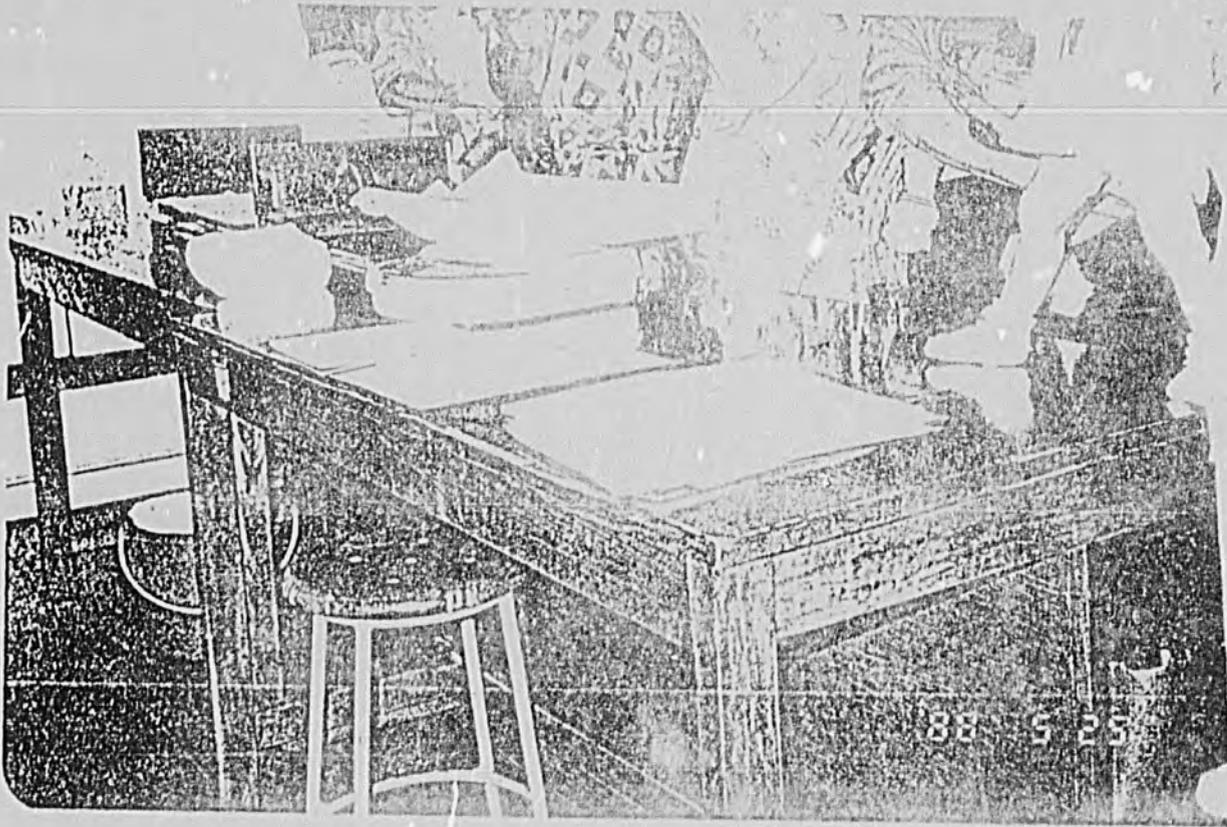


ANOTHER BED READY IN VS UNIT (PHOTO #4)

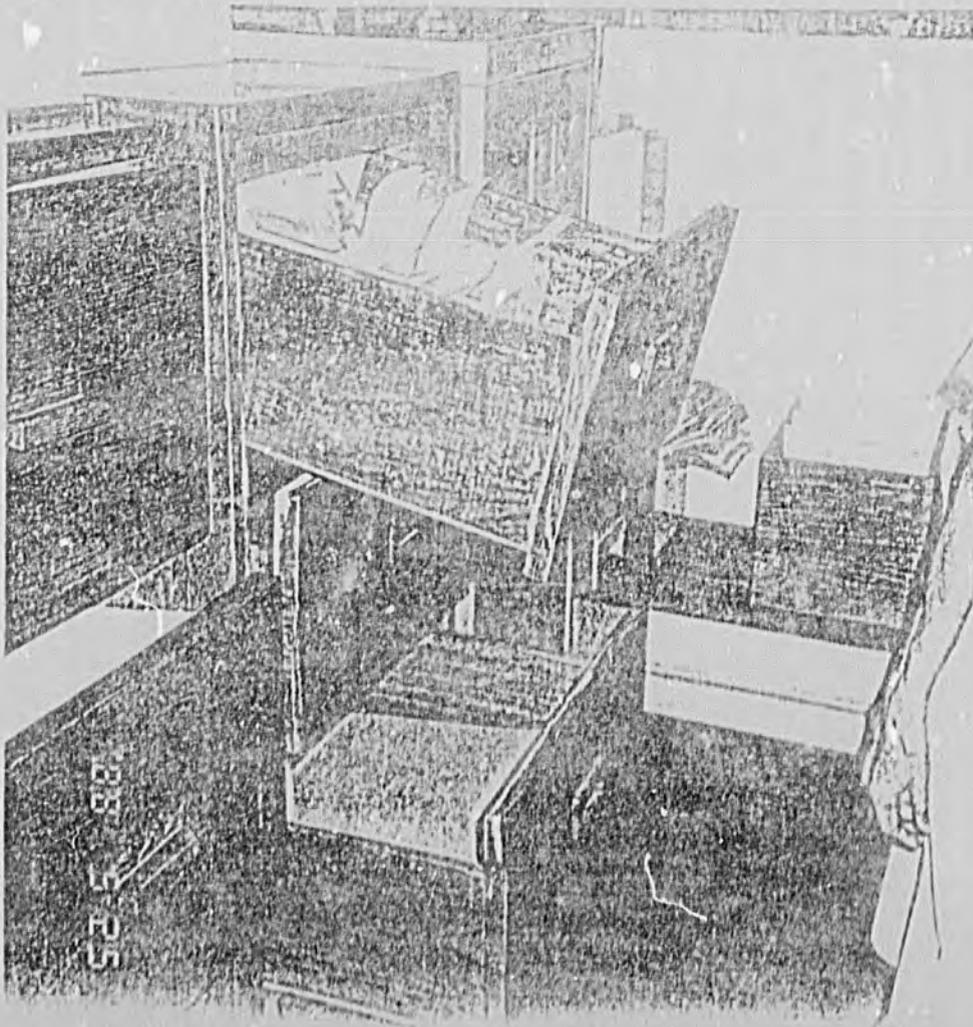


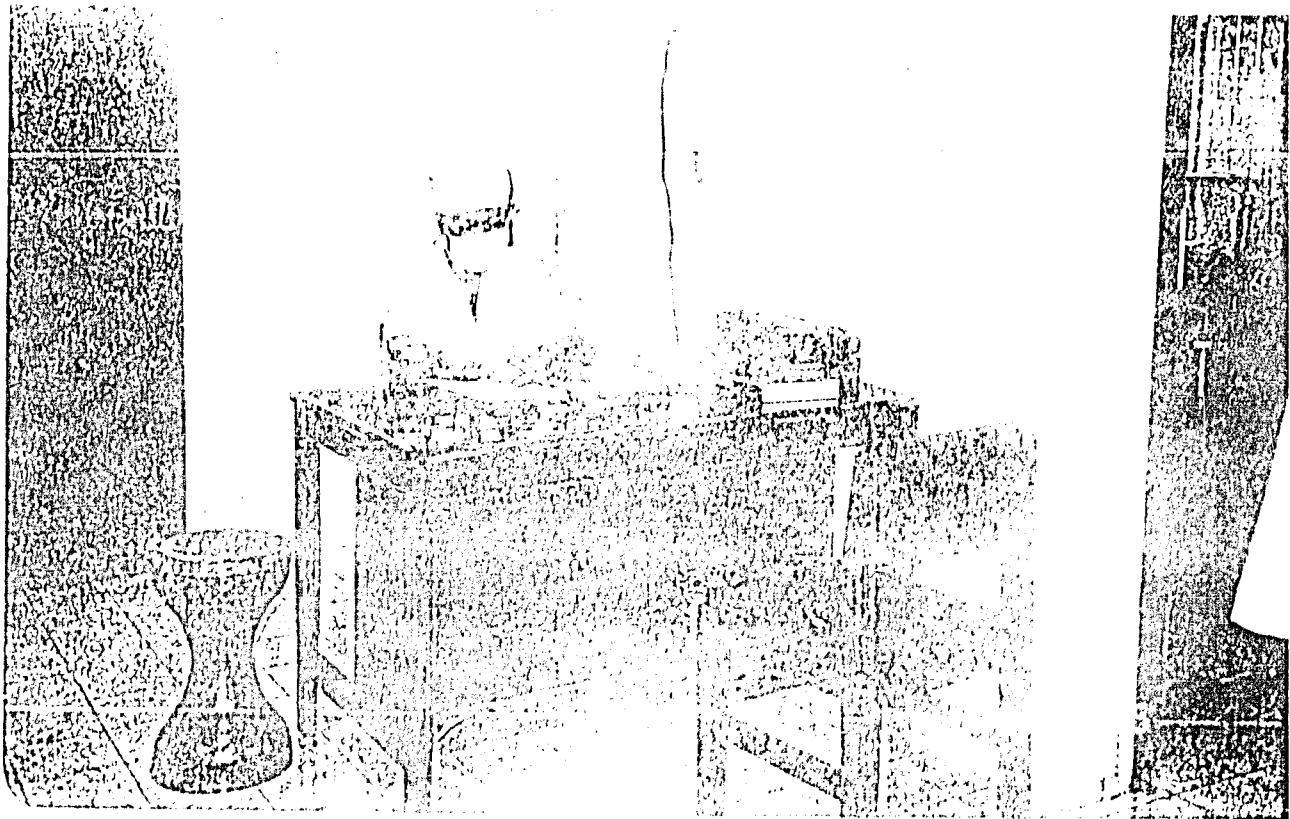
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TWO TABLES WELL USED AT THE SERVICE CENTER (PHOTO #5)

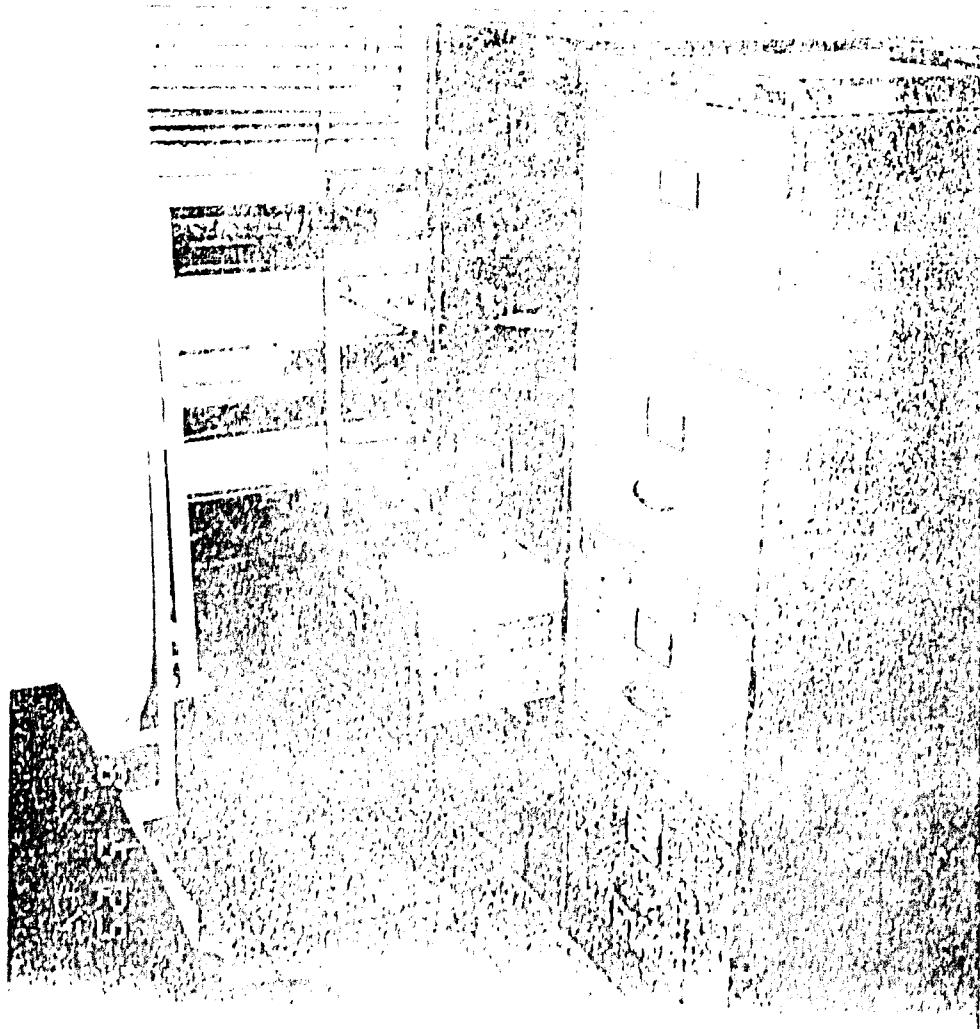


CARD FILE IN USE (PHOTO #6)

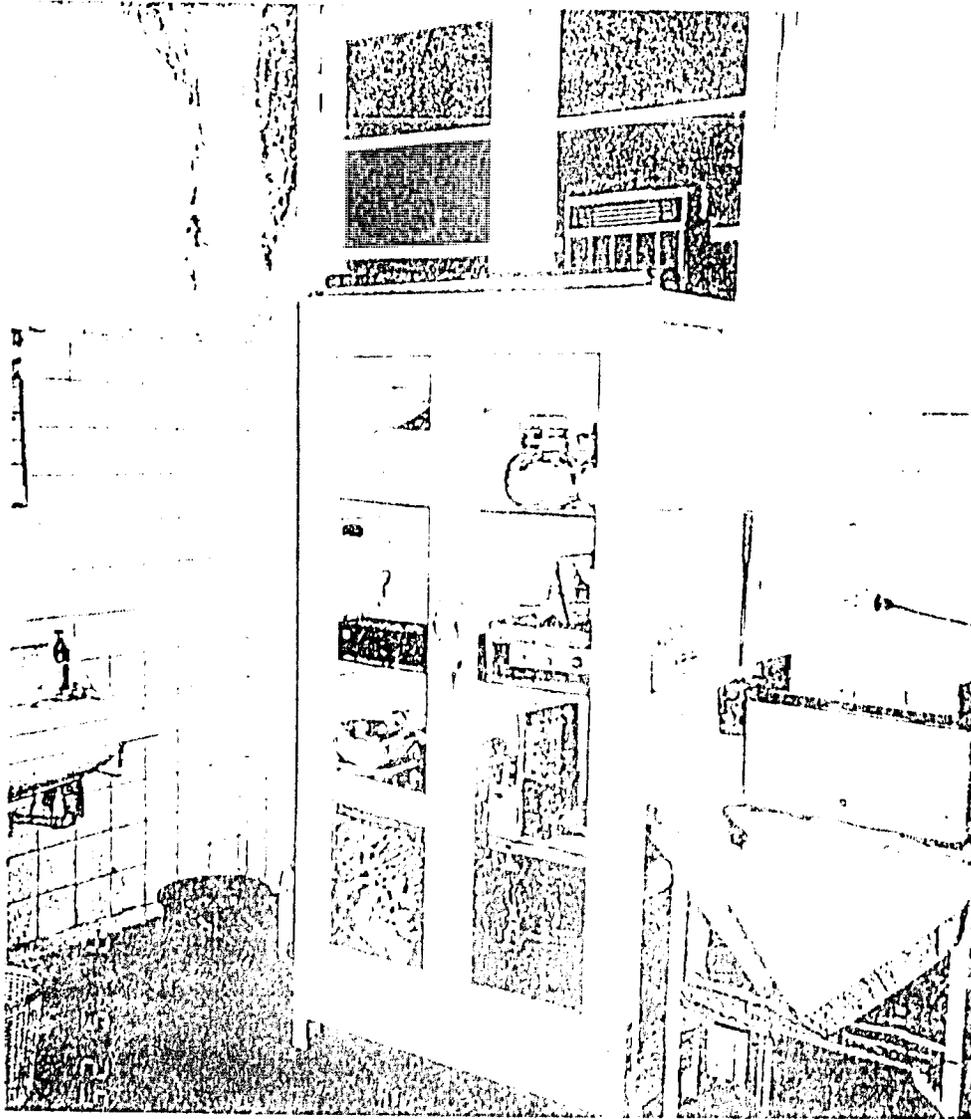




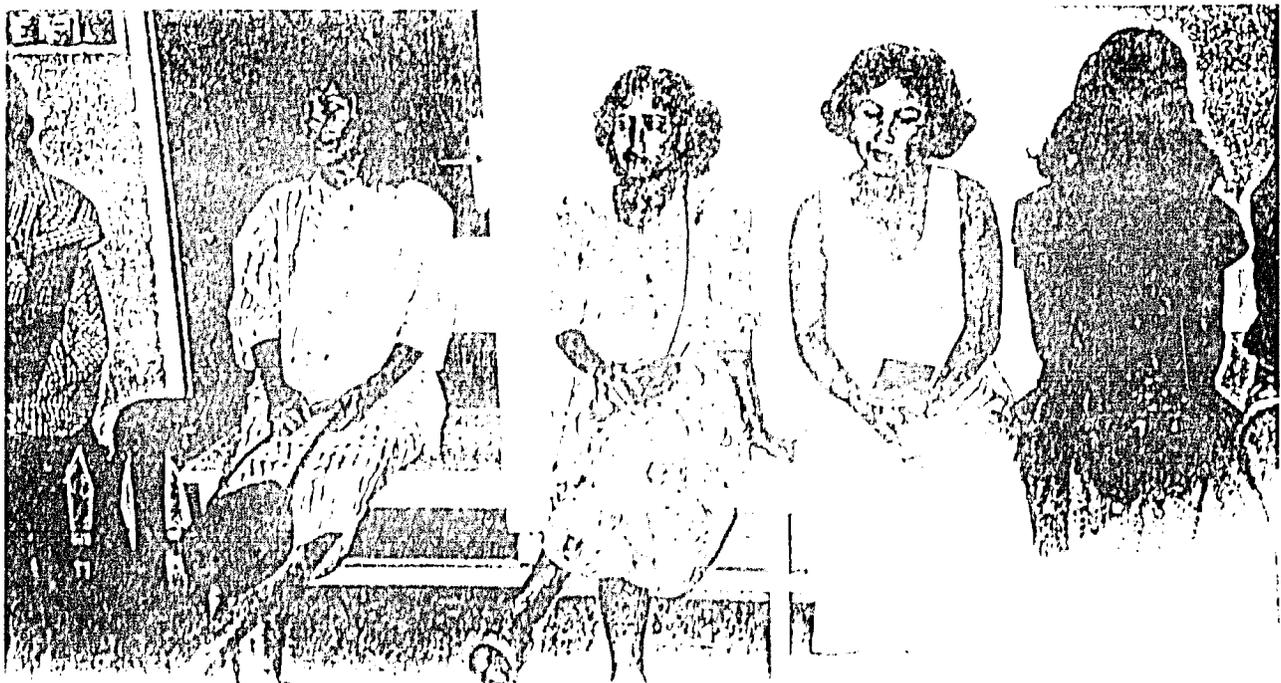
THE CHAIRMAN'S OFFICE, U.S. HOUSE OF REPRESENTATIVES



LABORATORY CABINET (PHOTO #9)



WAITING ROOM BENCH (PHOTO #10)



List of Recommendations

Recommendation No. 1

Page

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We recommend that USAID/Indonesia develop criteria for selecting hospitals and health clinics in the 14 additional provinces for upgrade under Phase II of the Voluntary Sterilization component to include potential demand for voluntary sterilizations and distances between facilities to be upgraded.

Recommendation No. 2

10

We recommend that USAID/Indonesia not fund building renovations and host country local purchase of furniture and equipment for hospitals and clinics to be upgraded during Phase II of the Voluntary Sterilization component unless the Mission ensures that:

- Site visits are made while building renovations are in progress to assess the quality of work being performed;
- Excessive delays between assessing the furniture equipment needs of hospitals and clinics and delivery of materials are avoided; and
- Furniture specifications meet the needs of local hospitals and clinics.

Recommendation No. 3

10

We recommend that USAID/Indonesia:

- Assess the quality and utilization of furniture and equipment provided to hospitals and health clinics under Phase I of the Voluntary Sterilization component;
- Recover costs for furniture and equipment of poor quality; and
- Collect furniture and equipment in excess of needs for redistribution during Phase II of the Voluntary Sterilization component.

Recommendation No. 4

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We recommend that a method be developed to assess the effectiveness of the Modern Management Technology, Research and Development and Training components of the Family Planning Development and Services II Project.

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