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INDONESIA
PILOT PROJECT ACTIVITIES
KB-MANDIRI PEDESAAN

FINAL REPORT
April 1989 - September, 1990

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Management Sciences for Health

MANAGEMENT SCIENCES FOR HEALTH
A non-profit organization

TO: SARA SEIMS, DIRECTOR FPMT
FROM: Marc Mitchell
DATE: September 19, 1990
CC: Pak. Kusnadi, Chief, PIM Bureau, BKKBN
John Rogosch, Chief OPH, USAID Jakarta

RE: Final Progress Report [June - September, 1990]

As you know, my contract in Indonesia has been completed, and I will be leaving to return to MSH in Boston. In order to make this report more useful to a wider audience, including those who have recently come to USAID/Jakarta, I am including a recap of what has been done during the 18 month period that I have been in Indonesia. I will first discuss the activities which have been accomplished during the past quarter.

PROGRESS THIS QUARTER:

Analysis of Minisurvey results: The mini-survey has been completed in all provinces, and the preliminary analysis has been completed. These findings are presented in appendix 4. Of note in the results is the very large number of people who already pay for family planning services, the large number of people who already use private providers or pharmacies. One concern, however, is the significant number who pay because there is no source of free services, or because they are told to do so. It is also interesting that apparently the most effective source of information about KB-Mandiri is television and radio, with printed media being a very small source of information. This may cause us to reconsider the type of social marketing campaign which is most effective.

Regional Meetings to discuss Pilot projects: The regional meetings were held as planned, were, I believe, very successful. A complete report of these meetings is given in appendix 2. While it is difficult to summarize all the discussions of these meetings, some key points which were discussed were the need for further clarification of the meaning and role of partial mandiri and these pilot projects in the overall strategy of BKKBN, problems with the current distribution policies of Blue Circle products as it relates to village activities, and a concern about the need for further commitment by pusat in the non-Blue Circle KB-Mandiri activities. Also discussed was a concern about the current widespread practice of sales of program contraceptives undermining both the Blue Circle program and the government provision of free services.

Strategy: The implementation strategy which was discussed in last quarters report has been distributed to BKKBN and discussed. The main points were agreed with by Dr. Haryono. The full document is presented in appendix 5.

TRAVEL TO FIELD:

July 30-31 Riau
Aug. 1-3 W. Sumatra
Aug. 20-21 Palembang
Aug. 22-24 Medan
Aug. 27-28 Surabaya
Aug. 29-31 Ujung Pandang
Sept. 21 leave Indonesia

SUMMARY OF ACTIVITIES DURING 18 MONTH CONSULTANCY

PROJECT DESIGN: KB-MANDIRI PEDESAAN PILOT PROJECTS: The Family Planning Management Training Project was asked by the Government of Indonesia for assistance in developing pilot projects for testing different models of sustainability in rural areas of the country and formulating a long term strategy for its KB-mandiri program. Following a workshop for senior level BKKBN staff involved in the KB-Mandiri program, a long-term advisor was requested to assist in the planning, implementation, and evaluation of pilot projects in 18 provinces. The first step was the development of a casebook with BKKBN to formulate operational objectives for KB-Mandiri, develop a framework of financing models, and define operational guidelines for the design and selection of pilot projects in 18 provinces. This casebook was translated into Indonesian and distributed to the 18 provinces.

Subsequent to the distribution of this casebook, I visited 16 of the 18 provinces (the other 2 were visited by PIM staff) with KB-Mandiri pilot projects to help them develop proposals for pilot project activities. Discussions with the provinces focused on:

- o policy guidelines regarding the KB-Mandiri pilot projects;
- o timetable for project planning and implementation;
- o development (with BKKBN staff) of an outline for project proposals;
- o discussions regarding project strategies and the proposal requirements;
- o evaluation (with BIPIM) of each proposal as submitted with recommendations (if any) for improvement;

One of the interesting but challenging aspects of this consultancy has been the use of the KB-Mandiri pilot projects by BKKBN to promote a decentralized planning process at the Provincial level. With this project, Provincial staff are being provided with only general guidelines rather than more detailed instructions and are being asked to develop comprehensive implementation plans for their Province. This approach encourages innovative and diverse approaches to KB-mandiri pedesaan but is more difficult for the Provincial staff who may be unused to this level of autonomy in their strategic planning. This also requires a new role for the PIM bureau since they must now provide guidance and support to the provinces without being overly directive in terms of project design. The challenge for me in my role as long term advisor has been to help both the Provinces and the PIM bureau function more effectively within this decentralized environment. For the PIM bureau, this means acting largely as internal consultants to the Provinces while continuing to ensure standard levels of quality throughout the country. While this is not an altogether new role for the bureau, this project seems to be particularly suited for promoting decentralization.

MINI SURVEY: Because the KB-Mandiri Pedesaan pilot project activities seek to change peoples attitudes toward family planning as well as specific behaviors, it was felt that project evaluation required a system which could monitor changes in clients attitude as well as behaviors such as paying for services. For this reason, a system was required which would be population based and repeated over time to test whether there was any significant change in clients attitudes or behaviors. On the other hand, because these pilot projects were to take place in 18 provinces, with approximately 6-10 villages included in each province, a wide scale KAP survey would be too expensive and time consuming.

Because of the very low budget which was available (approximately US \$1000 per province) and the limited time frame (2-3 weeks to complete the baseline survey) the focus was on the development of a survey methodology which was as simple as possible but would still yield valuable and reliable information about the project impact. The result was the development of a specialized mini survey technique, using a very limited number of questions, and a very simple sampling frame, for use in monitoring these pilot activities. The key to the success of this method is the ability to use locally available personnel such as school teachers or women's group leaders for house to house data collection after a very short training period of only 1-2 hours, and the use of a very simple sampling framework which did not require field level sampling of households. Data entry was done at the provincial level using an input template identical to the questionnaire. The data entry was done using Lotus 1-2-3, a program with which data entry personnel were already familiar, eliminating the need for further training to learn a new program. Data collection requires entering checkmarks only on a single form with space for responses from 17 respondents. Each village in the survey was provided with a small booklet which contained complete instructions for each question and 20 pages of forms (sufficient for 340 respondents).

No sampling of households is done in the field, eliminating the need to train data collectors in sampling methodology or complex algorithms developed to maintain the integrity of the sampling framework. The instructions to the data collectors are clear: every household in the village must be visited and every woman aged 15-45 must be questioned and her responses recorded. The result is a complete enumeration of all women of child bearing age who are resident in the village on a particular day. This methodology is similar to that used by a national census.

Because of the diversity in village size through Indonesia ranging from approximately 50 households to over 1000, it was decided to use the namlet (a village subdivision) as the basis of the sample rather than the entire village. In order to eliminate the need for sampling of individual households, but maintain a feasible number of respondents, 1-2 hamlets totaling approximately 100-200 households were selected from each village with pilot activities. It was not assumed that the hamlets were necessarily representative of the villages from which they are chosen, but were in fact most often chosen on the basis of easy access or availability of suitable data collectors.

The key consideration in the development of the questionnaire was simplicity. It was decided that the simplest form would require only checkmarks by data collectors, would be contained on a single page of paper, and would not require any specialized training on the part of the data collectors. On the other hand, in order to be useful in monitoring client opinion the questions would need to go beyond typical census data such as number of children and use of family planning by type. The form which was developed is shown in appendix 3. This form was the result of two field trials and a workshop discussion with participants from around the country. The form was designed so that each page had space for 17 respondents. Each booklet of 20 pages was sufficient for an entire village, thereby reducing the paper requirements, and hence the logistic considerations.

The results of the mini survey are presented in appendix 4. Note that it is planned that the survey will be repeated at the end of this year, in order to get comparison results before and after the survey.

REGIONAL MEETINGS: A series of 4 regional meetings took place to facilitate discussions of the projects in all 18 provinces and the results of the baseline mini survey. The meetings took place on a regional basis in order to encourage the active participation of Provincial chairmen and staff. Participants from all 18 Provinces with USAID-funded KB-Mandiri Pedesaan field projects attended.

A full report on these meetings is presented in Appendix 2.

OPERATIONAL STRATEGY KB-MANDIRI: Based on the recommendation of the KB-Mandiri group at the national BKKBN meeting, I wrote a proposed operational strategy for KB-Mandiri. This strategy, written for BKKBN, highlights some of the broad issues regarding KB-Mandiri, and synthesizes the findings from the various projects through which KB-Mandiri has been tested. This includes the 18 pilot projects with which I have been working directly, the various operations research projects of URC, and the social marketing projects including the Blue Circle products and services. I have summarized some of the lessons learned thus far, with recommendations for going beyond the current stage of project innovation towards expansion and institutionalization of the program. The main points of the strategy are:

- During the Introductory Phase of KB-Mandiri the emphasis was on innovation and testing of new approaches to sustainability. During this period, the strategy was kept deliberately general to encourage the widest possible innovation. Now BKKBN is ready to begin the second phase of implementation: Expansion, and this will require some further specification of KB-Mandiri, particularly with regard to the relationship between Mandiri and those who still cannot afford to pay for family planning services. While flexibility in the specific approaches to be used is still required, many provinces need further guidance on ways to include partial mandiri in their overall strategy.
- There is a need for the KB-Mandiri to develop an identity separate from that of the Blue Circle marketing campaign. One possible mechanism is the establishment of a message and logo for KB-Mandiri independent of the blue circle logo.
- The marketing approach of KB-Mandiri requires increased use of targeted messages to different segments of the population. This market segmentation approach should be emphasized, and specific messages developed for each segment of the population. These messages, should in turn, be linked to specific outputs and specific indicators of success in order to measure the success of the various components of the marketing approach.

APPENDICES:

1. SCOPE OF WORK
2. REPORT OF REGIONAL IMPLEMENTATION REVIEW MEETINGS
3. SURVEY FORM: MINI SURVEY
4. RESULTS OF MINI-SURVEY
5. PROPOSED IMPLEMENTATION STRATEGY: KB-MANDIRI

CONTINUATION SHEET	UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY AGENCY FOR INTERNATIONAL DEVELOPMENT	<input type="checkbox"/> Variation <input type="checkbox"/> Extension	PAGE ____ OF ____ PAGES
	<input type="checkbox"/> FOC <input type="checkbox"/> FOP <input type="checkbox"/> FOT <input type="checkbox"/> PA/PR	1. Cooperating Country	
		2. FID Number	<input type="checkbox"/> Original OR No. _____
		3. Project Number and Title	
Indicate block numbers	Use this form to complete the information required in any block of a FOP, FOT or PA/PR. For FOC, furnish the block number, quantity, description, location, starting and ending dates, and price when available.		

Attachment A

SCOPE OF WORK

(April 1989 - Sept. 1990)

Background:

In the evaluation of the Village Family Planning Program conducted by USAID/BKKBN in 1987, recommendations were made to: (1) reduce dependency of the village family planning program on BKKBN resources and to increase self-sufficiency through the use of a semi-commercial approach; and (2) address problems by improving the quality of the delivery of services. These two objectives were to be achieved through the combined efforts of the village communities and private sector agencies, including hospitals, physicians, nurse-midwives, and specially trained outreach workers.

As there had been little experience in self-sufficient Family Planning Programs in Indonesia, the BKKBN requested Management Sciences for Health, through its Family Planning Management Training (FPMT) project, to conduct a special comparative study and workshop for BKKBN and NGO managers who were involved with the village family planning program. The objectives of this training program were to improve the knowledge and skills of 16 BKKBN and NGO managers in developing and implementing self-sufficient family planning programs at the village level; to observe self sufficient/cost-recovery family planning programs in the U.S. and Latin America; and to develop action plans to be implemented in Indonesia. The workshop, conducted in June, 1988, began with a review of the concepts and methodologies for financial self-sufficiency. During the second week the participants were divided into four small groups - each group sent to observe model self-financing programs in Brazil (two groups), Mexico, and the United States. The last week was spent in Boston, during which time self-sufficient action plans for Indonesia were drafted. Pre- and post-orientation briefing sessions were held in Jakarta for the participants and other selected BKKBN staff.

Overall Description of Consultancy:

As a follow-up to the FPMT activity described above, the BKKBN is requesting the services of a long-term FPMT advisor to work with the Bureau of Community Institutional Development (PIM) to develop "KB Mandiri" (self-sufficient family planning) pilot projects in 13 high density provinces, namely, East, Central and West Java; North, West and South Sumatera; Lampung; South Sulawesi; East and West Nusa Tenggara; Aceh; Riau and West Kalimantan and to also examine ways and means of

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		2. FID Number	<input type="checkbox"/> Original OR No. _____
Indicate block numbers	3. Project Number and Title		
Use this form to complete the information required in any block of a FOP, FOT or PA/PR. For FOC, furnish the block number, quantity, description/specification, including catalog stock number and price when available.			

(Cont'd Scope of Work)

improving contraceptive prevalence, preferably through KB Mandiri approaches, in five new low prevalence provinces, namely Irian Jaya, Maluku, Central Sulawesi, East and Central Kalimantan. The PIM Bureau is developing a two phase approach. In the first "preparatory" phase, the PIM Bureau, in conjunction with other BKKBN Bureaus and outside institutions, will prepare a "case book" of examples of self-sufficient family planning projects with examples drawn from projects within Indonesia and outside. To prepare this casebook, a survey will be conducted in six provinces to study model approaches. After the casebook is prepared, a series of orientation meetings will be held at Central and Provincial levels to inform local officials, and public and private sector providers of the intent of the KB Mandiri program. The PIM Bureau will then work with each province to develop KB Mandiri proposals which may involve fee-for-service, community financing, pre-paid plans, various IEC or training programs, and/or innovative linking mechanisms between government and private sector services. After review and approval of the proposals at the BKKBN Central Office, USAID funds will be provided to the provinces to carry out the projects.

An advisor who is expert in strategies for self-sufficiency is needed to assist the PIM Bureau in the following tasks:

Specific Consultancy Objectives:

- A) To assist BKKBN, particularly the PIM Bureau, to formulate self-sufficiency family planning strategies for the village family planning program in Indonesia; to liaison with the KB Mandiri operations research project in three high prevalence provinces to ascertain what strategies can be transferred to the 18 province program.
- B) To assist the PIM Bureau to work with provincial level Government and Private Sector representatives to develop appropriate pilot or demonstration projects suitable to the cultural/economic/programmatic situation of that province.
- C) To assist the PIM Bureau to review provincial proposals and assign priorities for implementation.
- D) To assist the PIM Bureau to monitor and evaluate the provincial projects during implementation.

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Indicate block numbers	Use this form to complete the information required in any block of a FIO/P, FIO/T or PA/PR. For FIO/C, furnish the item number, quantity, description/specifications, including catalog stock number and price when available.		

(Cont'd Scope of Work)

- E) To prepare for BKKBN a written analysis of lessons learned from KB Mandiri approaches conducted in the village family planning project.

Desired Qualifications:

- A) Expertise in self-sufficient family planning programs, preferably demonstrated by at least five years of practical experience in designing and/or managing such programs in addition to academic preparation in health care financing in developing countries (including community financing schemes) preferably at the doctoral level.
- B) Experience in working in developing countries, preferably with self sufficiency, health care financing projects.
- C) Previous experience in Indonesia, and knowledge of Bahasa Indonesia is highly desirable but not required.

Time Period:

A centrally-funded short term consultancy will be conducted in January 1989 to assist BKKBN to prepare the case book of KB Mandiri activities. The consultant will then return late March/early April to begin the 18 month long term consultancy. Funds from this PIO/T, which partially fund the budget, must be expended prior to May 30, 1990.

FINAL REPORT:
KB-MANDIRI PEDESAAN REGIONAL REVIEW MEETINGS

Marc D. Mitchell, Management Sciences for Health
Sri Djuarini, USAID/Jakarta OPH

September 6, 1990

During the last 2 weeks of August, 4 regional implementation review meetings were held to review the progress of the USAID-funded KB-Mandiri Pedesaan pilot projects in 18 provinces. The meetings took place on a regional basis in order to encourage the active participation of Provincial chairmen and staff. Participants from all 18 Provinces attended.

While each meeting had a slightly different agenda, the general pattern was the same. Each meeting opened with a speech by either one of the deputies of senior BKKBN personnel. This was followed by a discussion of the objectives of the KB-Mandiri Pedesaan projects and of this meeting. Then each Province presented what they have done thus far in this project and their results from the mini survey. Following each presentation, there was a general discussion of the specifics of each province, and of the general models which were being used in that province. Finally, there was a wrapping up and open discussion of key issues that had been raised. In the first 2 meetings (Palembang and Medan) there was the development of a matrix indicating the key problems and strengths of each type of model of KB-Mandiri Pedesaan that had been presented. In the meetings in Surabaya and Ujung Pandang this discussion was woven into the general comments during each presentation.

The components of the meetings are presented in this report as follows:

1. TERMS OF REFERENCE
2. OPENINGS OF MEETINGS: POINTS PRESENTED BY DEPUTIES
3. GENERAL OBSERVATIONS
4. SPECIFIC POINTS OF DISCUSSION
5. UPDATES OF PROVINCIAL PROJECTS INCLUDING MINI-SURVEY RESULTS

KB-MANDIRI PEDESAAN REGIONAL REVIEW MEETINGS
TERMS OF REFERENCE

OBJECTIVES:

1. To provide information to senior BKKBN officials regarding field implementation of KB-Mandiri Pedesaan pilot projects;
2. To provide a forum for senior provincial officials to share regional information regarding implementation of KB-Mandiri Pedesaan pilot projects;

PARTICIPANTS:

PROPINSI: Kapala Propinsi
Kabid Operasional

PUSAT: Deputy for Operations or Planning or Program Development
Kepala BIPIIM and/or BIREN or PUSIK
2 x Staff BIPIIM or Perencanaan

USAID: Marc Mitchell, consultant
Sri Djuarini, Susan Watson

Location: Palembang,
Date: Aug 20-21
Sumatera Barat
Sumatera Selatan
Lampung

Location: Medan
Date: Aug 23-24
Sumatera Utara
Riau
Aceh
Kalimantan Barat

Location: Surabaya
Date: Aug 27-29
Nusa Tenggara Timur
Nusa Tenggara Barat
Java Barat
Java Tengah
Java Timur
Kalimantan Tengah

Location: Ujung Pandang
Date: Aug 30-31
Sulawesi Selatan
Sulawesi Tengah
Maluku
Irian Jaya
Kalimantan Timur

OUTPUTS:

1. Information regarding province specific activities and more general model specific constraints to implementation of KB-Mandiri Pedesaan pilot projects--see updates of provincial summaries,
2. Results of Mini-survey
3. Recommendations from Provinces regarding implementation of KB-Mandiri Pedesaan;

KB-MANDIRI PEDESAAN REGIONAL REVIEW MEETINGS
POINTS PRESENTED BY DEPUTIES AT OPENINGS OF MEETINGS

- Pilot projects in 18 Provinces to test innovative approaches to KB-Mandiri Pedesaan; this experience will be combined with the experience from other Operations Research Projects and our experience in urban areas to develop a national KB-Mandiri strategy;
- This meeting is opportunity for Provincial staff to brief Pusat on potential of various models which have been tried in the field;
- In pilot projects such as these, we can learn as much from models which are not successful as from those that are; therefore, it is important that problems as well as successes be discussed at the meeting to ensure that the less effective models are not repeated on a national scale;
- The output from these regional meetings will be used to help pusat develop a national strategy for KB-Mandiri.
- Pusat remains concerned that all people, rich and poor continue to have good access to modern contraceptives. This means that those who are unable to pay for contraceptives will continue to be guaranteed free supplies of their method of choice.
- KB-Mandiri goes beyond the collection of fees from acceptors. It is also a change of attitude by acceptors that they must accept some responsibility for their family planning. For some this will be a financial commitment; for those too poor to pay, it will be a commitment to assist the program in other ways through acceptor groups and other institutions.
- KB-Mandiri is in several stages. The first stage will be the development of Kelompoks which are Mandiri. The second stage will be individuals which are Mandiri.

KB-MANDIRI PEDESAAN REGIONAL REVIEW MEETINGS
GENERAL OBSERVATIONS

Overall, the forum of the regional meetings provided a good opportunity for the Provincial participants to discuss in depth their projects, and some of the potential problems which they anticipated. It also offered a more free environment to discuss openly any conflicts which the provinces had with national policy or with operational issues. Each meeting was very different, although the general outputs and recommendations of the meetings were consistent.

The meeting in Surabaya was particularly instructive as the provinces in Java have had much more experience with the KB-Mandiri Pedesaan models, and had taken them much further during this project. All 3 Java provinces have begun field implementation, and developed the necessary guidebooks, IEC materials, and reporting system to manage the project. Also the Java provinces took a much more comprehensive approach to this type of intervention, and saw it in the context of an overall family planning program, rather than as an isolated project. On the other hand, these provinces also had a better understanding of potential conflicts between the expansion of this project and some aspects of national policy. This was particularly clear in their concern regarding the lack of support from the LiBi distributors for their village based activities.

One positive outcome of the meetings was the enhanced interest by provincial chairmen in KB-Mandiri pedesaan and these pilot projects. Through these meetings they were better able to see the relationship between these pilot projects and the overall strategy of BKKBN. For this reason, it was somewhat disappointing that more senior BKKBN officials were not able to attend the meetings and stay beyond the opening ceremony.

Several of the meetings focused on the question of commitment by BKKBN to KB-Mandiri pedesaan, citing that the message seemed only to be "push blue circle" with a strong bias against partial mandiri. While partial mandiri is an interim situation on the path to full mandiri, for many areas this temporary situation will remain for a long time, and needs more clarification and support from pusat.

KB-MANDIRI PEDESAAN REGIONAL REVIEW MEETINGS
SPECIFIC POINTS OF DISCUSSION:

The following points were discussed at all the regional meetings and there was considerable consensus on them.

Purpose and Definition of KB-Mandiri: There was considerable discussion in the Surabaya meeting regarding the definition of KB-Mandiri pedesaan, especially the difference between pekotaan and pedesaan. While initially the village based activities focused primarily on the use of community institutions and partial mandiri, with the increased emphasis on the sale of LiBi products through KUD's and the training of midwives to open private practice, the distinction between these activities and the urban activities is unclear. This merging of urban and rural models may be desirable, but requires the availability of LiBi products at the kecamatan and village level, and more focus on the mechanism for supporting private practice in the rural areas.

It was also discussed whether the goal of KB-Mandiri pedesaan is to improve the capability of community institutions or to promote individual mandiri through partial contribution. In either case, partial mandiri is seen as a transit on the path to full mandiri, but during this period of transition, the implications may be different for the individual user and acceptor group deciding whether to focus their activities on individual responsibility or group strength. For example, using fees which are collected to buy LiBi leads to individual mandiri, while setting up UPPKA may better strengthen community institutions, but will less quickly lead to full mandiri.

KB-Mandiri and MKET: There was considerable discussion about whether the promotion of KB-Mandiri would interfere with the promotion of MKET. The concern is that village distributors faced with a choice of promoting IUD's which are free or selling pills and keeping a profit will more likely promote pills. While most provinces felt this was a significant concern, representatives from pusat generally did not agree. Their argument is that in the long run, clients will be expected to either use long term methods or buy their pills, injectables and condoms, so there will be no conflict. The question really hinges on two issues: (1) whether in the short term the two ideals of mandiri and MKET are consistent and (2) what will really happen to those too poor to pay for services. As an example, a woman who has serious side effect from her IUD and eventually wants another child has few options.

Mini-Survey: There is general agreement that the mini-survey has been a useful tool for the initial assessment and follow up of KB-Mandiri activities. It seems to have been implemented without significant problems. On the other hand, several issues have been raised concerning the way in which the data is to be used, and the analysis. First, it was noted that some of the data is internally inconsistent and may come from a bias by using PLKB as data collectors. Indeed, in

those provinces which used PLKB, the results seem least reliable. A second concern is that we not overread the data which was collected. The results may not be representative of the province as a whole, and only gives us a picture of where we are beginning. On the other hand, it has been very useful in sensitizing the provinces to the situation as it is in the field, and in raising specific questions regarding current users who pay and what is their motivation. Of particular concern is those who pay because there are no free services available. Finally, it has been noted that the analysis by most provinces was not sufficiently insightful, and appears to represent a lack of understanding of what the underlying logic of the instrument was. Thus, many provinces did an average age of the respondent women rather than looking whether women of different ages had different patterns of contraception. Some provinces, however did excellent analysis, particularly Lampung. It was also noted that only Java Barat had compared the data which was collected with their regular service statistics to see whether there were differences. Java Barat had also developed a routine reporting system which parallels the mini-survey which tracks the progress of their project.

Problems with LiBi Distribution: Since many of the models rely on the distribution of LiBi products through KUD's, DBS's, and other facilities, the issue of the very limited distribution and the poor responsiveness of the various distributors was discussed. It appears that there still are major coordination issues between the distributors, Mecosin, and Fortune with regard to the distribution to the rural areas and smaller provinces. Provincial chairman are confused and concerned about the relationship between BKKBN and Mecosin, an example of which is the recent price rise of all LiBi products. The announcement of this price change was signed only by the manufacturers and distributors, but specified that it had the approval of the chairman of BKKBN and DepKes. This price rise poses a problem for the Mandiri program at the provincial level, and they feel that they should be consulted on policy issues like this.

Funding: A significant and pressing point of discussion is the lateness of the funding available for this project, and the difficulty this poses for the provinces trying to plan activities and implement this complex project. It is generally felt that for the project to be successful, USAID will need to make a commitment to provide all earmarked funds by the end of September to enable to projects to end prior to the end of this PIL.

Timing of remainder of project: There was agreement that date for second mini-survey would be delayed until January 1991 with a national meeting to be held in March, 1991 in time to give results to Rakernas in April.

MODELS OF KB-MANDIRI PEDESAAN

DANA MASYARAKAT: There are many variations of this model which have as a common goal the strengthening of community institutions through a community financing scheme. Funds are collected from acceptors and used transportation, treatment of side effects, small scale income generating activities, and purchase of commercial contraceptives. In general, this is most widespread in Java where the traditional community institutions are already well developed. Problems which have arisen, especially in the outer islands, include:

- many of these community institutions are not strong and their ability to manage the money is poor;
- linkage with BKKBN is not clear and the supply of program contraceptives or LiBi products raises legal and operational issues. For example, at what level is it most appropriate to distribute products and manage funds.
- It appears that from the results of the mini-survey, many acceptors are being told to pay with little options available for free services. This poses a question of equity and availability of services to those too poor to pay.

KUD: KUD's are being used in a variety of ways to promote KB-Mandiri. This includes: (1) KUD as a distributor of LiBi contraceptives; (2) KUD as manager of funds collected through acceptor groups; and (3) KUD a service provider through the use of mobile doctors and midwives who come to the village. These model, while initially not very common has been pushed by the recent private sector development and the support of the President and Chairman. Yet, there are many concerns about the capability of the KUD's. One province (Sumatera Selatan) is using KUD mandiri only for their project. However, these are limited, and if KB-Mandiri is to be expanded throughout the country, there will need to be some type of evaluation criteria for KUDs.

DBS: Private doctors and midwives providing services on a fee-for-service basis is clearly the long term goal of KB-Mandiri. However, it is recognized that due to limitations of numbers of private practitioners in rural areas, and the high cost for many acceptors, it will be a long time until this model is widespread in rural areas. There is also a concern among some of the provinces that the private doctors will not be responsible to the national program and so may not promote national policy goals. As an example, they may be more eager to promote resupply methods which are more profitable, rather than the more effective long term methods, leading perhaps to a higher fertility rate than projected.

PUSKESMAS: In many provinces, there is already a practice of requiring all users of PusKesMas to pay some of fee for service, including KB. This is most common in more remote areas where supplies and services

provided through the government are extremely limited and so the fees which are collected are used to support basic services which would be otherwise unavailable. The issue arises whether this is legal, and whether this is an appropriate model to promote as a type of partial mandiri. On the other hand, this model is already widespread, and without these fees, it is likely that services would be more limited.

EMPLOYER FINANCING: Employer financing is a relatively simple way to promote KB-Mandiri. Two models are being used. The first, in Sulawesi Selatan is to fund private clinics using LiBi products at factories and plantations. This is really an extension of the DBS model. The second is to have employers fund a revolving fund for village UPPKA activities. This model is being used in Sumatera Selatan. There was some discussion of whether employer financing should be included in these trials or whether it was separate from KB-Mandiri pedesaan.

UPDATES OF PROVINCIAL PROJECTS INCLUDING MINI-SURVEY RESULTS

- | | |
|---------------------|-------------------------|
| 1. Jawa Timur | 10. Kalimantan Barat |
| 2. Jawa Tengah | 11. Kalimantan Timur |
| 3. Jawa Barat | 12. Kalimantan Tengah |
| 4. Sumatera Selatan | 13. Sulawesi Selatan |
| 5. Lampung | 14. Sulawesi Tengah |
| 6. Sumatera Barat | 15. Nusa Tenggara Barat |
| 7. Riau | 16. Nusa Tenggara Timur |
| 8. Aceh | 17. Maluku |
| 9. Sumatera Utara | 18. Irian Jaya |

PROVINCE: JAWA TIMUR

TOTAL BUDGET: 71,527,000

NUMBER OF VILLAGES: 69

NUMBER OF KECAMATANS: 23

DESCRIPTION: Because of the size and long experience that this Province has had with KB-Mandiri, this proposal encompasses a very large number of villages and types of interventions. All potential sources of funds including acceptor groups, individual acceptors, other village based groups, etc. will be used as inputs into an overall scheme to finance KB activities.

Implementation of this project will be through working groups at each level of the government, but will provide special inputs at the Kecamatan level. The specific tasks of the working groups at each level are included in the proposal.

It is interesting that the Province has linked this program with its program to increase the use of "effective methods," (MKET) a logical linkage since the use of effective methods will have an important effect on the long term recurrent costs of providing family planning, and since acceptors who are "Mandiri" can be reasonably expected to choose those methods which are most effective. To be developed through this project are manuals on financial recording, selection and use of more effective FP methods for use in the many training activities.

While very ambitious, the success that this Province has had in the past in managing other KB activities lends additional credence to its ability to manage this multi-faceted project. As an example, the choice of village is made in part by the ratio of PLKB to villages to ensure adequate supervision at the Kecamatan level.

UPDATE: Initially, there was decision to include all Kabupatens with at least one village. Following this, some Bupati's have decided to include all villages in Kabupaten, so the actual number of villages is large. Activities have begun with the development of IEC and training materials and training at all levels. A variety of models are being

used. Most focus on community financing, but some on inclusion of factories, private doctors/bidans. In fact, this project is only one part of the KB-Mandiri Pedesaan activities with significant funding provided through the government budget. Mini survey done and good analysis was done. Following this, there will be a seminar for staff on the results of the survey. This project continues to be seen within the overall context of the entire KB program, so is quite complex and requires good coordination at all levels, including the political structures.

MINI-SURVEY:

n=553 ?

source: clinic 62% commun. inst. 28%; DBS 9.5%; apotic 0.3%

pay: 74% ; 11% > Rps. 1500

PROVINCE: Java Tengah

TOTAL BUDGET: 68,092,000

NUMBER OF VILLAGES: 18

NUMBER OF KECAMATANS: 9

DESCRIPTION: Central Java has the most experience of all Provinces with KB-Mandiri type of activities so their project builds on this experience and tries to review the current status of existing projects. For this reason, this project is one of the most comprehensive. One component of this project, therefore, will be to use a university professor to review and document the experience to date with KB-Mandiri in the province. A part of this will be to select a particularly successful Kabupaten which will be documented and circulated to all the Kabupatens in the province for possible expansion. Another unique component of this proposal is to set up an in-house evaluation team to review the ongoing progress of these projects and develop criteria for success.

The main financial model is a village based distribution system which will set up FP depots in the village which can then be used by village members. Private doctors and bidans will be subsidized to come to the villages who can then prescribe commodities from the depot to be sold. Thus, village clients can receive services from private practitioners at a somewhat subsidized rate. In addition, refill of condoms and pills will be readily available at the depot. Emphasis will be put on training the doctors and midwives who provide this type of service to give advice to clients on healthy reproduction, and the use of most effective methods, and the use of pills for only new acceptors. A second model will be to augment the current use of private doctors and midwives when they are available through IEC and orientation of PLKB and PPKBD. Funds will be used for the development of IEC materials, orientation of doctors and PLKB and PPKBD, and orientation for field staff and villages involved with this project.

UPDATE: As in the other Java provinces, this project is a major undertaking to bring the various models to all areas of the provinces.

All the preparatory work has been done, but village level implementation has been delayed due to funding delays from USAID.

MINI-SURVEY:

n=2052

prev. 77%

source: clinic 61%; inst.masy 15.6%; DBS 21%; apotik 1.3%

pay 30%

PROVINCE: Java Barat

TOTAL BUDGET: 78,258,500

NUMBER OF VILLAGES: 24

NUMBER OF KECAMATANS: 12

DESCRIPTION: Because West Java already has wide experience with KB-Mandiri, this project will use a variety of activities to further promote KB-Mandiri, and to institutionalize it within the overall Family Planning development strategy for the province. Within this context, there are 5 specific objectives for the family planning program: (1) equalize the FP acceptance and institutions amongst the Kabupatens; (2) focus on the method mix amongst those areas not yet using the most effective methods; (3) institutional development at the community level; (4) KB-Mandiri at the individual level; (5) institutionalization of KB-Mandiri throughout the province.

In order to meet these general objectives, a full range of financing options is made available to the population. This includes the sale of Blue Circle products and services with the use of discount cards as incentives; the promotion of voluntary sterilization which is co-financed by the acceptor; and urban neighborhood based distributors of pills and condoms.

In addition to these largely "full mandiri" activities, there will be a range of community based financing options. The first stage of this type of activity will be small fees paid to the kaders to be used exclusively for family planning activities. At the second stage, funds will be managed through the Pos-Yandu to be used for both health and family planning services. Contributions will be collected from all community members, not only from FP acceptors. In the third phase funds will be managed by section 7 of LKMD and will be used for a variety of activities which increase the welfare of the community. These funds will be augmented by funding from local government, other self-help projects and outside donors. Finally, because the province is aware of the problems of collecting accurate statistics in the area of KB-Mandiri, they also have initiated a full client registration system, which will, in the coming year, be fully automated at the Kabupaten level.

UPDATE: This province continues with its comprehensive approach to KB-Mandiri which includes both individual KB-Mandiri and Kelompok mandiri. All activities such as preparation of materials, development of monitoring system, orientation meetings, and training of staff. In addition, village level activities began in Jun/July. An example is

the development of a chit which is given to those who pay a monthly fee in the village and provides for reduced prices at the puskesmas for other services. They also have their new information system in operation, and are able to compare results with those of the mini-survey to track their progress.

MINI-SURVEY:

n=2432

prev.=67% (IUD 23%, Pill 27%, inj. 36%)

source: clinic 56%; comm.inst. 23%; DBS 19%; Apotik 0.8%)

pay 59% (51% pay monthly) 54% < or = Rps.1000

PROVINCE: Sumatera Selatan

TOTAL BUDGET: 33,271,000

NUMBER OF VILLAGES: 8

NUMBER OF KECAMATANS: 4

DESCRIPTION: This Province is using two basic financing models. The first relies on existing KUD village cooperative, where capital and management capability already exists. The second will use the family planning village distributors as a focal point for financial management. The village distributors will be given a small amount of capital for use in income generating activities which will need to be repaid in two yearly installments of 1/2 each. In both cases acceptors will pay a monthly fee which will be used for assisting with health and family planning activities in the community, and added to the general fund for other income generating projects. An interesting mechanism for promoting this activity is running observation tours within the Province for villages which participate in this program. They will visit other villages which already have KB-Mandiri activities to discuss the methods of implementation and some of the problems which might be anticipated. Training and orientation will be provided to the PLKB, PPKBD, and acceptors groups.

UPDATE: Sumatera Selatan has completed all orientation and training activities but the project has not begun in the field due to delays in funding.

MINI-SURVEY:

n=837

prevalence 71%

pay for services 31%

source: clinic 61%; comm.inst. 21%; DBS 11%

PROVINCE: Lampung

TOTAL BUDGET: 35,555,000

NUMBER OF VILLAGES: 12

NUMBER OF KECAMATANS: 6

DESCRIPTION: This project focuses on the use of private doctors and midwives, building on their experience with the URC-funded operations research project. One of the important mechanisms being tested in this

intervention is the linkage between the family planning field workers and the private practitioners. One innovative activity will be the use of private doctors and midwives to travel out to villages to provide services on a fee for service basis. This is arranged through the family planning village distributors, who get a referral fee for the patients seen. Because there has already been a high demand for injectables but a high drop out rate as well, the activity will concentrate on providing effective counsel and treatment of side effects from injectables through private practitioners. Practitioners going out to the villages will use Blue Circle products and will receive IUD kits as an incentive. For those who are unable to pay on a fee for service basis, smaller contributions can be made to the acceptor group which will finance anyone who needs treatment for side effects. Any additional funds will be used for other health and family planning related projects.

Training will focus on financial and administrative management, record keeping, and selection and referral of eligible couples. Training will be for private doctors and midwives, PLKB, and PPKBD. Also involved in the orientation will be the mothers groups for the target villages.

UPDATE: Lampung had done all orientation and training, and began with some field activities, building on their experience of previous O.R. projects. Manuals have been prepared for BKKBN staff and private doctors and midwives, and training courses completed.

MINI-SURVEY: The analysis done by Lampung was extremely sophisticated and well done, looking across variables as well as individual variable responses.

n=1590

prev. 69%

source: clinic 48%; Inst.Masy.35%; DBS 15%; Apotik 0.5%

pay 46%

PROVINCE: Sumatra Barat

TOTAL BUDGET: 34,371,000

NUMBER OF VILLAGES: 18

NUMBER OF KECAMATANS: 9

DESCRIPTION: Because this province has relatively weak community organizations, the approach will focus more on the introduction of private FP services into the rural areas. For this to be implemented, doctors, midwives and paramedics will be trained and provided with signs and other promotional material. FP field workers will be used to coordinate these efforts and promote the use of private providers. In addition, some capital will be given to the community institutions to help strengthen these organizations. These start up funds will be on a loan basis.

UPDATE: Sumatera Barat has selected 9 kecamatans: 3 are relatively more advanced, 3 less advanced and 3 in the middle in terms of socio-economic development. In this way, they hope to get a broad perspective on the factors leading to success of KB-Mandiri. The province has completed preparatory activities including all training, preparation of manuals, and orientation. Field activities have yet to start.

MINI-SURVEY:

prevalence 42%

pay 21%

source clinic 75%; comm.inst. 6%; DBS 19%; Apotik 0.5%;

PROVINCE: RIAU

TOTAL BUDGET: 29,779,000

NUMBER OF VILLAGES: 8

NUMBER OF KECAMATANS: 4

DESCRIPTION: This Province will use three models: community financing, private practice, and industrial support of FP. The community financing will use arisan, jimpitan, voluntary contributions, village cooperatives, and will be collected through the kaders and used for a variety of local activities. The collection process will be somewhat complex as it will proceed through several levels of the administrative structure.

UPDATE: This province poses some interesting questions relating to KB-Mandiri. In Riau, because the program is relatively less developed, many acceptors have always paid for services. This includes the paying of fees to Puskesmas in more remote areas, and the use of private doctors and midwives and commercial contraceptive products, many of which come from Singapore. Thus, the models which are now being used parallel these methods of payment which are already in place. This may be an effective way to promote KB-Mandiri, but may raise questions of equity and legality if promoted on a widescale basis.

In terms of actual implementation, Riau has done very little so far.

MINI-SURVEY: survey results all done by hand.

pay 53%

PROVINCE: D.I. Aceh

TOTAL BUDGET: 39,066,250

NUMBER OF VILLAGES: 27

NUMBER OF KECAMATANS: 9

DESCRIPTION: This project will use the community financing mechanism based at the level of the Jirong and Gerong. Funds will be collected from all community members and from other income generating activities. Teams of private doctors and midwives will be asked to visit rural

communities to provide services and will be reimbursed through the funds collected at the Jirong or Gerong level. In areas with plantations or other large employers, funds will be collected from these institutions to offset the costs of family planning services. Finally, for those who can afford it, the availability of private doctors and midwives will be publicized to all communities in the project.

UPDATE: Aceh has completed preparatory activities, and begun implementation. Most of the work which they are doing relates to Promotional activities through existing village organizations and appears to be less direct interventions than most other provinces.

MINI-SURVEY:

n=915

prevalence = 62%

source: clinic 40%; DBS 40%; Inst. Masy 17% Apotik 2.7%

pay 50%

PROVINCE: Sumatera Utara

TOTAL BUDGET: 56,422,500

NUMBER OF VILLAGES: 20

NUMBER OF KECAMATANS: 10

DESCRIPTION: This project uses a community financing model using various existing community institutions. All funds will be collected by PLKB's through arisan (lotteries) from all acceptors, and used for complications, transportation to clinics, supplementary feedings for children under 5 years, and other community activities. A manual will be developed through this project for use by field staff. This manual will include selection of appropriate clients for KB-Mandiri, referral criteria, and follow-up routines for Mandiri couples. It will also provide information on financial and administration of funds, and the medical aspects to be included in IEC materials. The training will be directed toward the midwives, PLKB, PPKBD, and paramedical personnel at the clinics.

UPDATE: Sumatera Utara has done all orientation and training down to the level of the village. One interesting variation is their use of KUD for managing village funds, rather than as a distributor of contraceptives. They found that villages trusted the KUD better than another community institution to manage their funds, as they already had this type of experience.

MINI-SURVEY:

n=1162

prevalence 65%

source clinic 76%; comm.inst. 17%; DBS 14%; Apotik 2%

pay 27%

PROVINCE: KALIMANTAN BARAT

TOTAL BUDGET: 17,108,000

NUMBER OF VILLAGES: 12

NUMBER OF KECAMATANS: 6

DESCRIPTION: This project will use two models of financing: community financing and private doctors and midwives. The community financing model will be managed through the PKK and will be implemented in the 8 villages closest to large cities; while the private practice model will be reserved for those 4 villages distant from the cities. In the later model, doctors will be asked to have a mobile team which will visit the villages on a periodic basis and provide services for a fee which will be collected by the acceptor group. Money from the community financing will be used for transportation to health facilities, payment for sterilization and methods which are otherwise unavailable.

UPDATE: This province has done all planning and training activities, but is yet to begin actual implementation to the field.

MINI-SURVEY:

n= 1010

prevalence 60%

pay 45%

source: clinic 59%; inst.masy. 30%; DBS 8%; 3%

PROVINCE: Kalimantan Tengah

TOTAL BUDGET: 44,985,900

NUMBER OF VILLAGES: 4

NUMBER OF KECAMATANS: 2

DESCRIPTION: This project uses a community financing approach using the acceptor group to collect fees for injectables and pill use. Fees for IUD and condom use will not be collected. These funds will be used to help support health and FP activities; savings and loans activities; and for the kaders. An interesting approach to IEC will be to take people from less successful areas (in terms of KB-Mandiri) and show them relatively more successful areas within the Province. Other IEC materials such as posters, leaflets, and billboards will also be developed.

UPDATE: Already implementing project in all villages. Problems include unavailable of LIBI products in Province; problems with reporting by villages; shortages of program injection and implant.

MINISURVEY: n=621

children=3.27; prev. 64.57%;

source: clinic 69%; inst masy 18%; DBS 12.5% Apotik .5%;

47.5% pay ; 21% pay >Rps 1500;

PROVINCE: Kalimantan Timur

TOTAL BUDGET: 42,844,000

NUMBER OF VILLAGES: 4

NUMBER OF KECAMATANS: 2

DESCRIPTION: This project uses a community financing approach using the acceptor group to collect fees for all contraceptive use. These funds will be used to help support health and FP activities; savings and loans activities; and for the kaders. An interesting approach to IEC will be to take people from less successful areas (in terms of KB-Mandiri) and show them relatively more successful areas within the Province. Other IEC materials such as posters, leaflets, and billboards will also be developed.

UPDATE: This province has already implemented activities for 6 months. This has included orientation, training, meetings with villages, development of KIE materials, and establishment of a mechanism for collecting monitoring and distributing funds. Specifically, during the past 6 months they have collected Rps. 2.5 million so far, with fees of Pil: Rps. 250; Suntikan Rps. 1000; Implant Rps. 2500; IUD Rps 1000. The money is used as follows: services-30%; transp-20% UPPKA-30%; petugas-20%. This province made an active decision to not use LiBi as part of this project due to lack of availability of these products at this time.

MINI-SURVEY

did mini-survey but thought analysis to be done by Pusat.

PROVINCE: Sulawesi Selatan

TOTAL BUDGET: 56,701,000

NUMBER OF VILLAGES: 16

NUMBER OF KECAMATANS: 8

DESCRIPTION: This proposal will use a variety of financing mechanisms in the various Kabupaten. In the southern region where there are large plantations, these will be asked to contribute to the operating costs of the FP program, particularly implants and injectables, which are popular but expensive methods in this region. In one region, the project will be used KB-Mandiri to promote the use of IUD's as the most cost effective method available. Funds will be collected from IUD acceptors and used to provide motivational material for other IUD acceptors. Sterilizations for high risk mothers will also be promoted and co-financed through the community organizations. In a third Kabupaten, where most users prefer injectables, all users of injectables will be asked to contribute to offset the cost of commodities. At some later time, users of other methods will also be asked to contribute. In the fourth Kabupaten, the LKMD will manage and collect fees from the community for use in all village activities related to increasing the usage of FP, and to institutionalize acceptors groups. A competition will be organized between Dasa Wisma for KB-Mandiri activities. In addition, IEC materials will be developed

for the various levels of the health structure in KB-Mandiri, and private doctors and midwives will be trained.

One interesting consequence of this proposals will be the ability to see whether charging for one contraceptive method only induces a shift in usage patterns to other methods. This will be useful for future planning of KB-Mandiri.

UPDATE: Have completed orientation only in most areas due to funding delays. However, some kabupatens have already begun activities. At this point it does not appear likely that all the anticipated activities will be carried out.

MINI-SURVEY:

n=1160

prev. = 62%

source: clinic 59%; inst.masy. 37%;DBS 0.97%; apotik 0.14%

37% already pay monthly

PROVINCE: Sulawesi Tengah

TOTAL BUDGET: 41,237,000

NUMBER OF VILLAGES: 9

NUMBER OF KECAMATANS: 3

DESCRIPTION: This province has two models. The first is community financing in which fees will be collected through the PLKB for pills and condoms only. These funds will be used for referral of clients with contraceptive side effects, transportation of clients wishing sterilization, and for other income generating activities.

The second model will provide partial mandiri through the limited use of blue circle products. For this model, an arrangement with the IDI and IBI and IPPI will be made. Private doctors and midwives will provide IUD, implant, and injectables to rural areas on a per capita basis. For this program, community members will be selected for recording activities and as a liaison person with the private providers who will visit the villages only on a periodic basis. It is anticipated that in these villages, fees will be set slightly higher than actual costs so that those who cannot afford the full cost will be subsidized by the others.

UPDATE: Orientation, development of materials, training already done. 30 doctors; 30 bidans. There remains a problem with the opening of private midwife practices since the doctors will not guarantee these practices, so this model awaits official approval.

MINI-SURVEY:

n=1130

prev. 51%

pay 45%

16

PROVINCE: Nusa Tenggara Barat

TOTAL BUDGET: 33,330,000

NUMBER OF VILLAGES: 12

NUMBER OF KECAMATANS: 6

DESCRIPTION: This project builds on an existing community institution called RKB-PKK which is specific to NTB. This organization will collect fees from users and other members in the form of rice as well as cash. These funds will be used for referral of clients with contraceptive side effects, transportation of clients wishing sterilization, and for other income generating activities.

The implementation plans includes training of doctors/midwives; other FP workers; and RKB-PKK staff. Also included are development of training manuals; IEC materials for both village and private doctor/midwife practices, and booklets for the community volunteers.

UPDATE: Manuals have already been developed for private doctors, PLKB, and kaders and about to be distributed, and training is more or less complete. There remain problems in using the private sector due to shortage of LIBI outlets in Province.

MINI-SURVEY:

n=2059

prev. 65.32%; (IUD 48%, pil 43%, imp. 4.6%,)

source: clinic 58%; comm.inst. 33%; DBS 8.6%; apotik 0.15%

pay: 10.6%

PROVINCE: NUSA TENGGARA TIMUR

TOTAL BUDGET:

NUMBER OF VILLAGES: 24

NUMBER OF KECAMATANS: 12

DESCRIPTION: This Province will use a community financing model utilizing the PKK and PPKBD to administer the program. The village head will be responsible for collecting the funds from each acceptor. Funds will be used for transportation to health facilities, for helping the village volunteers (kaders) with their activities, and for income generating projects.

Funded out of this project will be training materials, IEC materials, funds to help the village acceptor groups start income generating projects, orientation meetings for private providers and pharmacies, PKK and village heads, and other local officials.

UPDATE: 2 Kabupatens have been selected which represent one low and one high prevalence. Clients will pay pill Rps. 100; inj 500; IUD 1000. Timetable is planning/orientation=May-Jul; Imp.=Aug-Dec.; eval=Dec.

MINISURVEY: N = 728; use KB 59%; MKET 29%;

avg. # children 2.72

source: posy 34%; TKBK 17%; klin 45%; RS 32%; DBS .7%

pay: 5.73%

PROVINCE: Maluku

TOTAL BUDGET: 43,060,000

NUMBER OF VILLAGES: 12

NUMBER OF KECAMATANS: 6

DESCRIPTION: Maluku faces a major constraint because of the geographic isolation of many of its areas. For this reason, it has chosen areas which are fairly accessible from the capital and yet are still very rural, and have chosen interventions which do not rely on good access from a central point. Acceptor groups with already existing income generating projects were selected, and activities in these areas will be expanded to include KB-Mandiri activities. The acceptor groups will themselves manage the funds which are to be collected on a monthly basis from the FP users. Funds will be used for referral of clients with FP side effects, and for promoting new skills within the user groups which can be used for further income generation. Many of these groups already have "dana sehat" [health fund] programs with the money from that activity going toward transportation to the Puskesmas for those with serious medical problems. Under this project, training will be provided to the acceptor groups in financial management and KB-Mandiri. Training and IEC will also be provided to private doctors and midwives who wish to provide Blue Circle services and products.

UPDATE: Only general orientation has so far been done.

MINI-SURVEY:

n=1074

pay = 14%

prev. 64%

source: clinic 75%; ins.masy. 6%; DBS 4.2%; apotik 0.72%; no response 10%

PROVINCE: Irian Jaya

TOTAL BUDGET: 76,478,288

NUMBER OF VILLAGES: 6

NUMBER OF KECAMATANS: 3

DESCRIPTION: This project proposed community financing to be managed through the PPKBK or the PKK. These funds will be used for IEC activities, contraceptive complications, and the Posyandu. Each acceptor will be asked to pay Rps. 200 / month for pills; Rps. 1000/ 3 months for injectables to the kelompok. Because of the stage of development of this province, the interventions focus primarily on client-oriented IEC which is addressed to the eligible couples. The audience for the training and orientation will be the traditional leaders, implementing institutions in the intervention areas, and project implementation personnel. Note that many of these villages are transmigration areas.

UPDATE: Activities not yet begun...they plan to begin in September. There is a question of this province whether this activity is a priority of the province since in reality, in most areas the concept of mandiri is not feasible. Within the selected areas of this project, it can perhaps be implemented, but these are for the most part transmigration, and the models used will not be appropriate for the rest of the province.

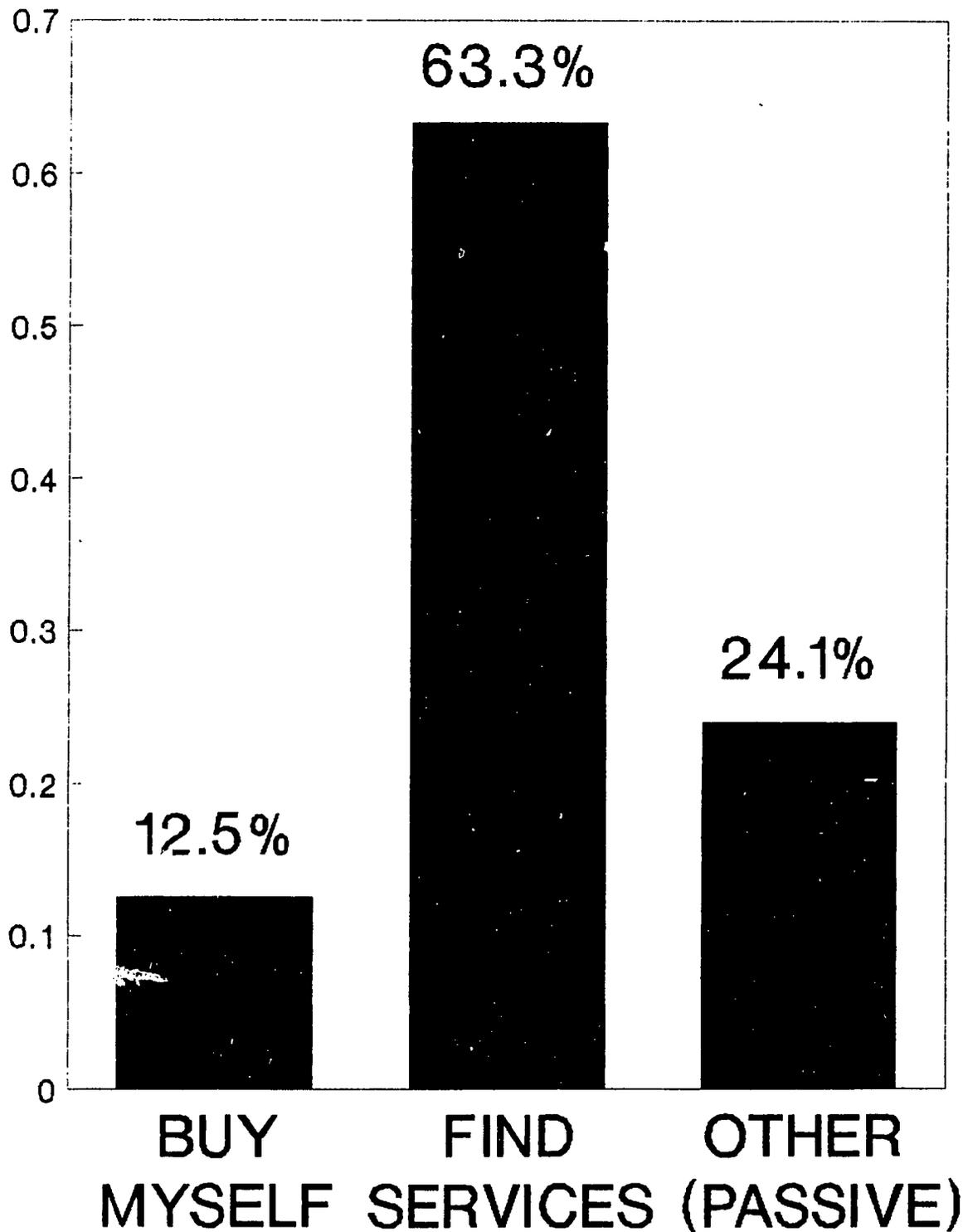
MINI-SURVEY:

n=1526

pay 20%

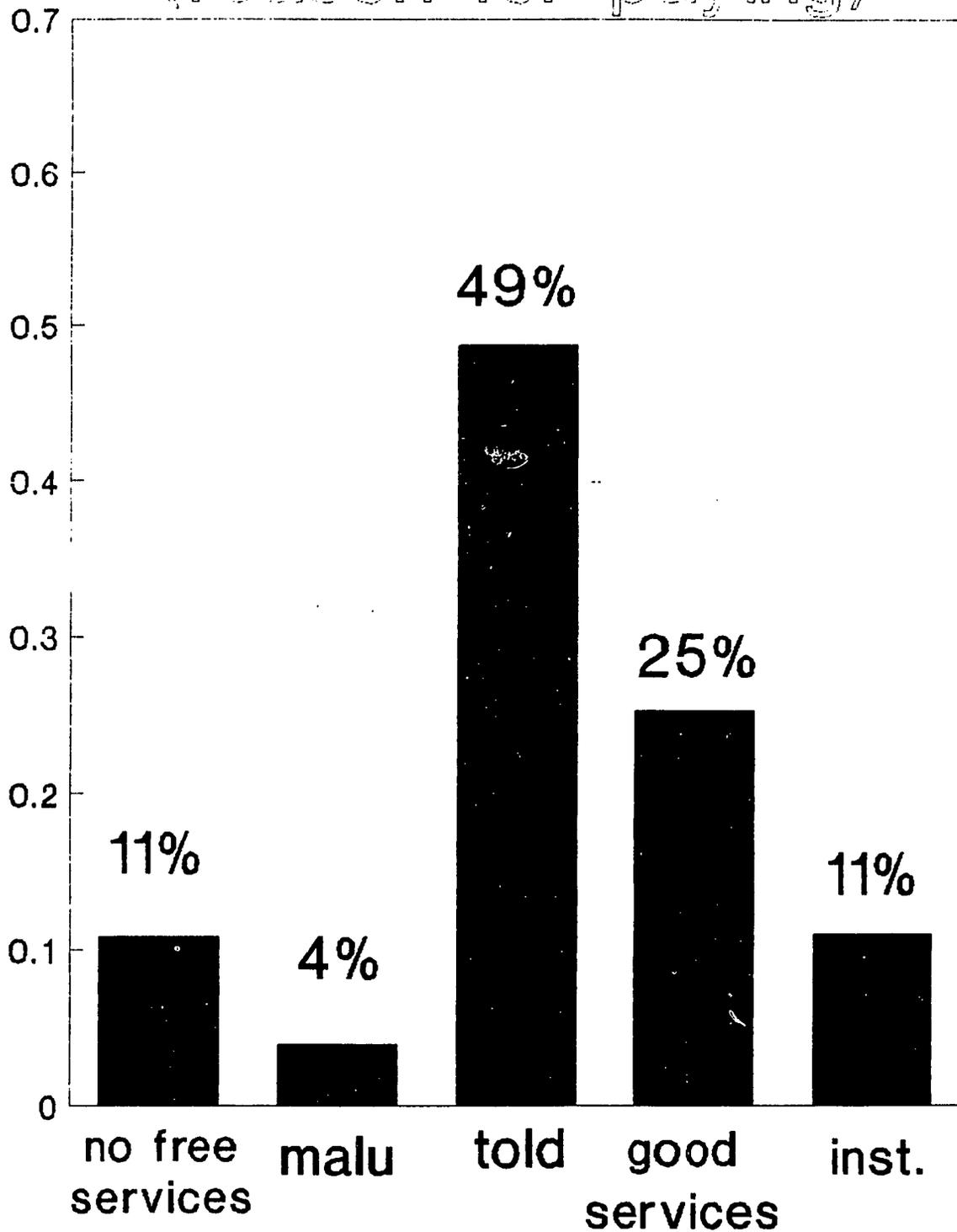
PROVINCE	PREVAL	% Pay	DBS APOTEK
JAVA BARAT	67.3	47.7	48.8
JAVA TENGAH	55.5	36.2	49.8
JAVA TIMOR	66.5	73.9	13.1
SUMATRA BARAT	42.4	21.0	19.2
SUMATRA SELATAN	71.4	39.0	30.2
SUMATRA UTARA	65.1	41.8	15.9
RIAU	69.4	52.9	7.0
LAMPUNG	68.9	66.7	15.6
D. I. ACEH	61.9	32.0	43.1
KALIMAN. BARAT	54.7	49.0	30.1
KALIMAN. TENGAH	64.6	13.4	13.1
KALIMAN. TIMOR		14.3	
SULAWESI SEL.	62.2	72.5	1.1
SULAWESI TENGAH	56.0	41.2	7.1
IRIAN JAYA	65.4	21.7	25.0
MALUKU	64.2	21.1	3.6
NUSA TENG. BAR.	65.3	7.1	55.6
NUSA TENG. TIM.	58.5	9.6	
total	63.5	37.4	22.5

WHEN YOU NEED RESUPPLY



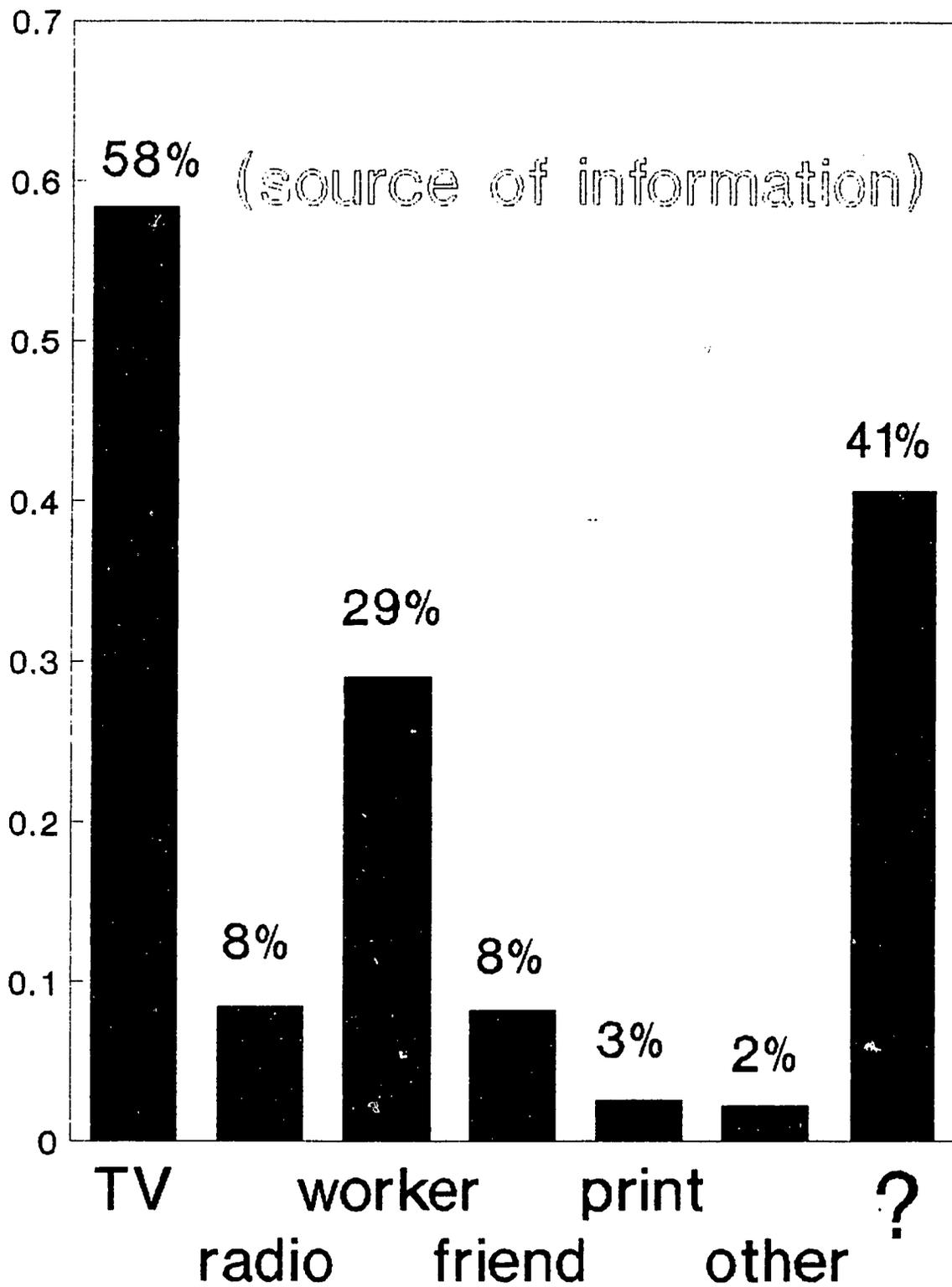
ALASAN MEMBAYAR

(reason for paying)



33

SUMBER INFORMASI KB-MANDIRI



RINGKASAN HASIL ANALISA MINISURVEY
DI 18 PROPINSI UJICоба KB MANDIRI PEDESAAN

I
PENDAHULUAN

A. Daerah Minisurvey

Minisurvey dilaksanakan di 18 Propinsi Ujicoba KB Mandiri Pedesaan, yaitu Propinsi Jawa Barat, Jawa Tengah, Jawa Timur, Di Aceh, Sumatra Utara, Sumatra Selatan, Sumatra Barat, Lampung, Nusa Tenggara Barat, Nusa Tenggara Timur, Kalimantan Barat, Kalimantan Tengah, Kalimantan Timur, Sulawesi Selatan, Sulawesi tengah, Riau, Maluku dan Irian Jaya. Dari masing-masing propinsi diambil 138 Desa dan dari sejumlah desa tersebut dipilih lagi beberapa dusun (1-2 Dusun) untuk dijadikan daerah/satuan penelitiannya.

B. Pengolahan data

Data diperoleh dari Propinsi dalam bentuk disket dan hasil analisa . Disket dikirim oleh Propinsi isinya terdiri dari dua model. Pertama dalam disket yang berisi data mentah (dalam bentuk formulir-formulir yang belum diolah) dan yang kedua data masak (dalam bentuk uraian dan tabel-tabel hasil olahan).

Untuk yang mengirim disket dalam bentuk data mentah (daranya lengkap dan dikirim sebelum tanggal 10 Agustus 1990) diolah dengan Komputer (SPSS), sedangkan setelah tanggal 10 Agustus 1990 data diambil dari hasil presentasi propinsi dalam Pertemuan Regional yang dilaksanakan pada tanggal 19 - 31 Agustus 1990, yang diselenggarakan di Palembang, Medan, Surabaya dan Ujung Pandang.

Mengingat data dari paper presentasi Pertemuan Regional, tidak selengkap dengan data mentah, maka dalam uraian ringkas ini ada beberapa tabel yang tidak lengkap 18 Propinsi, namun untuk beberapa tabel sajikan lengkap 18 Propinsi.

C. Responden

Jumlah responden dalam kegiatan Minisurvey ini adalah 21.960, yang terdiri dari Pasangan Usia Subur (PUS), kecuali Jawa Timur ada sejumlah 8 responden yang bukan PUS.

II HASIL MINISURVEY

A. Alat kontrasepsi yang dipergunakan

Dari sejumlah 21.960 responden diperoleh gambaran bahwa sejumlah responden telah menjadi peserta KB sebanyak 13.425 atau 63,5% dari Pus 21.952 (tabel 10). Proporsi terbesar dari peserta KB tersebut menggunakan kontrasepsi Pil (35,5%), kemudian disusul dengan kontrasepsi IUD (25,2 %) dan terendah adalah kondom (4,7%).Tabel 1.

Apabila dilihat dari kesertaan MKET dan Non MKET maka kesertaan MKET telah cukup besar bila dibanding rata-rata Nasional, yaitu tercatat peserta MKET besar 36,5% , dengan perincian IUD : 25,2%, Susuk 5,4 % dan MOP/MOW 5,9% . (lihat Tabel 1).

B. Metode kontrasepsi dan tempat memperoleh pelayanan

Untuk metode kontrasepsi dan tempat memperoleh pelayanan , disini hanya dapat disajikan untuk propinsi yang memasukkan data secara lengkap, sedangkan propinsi lain tidak disajikan karena data yang dikirim kurang lengkap . Propinsi yang lengkap mengirimkan datanya adalah 8 Propinsi. Dari 8 Propinsi (tabel 3) tersebut , diperoleh gambaran sebagai berikut :

- Bahwa Ibu-ibu peserta KB Pil sebagian besar memperoleh pelayanan dari Institusi masyarakat 61,8%, Klinik KB 30,4%, sedangkan di tempat pelayanan DBS/Swasta 6,3% dan Apotik 1,6% (lihat tabel 3). Dengan proporsi 61,1% pengambilan PIL dari Institusi Masyarakat ini merupakan indikator semakin besar dan kuatnya mutu pengelolaan KB di tingkat Institusi yang mengarah pengelolaan program bersama masyarakat.
- Untuk Peserta KB IUD sebagian besar memperoleh pelayanan dari Klinik KB (80,7%) dan tempat pelayanan DBS/Swasta tercatat 12,2% .
- Peserta KB Kondom sebagian besar memperoleh kondom dari Apotik (34,4%) kemudian DBS/Swasta (26,8%). Lainnya memperoleh kondom dari Klinik KB (23,8%0, dan Institusi Masyarakat (14,0%).

- Untuk peserta KB Suntik pelayanan KB dari Klinik KB masih dominan (54,3%) disusul kemudian pelayanan di DBS/Swasta (41,0)
- Demikian pula untuk metode Susuk dan MOW/MOP masih terbanyak dilayani di Klinik KB (81,2% untuk Susuk dan 79,9% untuk MOW /MOP).

Dari sisi tempat pelayanan, dari 5391 responden yang telah menjadi peserta KB atau secara keseluruhan dengan tidak membedakan metode kontrasepsi yang digunakan , maka diperoleh gambaran bahwa sebagian besar peserta masih memperoleh pelayanan di Klinik KB (57,0%), disusul kemudian pelayanan di Institusi masyarakat (23,6%), sedangkan yang lainnya, yang dilayani di DBS/Apotik adalah 19,4 %.

C. Metode yang digunakan menurut Umur

Metode yang digunakan peserta KB menurut umur (dari 10 Propinsi yang memasukkan data lengkap)diperoleh gambaran sebagai berikut :

- Bahwa bagi Ibu yang berumur sampai 19 tahun, sebagian besar dari mereka menggunakan kontrasepsi IUD (25,8%), disusul kemudian metode suntik (25,5%).
Data ini menunjukkan bahwa generasi baru/Pus muda di Pedesaan sudah mulai meminati metode IUD.
- Ibu yang berumur 20-24 tahun proporsi terbesar masih menggunakan metode kontrasepsi Pil (32,1%) berikutnya adalah Suntik (32,7%).
- Bagi Ibu yang berumur 25 - 29 tahun sebagian besar juga menggunakan kontrasepsi Pil (33,5%), berikutnya IUD (29,9%). Demikian halnya untuk Ibu yang berumur 30 - 34 tahun dan 35 - 39 tahun sebagian besar menggunakan metode kontrasepsi PII dan IUD dengan prosentase masing-masing 34,5% dan 33,4% (untuk Pil) serta 29,9% dan 33,0 % (untuk metode IUD).
- Sedangkan untuk Ibu yang berumur antara 40 - 44 tahun dan di atas 45 tahun diperoleh gambaran masing-masing 38.4% dan 41,1% (untuk IUD) serta 32,6 dan 32,3% (untuk metode Pil) lihat tabel 8.

Dari data-data di atas telah memberi gambaran kepada kita bahwa metode IUD telah mulai banyak diminati ibu-ibu di Pedesaan yang berumur 29 -45 tahun.

D. Metode yang digunakan menurut jumlah anak

Penggunaan Kontrasepsi dikaitkan dengan jumlah anak (dari 10 Propinsi yang memasukan data lengkap)diperoleh gambaran sebagai berikut :

- Bagi ibu yang belum mempunyai anak atau bagi ibu-ibu yang menunda kehamilan anak pertama, sebagian besar menggunakan kontrasepsi Pil (38,8%), kemudian IUD (25,6%).
- Bagi ibu yang punya anak satu proporsi terbesar menggunakan kontrasepsi Suntik (33,8%) dan Pil (31,0%).
- Bagi ibu yang mempunyai anak 2 dan 3 diperoleh gambaran bahwa sebagian besar menggunakan kontrasepsi IUD (33,6% untuk yang anak 2 dan 33,9% untuk yang anak 3) dan PIL (29,2% untuk yang anak 2 dan 32,4% untuk yang anak 3).
- Sedangkan untuk ibu yang mempunyai anak lebih dari 3 sebagian besar dari mereka menggunakan kontrasepsi Pil (32,9%) dan IUD (31,9%) Lihat tabel 9.

Dari data di atas terlihat bahwa ibu-ibu yang mempunyai anak 2 dan 3 sebagian besar menggunakan kontrasepsi IUD. Demikian juga halnya dengan ibu-ibu yang mempunyai anak lebih dari tiga walaupun ada perbedaan sedikit dengan peminat metode Pil.

E. Sumber memperoleh Alat Kontrasepsi

Dari sisi sumber alat kontrasepsi yang digunakan peserta KB (tabel 2), maka diperoleh gambaran bahwa sebagian besar dari peserta KB tersebut mengambil Alkon di Klinik KB (50,3%), kemudian dari Institusi Masyarakat (21,2%), sedangkan dari Praktek Dokter/Bidan Swasta dan Apotik tercatat 17,5% dan 5,0% . Namun demikian bila dijumlah bagi yang mengambil diluar Klinik KB sebetulnya telah memperlihatkan adanya perbandingan tidak jauh beda dengan yang mengambil di Klinik KB yaitu 49,7% .

F. Upaya yang dilakukan peserta KB bila Alat kontrasepsi habis

Dari jawaban yang didapat bahwa bila persediaan alat kontrasepsi habis, maka sebagian besar dari responden menjawab mereka, yaitu 63,4% mencari tempat-tempat pelayanan, sedangkan mereka yang mau beli sendiri tercatat 12,5% dan lainnya 24,1% (lihat tabel 6).

G. Metode yang dibayar

Melihat kepada prosentase metode kontrasepsi yang dibayar (tabel 4) diperoleh gambaran bahwa metode suntik menduduki rangking teratas yaitu 29,6%, disusul kemudian yang tidak terlalu jauh bedanya adalah Pil, yaitu 28,3 sedangkan lainnya dibawah 16,5% .

H. Alasan membayar

Dikaitkan dengan alasan kenapa mau bayar (tabel 5), diperoleh gambaran bahwa mereka mau membayar sebagian besar karena alasan disuruh harus membayar (48,8) sedangkan lainnya yaitu karena pelayanan baik tercatat 25,3% dan dibayar Institusi masyarakat 11,0% , alasan gratis tidak ada 10,8% dan alasan gratis malu 3,9 %

I. Sumber Informasi KB Mandiri

Melihat pada sumber informasi KB Mandiri, diperoleh gambaran bahwa sebagian besar mereka menjawab bersumber dari Televisi (58,4%) kemudian menjawab tidak tahu (40,7%) dari Petugas 29.0% , sedangkan lainnya bersumber dari Tetangga 8,2% ,Radio 8,4% , Media Cetak 2,6% dan lainnya 2,2% (Tabel 7 da

III
KESIMPULAN DAN SARAN

A. KESIMPULAN

1. Secara keseluruhan Minisurvey telah dilaksanakan oleh Propinsi daerah Ujicoba KB Mandiri Pedesaan. Dalam pelaksanaannya setiap Propinsi ternyata bervariasi dalam menggunakan formulir, waktu pelaksanaan dan cara pengolahannya.

2. Walaupun demikian pada dasarnya hasil minisurvey telah digunakan oleh Propinsi yang bersangkutan sebagai data dasar, untuk pemilihan intervensi dan pengembangan KB Mandiri.

3. Dari Hasil Minisurvey, secara Keseluruhan didapat gambaran hwa dari 21.960 Responden yang ada di daerah Ujicoba telah menjadi peserta KB sebanyak 63,5% dan sebesar 37,4% dari mereka membayar jasa pelayanan.

4. Dari sejumlah peserta KB tersebut, terdapat peserta MKÉT sebesar 36,6% dan mereka memperoleh alat kontrasepsi diluar Klinik mendekati 50 % atau sebesar 49,7% .

5. Hal lain yang cukup menarik adalah proporsi terbesar dari ibu-ibu peserta KB di Pedesaan ini bahwa ibu-ibu muda yang berumur dibawah 19 tahun telah mulai banyak meminati metode ibu (25,8%), yang merupakan proporsi terbesar dari semua metode pada umur tersebut. Kemudian disusul dengan ibu-ibu yang berumur berkisar antara 25 - 49 tahun .

6. Dikaitkan dengan jumlah anak dengan metode yang digunakan ternyata bahwa ibu-ibu yang beranak 2 - 3 sebagian terbesar dari mereka menggunakan kontrasepsi IUD.

7. Untuk Sumber informasi KB Mandiri, sebesar 58,4% responden menjawab bahwa pertama kali mendapat sumber informasi KB mandiri adalah dari Televisi, 40,7 menjawab bahwa mereka tidak tahu dari mana pertama kali mendengar informasi KB mandiri, sedangkan yang bersumber dari Petugas sebesar 29,0%.

8. Untuk metode yang dibayar proporsi terbesar adalah suntik 29,6% kemudian Pil 28,3% , sedangkan metode lainnya dibawah 16%.

B. SARAN-SARAN

1. Untuk diperolehnya data yang lebih akurat (khususnya untuk tingkat Pusat), maka untuk pelaksanaan Minisurvey yang akan datang, kiranya perlu dipertimbangkan hal-hal sebagai berikut :

- a. Keseragaman bentuk Formulir
- b. keseragaman program dalam pengolahan data
- c. Ketepatan waktu pengiriman data (disket).

2. Bahwa hasil Minisurvey betul-betul digunakan oleh daerah untuk kepentingan operasional dan untuk pemilihan intervensi dalam rangka pengembangan KB Mandiri.

Jakarta, Agustus 1990

BIRO PEMBINA

Table 1
 Comparison of the 1960-61 and 1959-60 Cattle and Buffalo
 Stocking and Grazing Practices in the State of Karnataka
 (Percentage)

Sl. No.	Practise	1960-61	1959-60	Diff.	1960-61	1959-60	Diff.	1960-61	1959-60
1.	Land	383	343	2%	494	54	107	140%	
		27,3 %	24,5 %	1,6 %	35,2 %	3,8 %	7,3 %	10,9 %	
2.	Land use	148	134	3%	160	16	25	15%	
		40,2%	33,6%	0,8%	13,9%	66,2%	6,7%	2,9%	
3.	Land use	208	608	5%	212	77	167	100%	
		15,2 %	47,2 %	4,0 %	15,8 %	5,6 %	12,2 %	10,7 %	
4.	Land use	19	166	47	19	17	12	100%	
		40,1 %	38,6%	8,1%	13,5%	2,9%	5,3%	4	
5.	Land use	55	100	13	66	29	34	100%	
		55,9 %	18,9 %	2,9 %	11,4 %	5,0 %	5,9 %	1,6%	
6.	Land use	100	19	4	56	11	7	100%	
		65,6 %	9,5 %	1,9 %	18,9 %	2,6 %	1,5 %	3,5%	
7.	Land use	1	1	0	2	1	2	100%	
		20,0 %	30,0 %	0 %	20,0 %	10,0%	20,0 %	10,0%	
8.	Land use	100	16	64	251	61	95	100%	
		29,3 %	22,2 %	6,9 %	24,9 %	6,6 %	10,0 %	7,3%	
9.	Land use	55	50	1	25	26	6	100%	
		38,1 %	55,9 %	0,1 %	2,6 %	2,7 %	0,6 %	1,1%	
10.	Land use	199	199	16	230	71	24	100%	
		49,4%	13,8	4,5%	22,7%	7,2%	2,4	7,9%	
11.	Land use	158	301	22	168	77	36	100%	
		41,8%	32,3 %	2,0%	15,3%	5,2%	3,3%	8,5%	
12.	Land use	134	50	10	138	25	22	100%	
		33,4%	13,5%	2,5%	34,4 %	8,7 %	5,5 %	3,1%	
13.	Land use	414	61	2	194	35	11	100%	
		57,3%	8,4%	0,3%	27,5%	4,8%	1,5 %	3,6%	
14.	Land use	228	10	263	162	11	16	100%	
		32,3%	1,4%	38,1%	23,4%	1,9%	2,3 %	5,4 %	
15.	Land use	209	106	12	115	29	24	100%	
		35,0%	19,5%	5,5%	19,1%	10,4%	9,7 %	5,3%	
16.	Land use	227	100	1	158	54	38	100%	
		36,2%	23,0%	0,1%	22,0%	9,2%	9,2 %	4,9%	
17.	Land use	19	100	1	15	50	34	100%	
		11,6%	30,3%	0,2 %	36,7%	11,8	9,2	3,3%	
18.	Land use							100%	
	TOTAL	4525	3215	606	2566	640	153	100%	
		55,5%	25,3%	4,7 %	20,9	5,4%	5,9 %	100%	

Table 2

MEMBER MEMBERSHIP ALAT KONTROL PESTISIDA
OF KONTROL PESTISIDA

NO.	MEMBERSHIP	KONTROL PESTISIDA	MEMBERSHIP	KONTROL PESTISIDA	MEMBERSHIP	KONTROL PESTISIDA
1.	Alasan	171	214	346	171	
		24,5 %	26,7 %	31,3 %	17,5 %	
2.	Keuntungan	121	122	119	117	
		43,7 %	6,5 %	44,7 %	5,1 %	
3.	Keuntungan	144	111	114	111	
		54,4%	32,7 %	12,6 %	0,6 %	
4.	Keuntungan	111	111	111	111	
		39,9%	17,0 %	40,4 %	2,7 %	
5.	Keuntungan	111	111	111	111	
		28,4 %	41,3 %	29,8 %	0,4 %	
6.	Keuntungan	111	111	111	111	
		48,3 %	21,6 %	19,9 %	10,2 %	
7.	Keuntungan	111	111	111	111	
		0,0 %	0,0 %	0,0 %	100,0 %	
8.	Keuntungan	111	111	111	111	
		68,5 %	6,5 %	22,8 %	2,2 %	
9.	Keuntungan	111	111	111	111	
		42,9 %	1,6 %	54,0 %	1,6 %	
10.	Keuntungan	111	111	111	111	
		50,1 %	41,4 %	5,0 %	2,0 %	
11.	Keuntungan	111	111	111	111	
		47,9 %	34,8 %	15,3 %	0,3 %	
12.	Keuntungan	111	111	111	111	
		68,9 %	18,0%	12,5 %	0,6 %	
13.	Keuntungan	111	111	111	111	
		59,6%	37,1%	1,1 %	0,1 %	
14.	Keuntungan	111	111	111	111	
		47,9%	6,2%	3,2%	0,4 %	
15.	Keuntungan	111	111	111	111	
		66,9%	17,1%	14,0%	1,8 %	
16.	Keuntungan	111	111	111	111	
		65,3%	27,4%	7,0%	0,1 %	
17.	Keuntungan	111	111	111	111	
		74,6%	6,2	18,7%	0,5	
18.	NET					
TOTAL		399	1685	1391	396	
		50,26%	21,2 %	17,5 %	5,0 %	

METODE KONTRASEPSI DAN TEMPAT MENYEROLAH PELAYANAN
 (Kecamatan Kertajati, Kabupaten Majalengka, Kalimantan Selatan)

NO. METODE	KELUAIK	TERPILAS	PERSEWARITA	GRUPA	TOTAL
1. PII	1024 30,2 %	1081 61,8 %	110 6,3 %	26 1,6 %	2141 32,4 %
2. IUD	1086 80,7 %	118 6,8 %	110 12,2 %	3 0,2 %	1317 31,9 %
3. Suntikan	11 23,8 %	15 14,0 %	44 26,8 %	64 34,4 %	134 3,6 %
4. Suntikan	1011 54,3 %	111 3,5 %	467 41,0 %	11 0,9 %	1600 41,7 %
5. Suntikan	1024 81,2 %	11 2,9 %	17 13,0 %	2 2,9 %	1054 4,3 %
6. Suntikan	1017 79,9 %	11 0,8 %	77 18,7 %	2 0,5 %	1107 7,1 %
Total	3078 32,0 %	1273 35,6 %	937 17,4 %	109 2,0 %	5397 100 %

Keterangan : proporsi lain tidak direkap di tabel ini,
 karena data kurang lengkap.

Tabel 4.

1) METODE YANG DIKAYAKAN PESERTA KR
PER PROPINSI

NO.	PROVINSI	GLI	TOP	KIRI	DIRI	JESUR	KELOMPOK	Jumlah
1.	Jawa	180	105	15	300	19	17	646
		28,9%	16,9%	2,3%	45,9%	2,8%	2,6%	100%
2.	Jember	30	110	7	100	60	19	326
		8,6%	25,9%	1,4%	24,9%	17,2%	4,9%	100%
3.	Jember	110	4	1	60	14	15	204
		51,1%	1,8%	0,5%	26,9%	6,4%	6,6%	100%
4.	Kabupaten	1	13	1	11	2	1	40
		2,5%	32,5%	2,5%	27,5%	5,0%	2,5%	100%
5.	Jawa	19	9	1	100	1	10	140
		13,6%	6,4%	0,7%	70,7%	0,7%	7,1%	100%
6.	KIRI	1	23	0	21	20	4	70
		1,4%	33,3%	0,0%	30,4%	29,0%	5,8%	100%
7.	KIRI	-	-	-	-	-	-	0
		-	-	-	-	-	-	0%
8.	Lampung	458	351	22	168	57	36	1093
		41,8%	32,1%	2,0%	15,3%	5,2%	3,3%	100%
9.	Kalimantan	-	-	-	-	-	-	0
		-	-	-	-	-	-	0%
10.	Sulawesi	325	-	-	116	10	9	460
		70,0%	0,0%	0,0%	25,1%	2,2%	1,9%	100%
11.	Tanah	-	-	-	-	-	-	0
		-	-	-	-	-	-	0%
12.	DI. Aceh	-	-	-	-	-	-	0
		-	-	-	-	-	-	0%
13.	Kalimantan	-	-	-	-	-	-	0
		-	-	-	-	-	-	0%
14.	Manuk	223	162	10	263	11	16	685
		32,6%	23,5%	1,4%	38,4%	1,6%	2,3%	100%
15.	Sulut	-	-	-	-	-	-	0
		-	-	-	-	-	-	0%
16.	Kalimantan	-	-	-	-	-	-	0
		-	-	-	-	-	-	0%
17.	Sumbang	8	21	1	53	1	5	89
		8,9%	23,5%	1,1%	59,5%	1,1%	5,6%	100%
18.	N I T	-	-	-	-	-	-	0
		-	-	-	-	-	-	0%
TOTAL		1141	770	94	1432	194	203	5973

Capital

PERCENTAGE OF TOTAL CAPITAL TO THE TOTAL PRODUCTION

PER PRODUCTION

no.	Production	DK, ADA	GP, DSA	DISTRIBUI	PRD	PRD, GP	Total
		base 100	base 100	base 100	base 100	base 100	
1.	Industri	3,5 %	8,1 %	48,7 %	23,4 %	16,0 %	15,2 %
2.	Industri	5,6 %	5,6 %	52,2 %	34,9 %	1,4 %	9,1 %
3.	Industri	4,8 %	1,5 %	89,7 %	3,3 %	0,7 %	5,3 %
4.	Industri	18,42%	7,9 %	40,35%	30,7 %	2,63%	29,0 %
5.	Industri	2,2 %	1,3 %	6,8 %	34,7 %	0,0 %	4,3 %
6.	Industri	20,0 %	8,5 %	46,5 %	23,9 %	52,9 %	4,5 %
7.	Industri	0,0 %	0,0 %	0,0 %	0,1 %	99,3 %	3,0 %
8.	Industri	4,0 %	3,4 %	85,1 %	4,7 %	2,7 %	2,8 %
9.	Industri	2,1 %	6,4 %	40,4 %	51,1 %	0,0 %	6,9 %
10.	Industri	24,4%	1,5 %	48,1 %	26,0 %	-	10,5 %
11.	Industri	1,1%	3,6 %	59,1%	34,3%	1,9 %	14,1 %
12.	Industri	12,9%	5,0 %	32,8%	46,9%	2,15 %	5,4 %
13.	Industri	40,3%	-	20,4	4,4%	34,9 %	10,1 %
14.	Industri	1,8%	8,7 %	7,3%	82,5%	-	2,1 %
15.	Industri	11,6%	10,0%	58,9%	22,0%	4,1%	6,1%
16.	Industri	1,2%	11,2%	66,5%	5,0%	15,8%	4,6 %
17.	Industri	2,8%	2,8%	14,8%	80,8%	-	1,7 %
18.	Industri	-	-	-	-	-	-
Total		10,8 %	3,9 %	48,4 %	25,3 %	11,0 %	10,0 %

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TABEL 1

URAYA KEMAHALAKATAN KESEHATAN
KOTA SURABAYA

NO.	PRINTEREST	RELI PENDIRI	MENCARI PELAYANAN	LAINNYA	TOTAL
1.	Orang tua	30	100	0	130
		4,3 %	74,9 %	20,7 %	16,0 %
2.	Orang tua	39	100	0	139
		6,8 %	72,7 %	20,5 %	17,0 %
3.	Orang tua	0	100	0	100
		3,5 %	63,3 %	16,2 %	5,0 %
4.	Orang tua	14	100	0	114
		6,0 %	57,7 %	26,9 %	6,0 %
5.	Orang tua	0	0	100	100
		0,0 %	9,0 %	99,0 %	5,0 %
6.	Orang tua	0	100	0	100
		1,8 %	97,3 %	7,9 %	3,0 %
7.	Orang tua	0	100	0	100
		6,1 %	74,3 %	25,0 %	8,0 %
8.	Orang tua	100	100	0	100
		62,1 %	37,89 %	0	4,0 %
9.	Orang tua	77	100	0	100
		25,0 %	70,6 %	4,4 %	10,0 %
10.	Orang tua	45	100	0	100
		13,4 %	83,8 %	2,7 %	3,0 %
11.	Orang tua	427	100	0	100
		59,1 %	29,0 %	11,7 %	7,0 %
12.	Orang tua	0	0	100	100
13.	Orang tua	0	0	100	100
14.	Orang tua	10	100	0	100
		1,39 %	53,7 %	44,9 %	10,0 %
15.	Orang tua	30	100	0	100
		3,9 %	78,7 %	17,3 %	7,0 %
16.	Orang tua	10	100	0	100
		7,0 %	90,5 %	2,4 %	5,0 %
17.	Orang tua	0	0	100	100
		0,47 %	18,25	81,3	4,0 %
18.	Orang tua	0	0	100	100
		0,0 %	0,0 %	100,0 %	0,0 %
	TOTAL	1412	3106	2911	1100
		12,5 %	63,3 %	24,1 %	100,0 %

Tabel. 7.

SUMBER INFORMASI KB MANDIRI YANG DIPEROLEH PESERTA KB
PER-PROPINSI

NO.	PROPINSI	TELEVISI	RADIO	PETUGAS	TETANGGA	MEDIA CETAK	LAINNYA	TIDAK TAHU	TOTAL
1.	Jabar	108	207	459	314	98	150	815	2.141
		5,0 %	9,6 %	21,4 %	14,6 %	4,1 %	7,0 %	38,0 %	25,5 %
2.	Jateng	65	120	546	196	88	77	675	1.767
		3,6 %	5,6 %	30,8 %	11,0 %	4,9 %	4,3 %	38,2 %	21,1 %
3.	Sumsel	39	70	360	146	7	13	173	508
		7,6 %	13,7 %	70,8 %	28,7 %	1,3 %	2,5 %	34,0 %	6,0 %
4.	Kalbar	97	239	55	56	9	4	340	800
		12,1 %	29,8 %	6,8 %	7,0 %	1,1 %	0,5 %	42,5 %	9,5 %
5.	Kaltim	0	0	3	0	0	0	539	542
		0,0 %	0,0 %	0,1 %	0,0 %	0,0 %	0,0 %	99,4 %	6,5 %
6.	Irja	202	39	322	47	107	33	260	828
		24,3 %	4,7 %	38,8 %	5,6 %	12,9 %	3,9 %	22,7 %	9,9 %
7.	N.T.B.	29	61	323	61	7	27	806	1.316
		2,2 %	4,6 %	24,5 %	4,6 %	0,1 %	2,0 %	61,3 %	15,7 %

Tabel. 7

SUMBER INFORMASI KB MANDIRI YANG DIPEROLEH PESERTA KB
PER-PROPINSI

NO.	PROPINSI	T.V	RADIO	PETUGAS	TETANGGA	MEDIA CETAK	LAINNYA	TIDAK TAHU	TOTAL
8.	Lampung	7092	70	1016	90	2	1	0	1271
		5,5 %	5,5 %	79,9 %	7,1 %	0,2 %	0,1 %	0,0 %	100,0 %
9.	Riau	14,6 %	11,5 %	58,2 %	2,9 %	0,9 %	0,0 %	11,9 %	100,0 %
10.	DI Aceh	4722	42	72	14	24	13	0	637
		68,1 %	8,1 %	10,5 %	7,9 %	3,5 %	1,9 %	0,0 %	100,0 %
11.	Jatim	77	26	51	9	1	3	386	553
		13,9 %	4,7 %	9,2 %	1,6 %	0,2 %	0,5 %	69,8 %	100,0 %
12.	Maluku	164	206	477	88	29	5	8	977
		16,8 %	21,1 %	48,8 %	9,0 %	2,9 %	0,5 %	0,8 %	100,0 %
13.	Sulteng	121	39	104	36	2	1	853	1156
		10,4 %	3,3 %	8,9 %	3,1 %	0,2 %	0,1 %	73,7 %	100,0 %
14.	Sumut	137	128	276	94	13	0	415	1063
		12,8 %	12,0 %	25,9 %	8,8 %	1,2 %	0,0 %	39,0 %	100,0 %

Label. 7.

SUMBER INFORMASI KB MANDIRI YANG DIPEROLEH PESERTA KB
PER - PROPINSI

NO. ! P R O P I N S I !	T.V.	RADIO	PETUGAS	TETANGGA	MEDIA CETAK	LAINNYA	TIDAK TAHU	TOTAL
15. ! Kalteng	! 52	! 8	! 257	! 57	! 5	! 4	! 81	! 464
!	! 8,37 %	! 1,29 %	! 41,38 %	! 9,18 %	! 0,81 %	! 0,64 %	! 13,04 %	! 100,0 %
16. ! Sulsel	! 25,02 %	! -	! 55,09	! 9,91 %	! 3,62 %	! 1,64 %	! -	! 100,0 %
17. ! Sumbar	! 136	! 19	! 44	! 26	! 18	! -	! 777	! 1020
!	! 13,34 %	! 1,86 %	! 4,31 %	! 2,55 %	! 1,76 %	! -	! 76,18 %	! 100,0 %
18. ! N.T.T.	! -	! -	! -	! -	! -	! -	! -	! -
T O T A L	! 8791	! 1274	! 4365	! 1234	! 400	! 331	! 6130	! 15043
	! 58,4 %	! 8,4 %	! 29,0 %	! 8,2 %	! 2,6 %	! 2,2 %	! 40,7 %	! 100 %

Keterangan :

1. Propinsi Riau dan Sulawesi Selatan data yang ada hanya prosentase.
2. N.T.T. tidak ada datanya
- 3.

Tabel 3.

PERSEPSI WARGA NISIPINJARAN TERHADAP LINGKUNGAN

Persepsi lingkungan di Kecamatan Nisipin Kabupaten Kutubungga, Sulawesi Tengah (2019)

No	Indikator	Skor	Nilai	Skor	Nilai	Skor	Nilai	Skor	Nilai
1.	19	581	61	45	29	18	37	101	100%
		16,4%	25,8 %	14,5 %	25,5 %	5,8%	11,9 %	4,1%	
2.	20	540	50	18	87	60	7	11	100%
		32,1%	27,9 %	1,5 %	32,7 %	5,0%	0,5 %	14,4%	
3.	25	579	57	34	434	130	68	107	100%
		33,5%	29,9 %	1,7 %	25,8 %	6,5%	2,5 %	24,5%	
4.	30	617	54	39	517	124	105	107	100%
		34,5%	29,9 %	2,1 %	20,5 %	5,1%	5,7 %	23,7%	
5.	35	488	44	16	5	13	132	107	100%
		33,4%	33,0 %	1,7 %	17,1 %	4,0%	10,1 %	16,5%	
6.	40	517	50	21	5	11	107	107	100%
		32,6%	38,4 %	3,0 %	9,5 %	1,9%	13,3 %	10,1%	
7.	45	111	104	13	24	4	47	50	100%
		32,3%	41,1 %	3,7 %	8,2 %	1,1%	13,4 %	4,4%	
TOTAL		2583	2534	199	1690	374	603	780	100%
		31,2%	32,1 %	2,5 %	21,4 %	4,7%	7,6 %	10,0%	

Keterangan :

* Aceh, Sumur, Riau, Kalteng, Sulteng, Sulsel, Jatim dan NTT dari klasifikasi umur perwalasesemonda tidak bisa dimasukkan dalam tabel ini.

Halaman 9.

REKORSE KAMI TERDIRI DARIPADA BERIKUT: JUPREAN (Sulawesi Utara),
 Laban (Kalabati, Kalbar, Sulsel, NTB, NTT, Kalimantan Timur, Kalimantan
 Selatan & Barat)

no	jumlah	Jawa	Min	Kon	Sunda	Achak	lain-lain	total
	orang							
1.	0	14	10	0	9	0	4	37
		37,9%	27,0%	0,0%	24,1%	0,0%	10,9%	100,0%
2.	1	357	318	21	389	49	6	1130
		31,6%	27,8%	1,8%	34,1%	4,3%	0,5%	100,0%
3.	2	524	623	77	444	101	84	1853
		28,2%	33,6%	4,1%	23,9%	5,4%	4,5%	100,0%
4.	3	479	500	45	292	58	100	1474
		32,5%	33,9%	3,0%	19,8%	3,9%	6,7%	100,0%
5.	3	739	696	35	390	112	274	2246
		32,9%	30,9%	1,5%	17,3%	4,9%	12,2%	100,0%
<hr/>								
TOTAL		1113	2147	178	1514	322	478	5762
		31,2%	31,8%	2,6%	22,6%	4,7%	8,3%	100,0%

Keterangan : Jawa, Riau, Sulsel, Sumut, Aceh, Sulteng,
 dll dan kalbar dapat klasifikasi sebagai anak-anak
 variasi, sehingga tidak bisa dimasukkan dalam tabel
 ini.

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Tabel 10

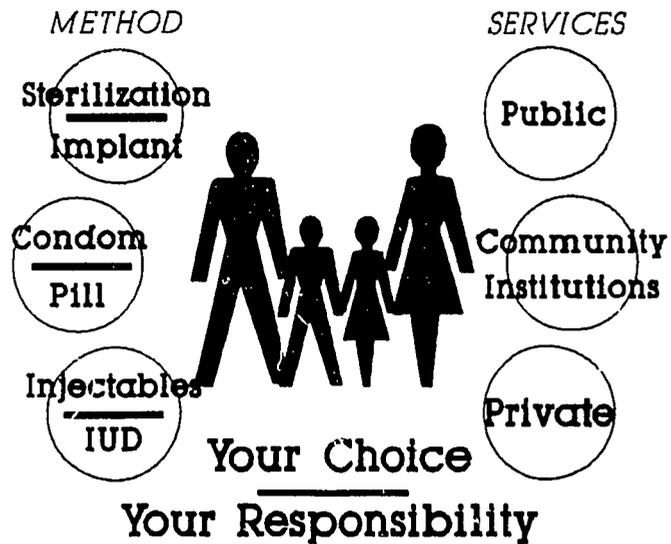
JUMLAH RESPONDEN PENELITIAN KE
GABUNGAN

NO.	DAERAH	RESPONDEN	Jumlah	Presentase
1.	Jakarta	1457	1457	66,3
2.	Riau	1457	1457	66,3
3.	Negeri	1160	1160	53,2
4.	Sumbar	994	994	45,4
5.	Langkai	1590	1590	72,5
6.	Sumut	1162	1162	53,1
7.	NT. Aceh	915	915	41,9
8.	Sulteng	1130	1130	51,9
9.	Maluku	1074	1074	49,0
10.	N.T.T.	728	728	33,2
11.	Kalteng	621	621	28,3
12.	N.T.B.	2059	2059	94,5
13.	Kalbar	1110	1110	50,6
14.	Trija	1526	1526	69,9
15.	Magelang	857	857	39,1
16.	Jabar	2432	2432	111,5
17.	Jateng	2057	2057	94,0
18.	Kaltim	552	552	25,0
TOTAL		21960	21960	100,0

DATA PESERTA KK MANDUKI PEDISESIAN
DI 18 PROPINSI

No.	Propinsi	Desa Uji coba	Jumlah Peserta KK	Peserta KK yg mendapat manfaat	
				Jumlah	%
1.	Jawa Barat	24	1402	669	47,7
2.	Jawa Tengah	18	1372	498	36,0
3.	Jawa Timur	29	308	277	90,0
4.	DI Aceh	27	587	188	32,0
5.	Sulawesi	10	551	27	4,9
6.	Lampung	12	1095	731	66,8
7.	Sulawesi	10	557	317	56,9
8.	Riau	8	1009	534	52,9
9.	Sulawesi	18	427	149	34,9
10.	Kalayar	12	465	228	49,0
11.	Kalimantan	18	404	154	38,1
12.	Kalimantan	4	1100	158	14,3
13.	Sulawesi	10	554	114	20,6
14.	Sulawesi	6	630	260	41,3
15.	Sulawesi	12	504	217	43,1
16.	NT T.	8	436	47	10,8
17.	Maluku	12	550	146	26,5
18.	ITIR	6	927	202	21,7
TOTAL		306	13923	5206	37,4

KB-MANDIRI



PROPOSED IMPLEMENTATION STRATEGY

written for:
Indonesian National Family Planning Coordinating Board

August, 1990

by:
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Management Sciences for Health

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KB-MANDIRI: PROPOSED IMPLEMENTATION STRATEGY

I. EXECUTIVE SUMMARY

The Indonesian National Family Planning Coordinating Board (BKKBN) has embarked on an ambitious program of self sufficiency called "KB-Mandiri." The goal of KB-Mandiri is to transfer the responsibility for family planning away from the government and onto the people themselves. This approach began with the initiation of the small happy prosperous family norm (NKKBS) and has progressed through a series of stages to reach the present stage of KB-Mandiri.

At the basis of this approach is the provision of a wide range of high quality options to the population with the directive to choose the product and service which is suitable and acceptable, and accept the responsibility for its use. Within this strategy, the first phase provided only broad policy guidelines to promote innovation in the development of implementation strategies in the field. Through a variety of private sector initiatives, operations research, and pilot projects BKKBN has developed considerable experience in the area of self-sufficiency.

Now, as KB-Mandiri becomes an integral component of the family planning movement, there is a need for a national operational strategy for KB-Mandiri to facilitate the expansion of the program from a series of field trials to a national movement. It is recommended that the following components be included in this national strategy:

- A single comprehensive strategy which integrates the role of Private and Public providers, commodities and distribution channels. Thus, policies which affect public programs will be reviewed in terms of their impact on the private contraceptive market. In the same way, policies which regulate private contraceptive sales and services will be coordinated with public program goals and targets. This will be of particular importance to the approach taken for promoting longer term methods of contraception.
- A single uniform message for the KB-Mandiri program should be developed which is independent of the Blue Circle marketing campaign. One possible such message is:

"FAMILY PLANNING: YOUR CHOICE-YOUR RESPONSIBILITY"

This or any other message should be thoroughly field tested to ensure its understanding and validity to the population.

- The marketing approach which has been used for Blue Circle should be expanded to include all of KB-Mandiri using targeted messages addressed to different segments of the population. This market segmentation approach should be emphasized, and specific messages developed for each segment of the population. These messages, should in turn be linked to specific outputs and specific indicators of success in order to measure the success of the various components of the marketing approach. These messages are presented in figure 1.

FIGURE 1: TARGETED MESSAGES: KB-MANDIRI			
TARGET AUDIENCE	TARGET ACTION	MESSAGE	INDICATOR
YOUTH	NKKBS	NKKBS	attitude new acceptors
NON-USERS FP	use FP	dua anak cukup use FP	prevalence new acceptors
USERS FP - UNABLE TO PAY FULL MANDIRI	MKET acceptor group	your choice- your responsibility MKET	MKET attitude
USERS FP - ABLE TO PAY FULL MANDIRI	DBS LIBI	use DBS LIBI	sales figures service stats.

- Community financing or income generating projects form the majority of the approaches to "partial mandiri." While this approach offers a convenient mechanism for community participation in the KB-Mandiri movement, it will not, in general, provide a way to pay for the costs of resupply methods of contraception. On the other hand, it can and should provide a mechanism for community groups to offset the costs of longer term methods, particularly IUD's, implants, and sterilization procedures through monthly installment payments by recipients of longer term methods.
- The NGO's have traditionally played an important role in the development of the family planning program. They have provided innovative models of service delivery, and have augmented the program with services or products not suited to the government delivery system. As the KB-Mandiri program moves from its introductory phase to an expansion phase, it will be important to support the NGO's in continuing to develop innovative approaches and providing key services to the population.

II. Introduction

"Dua anak cukup," two children are enough. From the beginning, BKKBN has focused on the need to build demand for family planning through promotion of the concept of the "small, happy, prosperous family." This internalization of demand for family planning forms the basis of the Indonesian family planning program, and is the foundation upon which has been built the successful program through community participation, political commitment, and service provision. This internalized demand for family planning is also the basis of KB-Mandiri.

KB-Mandiri is an innovative and exciting approach to increasing contraceptive use and coordinating a national family planning movement. Yet, most of the components of KB-Mandiri have been included in the family planning program from the beginning. The focus on strong community institutions, and the use of volunteers have been a hallmark of the program from its early stages. The focus on the "small, happy, prosperous family" norm as the basis of self-reliance have been instilled from the beginning. What is new is the specific goal of financial autonomy through the establishment of alternate revenue sources from the current mix of government and donor funding. This emphasis on the self-financing component has come as the result of the financial realities of projected decreases in both Government and donor funding of family planning. However, BKKBN recognizes that sustainability will require more than simply increased revenues and strong financial management. Rather, it has recognized that sustainability will come from a long and gradual effort to shift the responsibility for contraception away from the government and on to the users.

This does not mean that all family planning acceptors will pay for services; rather it means that individuals will make family planning a high priority of their family life, and adopt behaviors and attitudes that ensure its effective use. Families who want only two children will do whatever is necessary to protect against unwanted pregnancies. They will not require constant reminders from FP field workers, but will, on their own initiative ensure they are adequately protected. They will demand family planning services.

The timing of this stage of KB-Mandiri coincides with the need for the family planning program to expand and meet the needs of the growing number of family planning acceptors. In addition the inclusion of more remote and harder to reach populations in the program will require additional commitment and resources from the local communities to maintain the current growth and prevent a stalling of the fertility rate reductions which have been projected. Through the introduction of KB-Mandiri, BKKBN will be able to gradually shift the responsibility for contraceptive use to the individual client, and away from the government structure, with the result that existing resources can be redirected toward reaching new acceptors and the more difficult to serve populations. The long term effect will be a more sustainable program based on widespread individual and community support, and a concomitant freeing of resources for use in new areas. This is the goal of "KB-Mandiri."

III. KB-MANDIRI-INTRODUCTORY PHASE

Introductory Phase

GOAL:	Innovation
STRATEGY:	General
OPERATIONS:	Small Scale

BKKBN has been a leader in developing and implementing innovative approaches to family planning. Yet precisely because of its leadership role in developing new models and strategies for widescale implementation, BKKBN faces what may be its most difficult challenge to date, the

development of a model for sustaining the growth of the family planning program over the long term. Without appropriate models from other countries, Indonesia has had to search within itself, and encourage innovation among its own people to test new approaches to family planning service delivery and to uncover potential problems in the implementation of these approaches. During this first stage of KB-Mandiri, guidelines have been very general to encourage the widest possible political and popular support, and the greatest range for innovation. Pilot projects and operations research have been used in both urban and rural areas to develop and test potential strategies for KB-Mandiri.

KB-Mandiri was launched in 1987 with the development of a joint partnership between the private and public sector, including the training and supply of private doctors and midwives who provide contraceptive services in their private practices. This was followed by the introduction of commercial contraceptive products, first under the Dua Lima label, and then the Linkaran Biru (Blue Circle) product line. Finally, the concept of KB-Mandiri through community financing and commercial based sales has been tested in poorer urban localities and rural areas to test these approaches to self-sufficiency. Through a variety of private sector initiatives, operations research, and pilot projects BKKBN has developed considerable experience in the area of self-sufficiency. This experience includes:

- A highly visible and sophisticated social marketing campaign managed with cooperation from the private sector. Through this campaign, the population have become aware of the Blue Circle line of products and services and the options available to them in choosing the contraceptive provider and product which is right for their needs.
- The distribution of Blue Circle products through commercial distribution channels. The very high market penetration has demonstrated the viability of low cost but unsubsidized commercial distribution of commercial contraceptive products.
- The use of private doctors and midwives throughout the country to provide contraceptive services in their private practice.

- The use of many non-government organizations in the KB-Mandiri program as a way to increase participation, and encourage innovation. This has included both professional organizations such as IDI and IBI, and many NGO's such as Mohammedia, IPI, etc.
- The implementation of operations research and pilot projects in 21 Provinces and many cities to test various approaches to KB-Mandiri.

BKKBN has shown that KB-Mandiri can succeed. Many people have been skeptical of the ability to transform a successful government program into a more integrated private-sector public-sector partnership. Successful KB-Mandiri programs such as that in Bali have been important in demonstrating the ability to integrate private doctors and midwives into the government family planning program, and sell unsubsidized contraceptives to a wide market. Bali has also provided leadership in the development of IEC, training and operational materials many of which have been borrowed by other provinces for their own pilot activities. Virtually all provinces have now had some experience with KB-Mandiri pedesaan activities, and understand the issues involved in successful implementation.

Yet there remains much to be done. As the KB-Mandiri and the provision of non-government services expands, there will be several areas which require further emphasis or clarification in order to avoid potential pitfalls and realize the full potential of KB-Mandiri.

WHO IS MANDIRI?

The earliest stage of KB-Mandiri involved the integration of private doctors and midwives into the family planning program, through the provision of family planning services in their private clinics. In this program, private doctors and midwives were trained and provided some supplies and a blue circle logo to hang outside their office. To this program was added the introduction of the blue circle line of contraceptives, providing a comprehensive private family planning service to those able to pay. This program remains the cornerstone of full mandiri.

Yet, for any, the cost of private services poses a significant barrier to contraceptive use. In order to gain the widest possible acceptance for the program, BKKBN recognized that KB-Mandiri needed to include not only those who were able to pay the full price of private services, but those who were willing to contribute something towards their own contraceptive service. Accordingly, the concept of partial and pra mandiri were also included, since it was seen that the client's attitude toward family planning was as important to the program success as the ability to pay. While the inclusion of pra and partial mandiri have greatly expanded the appeal of the program, it has also added to the complexity of the concept of KB-Mandiri. Although BKKBN has been very clear to not equate KB-Mandiri with paying for services, there remains considerable confusion, about what exactly is meant by "pra" and "partial" mandiri, and the relationship between this program and the provision of free government services and commodities to those who

6'

cannot afford to pay. In order to ensure that KB-Mandiri not achieve success at the cost of social equity or overall contraceptive prevalence a very clear operational definition of Mandiri will need to be stated, and targets which are set will need to take into consideration the relationship between Mandiri, social equity and contraceptive use. This will need to include a way for PLKB and PPKBD to discriminate between who will receive free government services and who will be asked to pay.

THE MEANING OF THE BLUE CIRCLE LOGO

The Blue Circle logo was initially introduced as a symbol for private practitioners providing contraceptive services in their private practice. To augment this program the Blue Circle logo was also introduced as the trademark for a commercial line of contraceptive products, primarily for use in these private practices. Now the logo is being used as the symbol of all KB-Mandiri activities. However, because the Blue Circle logo has been so strongly associated with full mandiri, people may now believe that KB-Mandiri and the Blue Circle logo means paying for contraceptive services through private doctors and midwives. The very widespread use of the logo has caused confusion about the relationship between Blue Circle and KB-Mandiri. Does the logo represent all Mandiri activities or only those within the private sector? There are several alternatives to reduce this problem. One is to limit the use of the Blue Circle logo to full mandiri. A second is to develop a second logo for all of KB-Mandiri which can be used to help clarify the meaning of mandiri. One potential logo is suggested below.

PRIVATE PRACTICE: DOCTORS AND MIDWIVES:

BKKBN has put considerable efforts and resources into increasing the utilization of private clinics, doctors, and midwives areas with the expectation that in urban areas, private practice will account for a substantial proportion of all contraceptive services provided. While similar efforts are underway to promote private practice in rural areas, there remain substantial constraints to this, since virtually all doctors and most midwives are located in urban areas and almost none are available in rural areas of the country.

To overcome this lack of practitioners in rural areas, several innovative models have been tried. The most extensive to date has been in Lampung, where midwives were trained and subsidized to open private practices. Initially begun in peri-urban areas, this has been expanded to rural areas as well, where they are encouraged to travel out to villages to provide services either on a fee for service basis, or through payment received on a per capita basis. In some cases this is arranged through the family planning village distributor, who get a referral fee. One of the important mechanisms being tested in this intervention is the linkage between the family planning field workers and the private practitioners, which has posed a problem in the past.

While this model of the private practitioner is likely to remain the centerpiece of the KB-Mandiri program, there remain several issues to be resolved before expansion into the rural areas can be realized.

One issue is that in many areas, doctors provide most of the private services, however, cost and poor access to doctors services puts them out of the reach of many who need contraceptive services. In addition, doctors are reluctant to add contraceptive services to their practice unless provided with an incentive such as free contraceptive products, due to the limited profitability of these services. Bidans, on the other hand have been very enthusiastic about the program, but are often hampered in their efforts by legal and administrative regulations which favor doctors. The participation of the bidans in the program will have to be increased if private services are to be a viable option for many rural people. Incentives for doctors will need to be specified, and administrative and legal barriers to bidan's private practice will have to be eliminated for the expansion of private practice into the rural areas.

A second issue is the relationship between the BKKBN staff and the private practitioners. It has not yet been fully elaborated what the incentive is for referring patients to private practice, nor who clients should be selected for referral to either private or government services. A specific message for the field level workers will need to be developed in order to clarify their role in this program.

COMMERCIAL SALES OF CONTRACEPTIVES

Because of the high cost of providing free contraceptives to the growing numbers of contraceptive users in Indonesia, there has been considerable interest in the commercial sale of contraceptive products to those clients who can afford to pay. Based on the success of the urban blue circle products campaign, contraceptive sales has been urged through village cooperatives, local practitioners (doctors and midwives), and a greater number of commercial outlets, particularly pharmacies. However, as this mechanism has moved out into the rural areas, there will be a number of issues that have been identified.

PRICE: Blue Circle products were initially intended for the B and C socio-economic levels with monthly expenditures of Rps. 100,000 - 300,000. Because this is much higher than that of many rural acceptors, the price of these products is too expensive for a very large segment of the rural population. Yet, results from Bali and Bandung have shown that most people are willing to pay up to Rps. 300-500 for contraceptives without a significant decrease in prevalence. As long as the only alternative to free government products, is Blue Circle, many clients will continue to require the free products. However, if a subsidized low cost product were introduced, perhaps as part of the blue circle line, or by another name, many more people would be willing to pay.

DISTRIBUTION: Commercial distribution of contraceptives in Indonesia, has largely been limited to the major cities. As commercial products are being promoted into the smaller cities and rural areas, mechanisms

for distribution and local sales of commercial products have had to be established. Yet, distributors have been reluctant to distribute products in areas such as Irian where the market is small and the distribution costs are high, and where the normal commercial channels may not be profitable. In addition, wholesale distributors are reluctant to release contraceptive products to very small scale distributors on credit, yet most of these distributors do not have the working capital to buy these products on speculation without some type of guarantee that there will be a market for them in the community. Finally, the commercial distributors promote those products with the highest profit margins, rather than those which are most affordable. Even at the village level, KUD's may not want to sell blue circle products at the existing price structure, and may expect some sort of subsidy to promote these products. It may be needed to consider an alternative distribution system for the smaller cities and rural areas, rather than to rely wholly on the existing commercial channels.

THE ROLE OF COMMUNITY FINANCING

Community financing or income generating projects form the majority of the approaches to KB-Mandiri in rural areas. Yet, there remains considerable confusion about the role of community financing in the KB-Mandiri movement. It is not included in the current monitoring of KB-Mandiri. It is seen as a temporary step to the achievement of full mandiri. For many, it is not really seen as KB-Mandiri. This raises the question of the relationship between these projects and the overall approach to KB-Mandiri. Is community financing simply a temporary approach to achieve full mandiri? Should BKKBN be more direct about the appropriate uses of community?

While this approach offers a convenient mechanism for community participation in the KB-Mandiri movement, it will not, in general, provide a way to pay for the costs of resupply methods of contraception. It also relies heavily on the organizational capacity of the local institution for success, and not all communities are equally advanced in this regard. In addition, this type of program, while initially successful, may have difficulty sustaining interest by the community, with the result that the money is quickly dissipated, and the activities cease. A recent evaluation of the UPPKA program, which has funded very similar activities indicated the very high failure rate due to weak village level management and the difficulty in maintaining interest in this type of activity.

IV. KB-MANDIRI-EXPANSION PHASE
RECOMMENDED STRATEGY

Expansion Phase	
GOAL:	Expansion
STRATEGY:	Specific
OPERATIONS:	Nationwide

Having established the feasibility and potential of KB-Mandiri and developed a number of successful strategies for its implementation, BKKBN now must decide how best to expand the program. This will require a number of key policy decisions before KB-Mandiri expands to become a national movement.

COMPREHENSIVE STRATEGY

To now, KB-Mandiri has been largely developed in the urban areas, and has focused on the Blue Circle program. As this program expands throughout the country, and as rural areas are integrated into the mandiri approach, a single comprehensive strategy which integrates the role of private and public providers, commodities and distribution channels is needed. Thus, the PLKB who is being asked to promote mandiri, while at the same time being pressured to increase users and longer term methods, must have some clear message as to the priority of each and how they should interact. Should a new user with 3 children be asked to use blue circle pills, an IUD, or something else? Should blue circle products be made available through community based distributors? Should commercial distributors be pushed to sell pills in an area where the population density is too small to be profitable? These questions, and others, need to be considered in the light of an overall strategy for the implementation of KB-Mandiri throughout the country, in both urban and rural areas.

Coupled with the need for a comprehensive operational strategy is the need for a single uniform message for the KB-Mandiri program. This should be independent of the Blue Circle marketing campaign, and tell the population what is expected of them, similar to "dua anak cukup." Such a message will help develop the concept of Mandiri independent of "paying for family planning." One possible message is:

"FAMILY PLANNING: YOUR CHOICE-YOUR RESPONSIBILITY"



This or any other message should be thoroughly field tested to ensure its understanding and validity to the population.

MARKET SEGMENTATION WITH TARGETED MESSAGES

The key to the marketing approach of KB-Mandiri is the use of targeted messages to different segments of the population. For those who are able to pay for services, the message has been to use a private provider and Blue Circle products. For those who cannot afford private services, they are encouraged to continue to receive services from the government. In some areas, an additional partial mandiri message has been added. This market segmentation approach should be emphasized, and specific messages developed for each segment of the population. These messages, should, in turn, be linked to specific outputs and specific indicators of success in order to measure the success of the various components of the marketing approach. Recommendations for potential messages are presented in figure 1.

FIGURE 1: TARGETED MESSAGES: KB-MANDIRI			
TARGET AUDIENCE	TARGET ACTION	MESSAGE	INDICATOR
YOUTH	NKKBS	NKKBS	attitude new acceptors
NON-USERS FP	use FP	dua anak cukup use FP	prevalence new acceptors
USERS FP - UNABLE TO PAY FULL MANDIRI	MKET acceptor group	MKET; your choice- your responsibility	MKET attitude
USERS FP - ABLE TO PAY FULL MANDIRI	DBS LIBI	use DBS LIBI	sales figures service stat.

PRIVATE PRACTICE: DOCTORS AND MIDWIVES

Private practice will unquestionably become the single biggest component in the KB-Mandiri movement, and it is likely that at some time in the future, more clients will use private than government practice. Nevertheless, for the near future, the role of private doctors and midwives will be secondary to that of government service, and will need specific incentives to increase the private participation. For doctors, the incentives may be financial, including increased profitability from sale of Blue Circle products. For midwives, the encouragement will come from reducing the administrative and legal barriers for private practice. For both, a more specific mechanism for referral of clients from the community field workers will be needed. This, in turn, will require specific instructions for PLKB and PPKBD on referral policies and methods.

COMMERCIAL SALES

The successful Blue Circle campaign has indicated the potential to sell contraceptives through commercial outlets at competitive prices. Yet, because their price still remains high for at least half of all Indonesian, a lower priced alternative is suggested as a way to increase the participation of Mandiri and recover some of the cost of providing contraceptive products. While an additional product would certainly reduce the commercial sales of the Blue Circle products, in a country as large as Indonesia, there would certainly be a viable market for both. Nevertheless, the timing and implications of such a venture would need to be considered. Would BKKBN contraceptives be sold, or would there need to be yet another type of contraceptive introduced into the market. If BKKBN products are to be sold (as it appears likely they are already being done), what would be the incentive for buying these products? Perhaps, some program such as being tested in North Sulawesi could be tried, where villages are provided either free or commercial products, but not both.

COMMUNITY FINANCING

While community financing is perhaps the most common model of KB-Mandiri at the village level, its role remains somewhat unclear. It is a good mechanism to internalize the demand for contraceptives through a change in client's attitudes toward family planning, but does little to reduce the recurrent operating expense of the family planning program in the short run since the funds which are raised do not go back to the government nor pay for services which would otherwise have to be funded through government sources. On the other hand, in the long run, it may help to reduce program operating costs by encouraging use of more effective, longer term methods, and by reducing the reliance of clients on community based distributors.

On the other hand, community financing can provide an excellent mechanism for increasing the use of longer term methods. If funds collected through this mechanism are used for the payment of longer term methods, particularly IUD's and sterilizations, many communities can achieve full mandiri for their long term method users. Since these methods require a large, one time only cost, community financing provides an ideal way to help village people pay the cost of these methods on an installment basis. It may also be effective in the financing of injectables, since the popularity of these methods together with the limited supply in some areas has already caused a significant number of users to pay for this method. Community financing may offer a convenient way to cross subsidize from some users willing to pay as much as Rps. 3500 (in Kalimantan Tengah and Sumatera Utara) to others who can afford only a limited contribution.

Given these findings, the following recommendations are made:

- BKKBN provide provinces with a clear picture of the role of village financing in the overall KB-Mandiri and some direction whether it is seen as only a temporary state or a more positive goal.

- BKKBN Headquarters continue providing positive guidance to provinces while at the same time continuing to allow experimentation and diversity in the approach that Provinces take to village financing.
- BKKBN limit the uses of funds collected through this mechanism to priority items such as payment for longer term methods or cross subsidization on injectables. It should also be specified what type of fee structure is acceptable, so that enthusiastic acceptor groups do not set fees which are too high.

THE RELATIONSHIP BETWEEN MKET AND MANDIRI

Some methods, e.g. pills and condoms, lend themselves easily to commercial sales, since the outlays at any one time are small, and there is a need for constant resupply and, hence, a potential steady cash flow for the distributor. At the other end of the spectrum, sterilization requires a one time only large cash outlay with no prospect from future revenues. Between these two extremes lies injectables, the IUD, and implants, which are not appropriate for sale through community based distributors. Yet, it is precisely these longer term methods which are the most effective and, in general, most cost effective in the long run. Thus, any program which encourages resupply methods rather than longer term methods may actually increase rather than decrease costs in the long run.

Yet, many of the approaches to partial Mandiri have been focused on the resupply methods. Community based sales, use of KUD for distribution, and the sales of commodities at commercial outlets all are most profitable when resupply methods are used. The dilemma is that the need for a large one time outlay and professional services for the longer term methods does not lend itself to small scale, community based distribution. Village based family planning workers who are being asked to support KB-Mandiri while at the same time asked to promote MKET are unclear about how to support the two simultaneously. What is needed is a clear message for this level of worker about what message to promote. A possible approach is a strategy which promotes resupply methods for those who wish to pay and longer term methods for those who do not wish to pay. However, this must be considered in the context of offering the widest choice to all contraceptive users.

THE ROLE OF NGO'S

The NGO's have traditionally played an important in the development of the family planning program. They have provided innovative models of service delivery, and have augmented the program with services or products not suited to the government delivery system. As the KB-Mandiri program moves from its introductory phase to an expansion phase, the role of NGO's will be enhanced. While the government program turns its attention from innovation to implementation, new innovative approaches will continue to be needed for the program to develop further. Much of this innovation will come from the NGO's with a long history of innovation and pilot activities in support of the government program.

V. CONCLUSION

The delicate balance between promoting revenue enhancement and program expansion can only be achieved within the context of a long term perspective. The goal of sustainability in the Indonesian context is not an unsubsidized family planning program; rather it is to contain government subsidy requirements at sustainable levels in order to achieve zero population growth by the year 2050. Despite an extremely effective family planning program, Indonesia's population of 180 million continues to grow at a rate estimated at 1.9%. Yet, the financial implications of continuing to provide free contraceptives to the growing numbers of contraceptive users in Indonesia is staggering, and simply not feasible, given projected government revenues and cutbacks in donor funding. The program must continue to offer high quality, free contraceptives to all who demand it, in order to meet the needs of the growing number of family planning acceptors, and reach the more remote and difficult to serve populations who still do not use contraception. Yet, those who are able to pay for services must be convinced to do so. It is expected that through the introduction of KB-Mandiri, this can be achieved through a gradual shift of responsibility for contraceptive use to the individual client, and away from the government structure. The long term effect will be a more sustainable program based on widespread individual and community support.

The hallmark of the Indonesian Family Planning Program has been the sophistication and complexity of its approach to the development of its family planning program. A large part of its success has been due to its flexibility, and willingness to try innovative new approaches to implementation of its program in the field to test appropriate models under realistic field conditions. Through this type of approach, BKKBN has shown that KB-Mandiri can succeed. Despite early skepticism of the ability to transform a successful government program into a private-sector public-sector partnership, successful pilot programs such as that in Bali have demonstrated the ability to integrate private doctors and midwives into the government family planning program, and sell unsubsidized contraceptives to a wide market. Because of its very success, BKKBN now faces one of its greatest challenges to date: the expansion and institutionalization of its KB-Mandiri pilot projects into a comprehensive national program.