

PD-ABN-351
91775

FINAL EVALUATION
PRIVATE SECTOR FAMILY PLANNING PROJECT
INDONESIA

Project No. 497-0355

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U.S. Agency for International Development
Jakarta, Indonesia

May 1996

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ACRONYMS AND ABBREVIATIONS

AID/W	U.S. Agency for International Development/Washington
AVSC	Access to Voluntary and Safe Contraception
Bidan	Trained midwife
Bidan di desa	Village midwife
BKKBN	Indonesian National Family Planning Coordinating Board
CBD	Community-based distribution
CPR	Contraceptive prevalence rate
CSM	Contraceptive social marketing
CYP	Couple years of contraceptive protection
DepKes or MOH	Department of Health (Ministry of Health)
FY	Fiscal year
GOI	Government of Indonesia
IBI	Indonesian Midwives Association
IDHS	Indonesian Demographic and Health Survey
IDI	Indonesian Medical Association
IEC	Information, education and communication
IFY	Indonesian fiscal year (April 1-March 31)
ISFI	Indonesian Pharmacists Association
IUD	Intra-uterine device
JPKM	Guaranteed Community Health Services - guiding principles for Indonesian managed care health insurance programs
KB Mandiri	Self-sufficient family planning
MIS	Management information system
NGO	Non-governmental organization
NORPLANT	Contraceptive implant for women (trademark)
NU	Nahdlatul Ulama, Indonesian Islamic organization
PIL	Project implementation letter
PKBI	Indonesian Family Planning Association
PKMI	Indonesian Society for Secure Contraception
POGI	Indonesian Association of Obstetricians and Gynecologists
PosYanDu	Village post for integrated health services
PSFP	Private Sector Family Planning project (USAID)
PSG	Project Support Group
P.T. Mecosin	Private Indonesian marketing management firm contracted for the Blue Circle contraceptive marketing; company now called P.T. Unggul Wirya Adicitra (UWA)
PusKesMas	Sub-district health center
Rp.	Rupiah (Indonesian currency)
SDES	Service Delivery Expansion Support Project (USAID)
SOMARC	Social Marketing for Change project (AID/W)
TFG	The Futures Group
URC	University Research Corporation
USAID	U.S. Agency for International Development Mission in Jakarta
VFP	Village family planning program

VS
YKB

Voluntary sterilization
Yayasan Kusuma Buana, private Indonesian family planning foundation

ACKNOWLEDGEMENTS

The members of the evaluation team are humbled by the task of preparing in just three weeks a final evaluation of a six year project under which so many people have worked long and hard to implement a wide range of important activities to further family planning in Indonesia. We hope we have accurately summarized the accomplishments and identified the major problems encountered in implementing this project.

We wish to give special thanks to the following persons who have helped us carry out this evaluation:

- * the staff of USAID/Jakarta's Office of Human and Institutional Resources Development, especially Joseph Carney, Leslie Curtin and Pak Bambang Samekto;
- * Jack Reynolds of the Project Support Group for his five year perspective of the project, providing materials and answering our many questions about project operations; and some of the former long-term technical advisors to the project who are still in Jakarta; and
- * the staff of BKKBN at headquarters and provincial level for giving us their insights and perspectives during their own three day internal evaluation of the project.

EXECUTIVE SUMMARY

The Private Sector Family Planning project (PSFP) was designed as a five year project (1989-1994) to support efforts of the Indonesian national family planning program to become more self-sufficient and reduce fertility. It was extended later to six and a half years at no additional cost. The total project budget was \$28,553,300, of which USAID provided a grant of \$20,000,000. The host country contribution of \$8,553,000 (rupiah equivalent) was split between the government (\$7,188,600) and the Indonesian private sector (\$1,364,400). The host country contribution is now \$9.14 million.

USAID planned this project to be its final bilateral support for the Indonesian national family planning program. USAID assistance began in 1968 and has totaled over \$300 million for technical assistance, training, contraceptives and funds for local support for every aspect of population and family planning policy and program development.

The Indonesian National Family Planning Coordinating Board (BKKBN) was established in 1970 to coordinate family planning (FP) activities and develop a plan to extend services throughout the country. In a phased introduction beginning with Java and Bali and expanding to the other islands, the national family planning program utilized the Ministry of Health for clinical services and developed its own staff of field workers to promote village family planning acceptors groups and identify village volunteers to distribute non-clinical contraceptives. Starting in 1970 with contraceptive prevalence less than 5 percent of eligible couples, the program has achieved remarkable success over the past 25 years. Data from the 1994 Indonesian Demographic and Health Survey (IDHS) show that nearly 55 percent of eligible couples now use some form of contraception, almost all modern methods. A strong family planning infrastructure has been established at all levels of government, national, provincial, district, sub-district and village. The national program is largely funded by the Indonesian government, with major donor support from USAID and AID/W, World Bank and UNFPA.

Over the past decade and with strong encouragement and support from USAID, the BKKBN has increasingly promoted the use of private sector providers to reduce the burden on the government's budget and has promoted the concept of KB Mandiri (self-reliance) which in practice means paying for family planning services. In less than ten years, private sector providers have increased their share of the market from about 12 percent in 1987 to over 28 percent in 1994.

The goal of the Private Sector Family Planning project (PSFP) project was to assist public and private sector actions leading to a self-sustaining system for reducing fertility from 3.4 children per women of reproductive age in 1987 to 3.0 in 1994 and 2.4 by the year 2000. The purpose of the project was to expand the availability, quality, sustainability and use of private sector family planning service in Indonesia.

To achieve the project goal and purpose, the **anticipated 1994 end of project status indicators (EOPS)**, compared to the 1987 baseline figures, included:

- increase contraceptive prevalence from 48 to 53 percent;
- increase the percentage of couples using private sector doctors, midwives and pharmacists as the source of family planning services from 12 to 20 percent;
- increase the percentage of couples **paying** for family planning services from 23 to 50 percent in urban areas and to 40 percent in rural areas;
- increase nationally the percentage of couples paying all or part of the costs of family planning services from 36 to 45 percent.

USAID funding for the project was split between a contract with University Research Corporation (URC) (\$9,400,000) and a grant to the BKKBN for local support of the four project components (\$9,853,000). An additional \$350,000 was used for the 1994 Indonesian Demographic and Health Survey (IDHS) and \$447,000 was utilized by USAID for evaluations, audits and project management costs. Host country funding included BKKBN budget support for each project component and in-kind contributions for general project support, mainly office space; the Indonesian private sector contributed to a return-to-project fund based on sales of Blue Circle contraceptives and some marketing costs. The budget table below highlights the project funding.

**PRIVATE SECTOR FAMILY PLANNING PROJECT
BUDGET SUMMARY (U.S. \$ 000)**

<u>Project Activity</u>	<u>USAID</u>	<u>Host country</u>	<u>Total</u>
Project Contractor	9,400	250	9,650
Blue Circle campaign	475	660	1,135
Community-based distribution	3,339	2,842	6,181
Private Sector Delivery	2,161	1,146	3,307
Long-term Methods Use	3,878	3,605	7,483
Contraceptive Prevalence Survey	300	50	350
USAID evaluation, audit and project management costs	447	0	447
TOTAL	20,000	8,553	28,553

The contract with URC provided funds for a team leader, six long-term technical advisors, short-term technical specialists, a Project Support Group (PSG) to manage the project, procurement of computers and medical equipment, and a sub-contract with The Futures Group (TFG) to support the Blue Circle campaign. Funds for local costs of the four project components were divided between the USAID grant to the BKKBN and host country contributions. Host country contributions included funds from a return-to-project fund established under the social marketing

program by which each of the four Blue Circle contraceptive producers contributed 2-4 percent of gross sales for increased advertising. This fund amounted to 16 percent of host country funding for the project. Each of the four project components was implemented by the relevant bureau within BKKBN.

Overall, the project has been successful. The contractor provided an excellent team of long-term advisors who collaborated well with their BKKBN counterparts, with USAID staff and with staff of the many Cooperating Agencies (CAs) working in Indonesia. The accomplishments of the project have been significant and can best be described by showing the major planned targets and the realized results for each of the four project components.

A. Private Sector Delivery

Activities under this component were managed by BKKBN's Bureau of Integrated Program Services and implemented through grants to the national associations of doctors, midwives and pharmacists. To promote greater use of private sector service providers, the project planned to train 2,500 doctors, 2,500 mid-wives, and 2,000 pharmacists in family planning. The numbers actually trained were 1,682 doctors, 5,428 midwives, and 2,000 pharmacists.

The number of midwives trained was nearly double the planned amount. Midwives were anxious to receive the training and put the training to good use. The 1994 IDHS showed that midwives are by far the most popular private sector source of family planning services for Indonesian couples, serving nearly 58 percent of private sector clients.

Training of doctors was terminated. It was hard to find doctors willing to devote time to the training and it became apparent that general practitioners were not a popular private sector source for delivering family planning services. Similarly, pharmacists proved to be a minor source for providing family planning information and services. Training materials have been developed, tested and are in use.

The Indonesian Medical Association (IDI) has developed several model clinics to demonstrate that comprehensive health clinics under JPKM will increase significantly the private sector provision of unsubsidized FP services and do it in a sustainable manner after JPKM has been established beyond the demonstration phase. The Indonesian Midwives Association (IBI) depends largely upon volunteers to manage its headquarters, as well as provincial and district branches. Even with staffing limitations, IBI was able to implement a highly successful training program with project technical assistance (TA). The IBI could use more assistance in strengthening its national headquarters operations and thus provide more services to the branches. Continuing support is needed for IBI branches as well, since they are responsible for most midwife training.

The major lesson learned is that midwives already play a key role in providing family planning services through the private sector; they are enthusiastic to receive better training; and their role will likely increase in the future.

B. Community-Based Distribution of Contraceptives

Activities under this component were concentrated in the eight most populous provinces and were managed by BKKBN's Bureau of Community Institutional Development.

The major activity involved the training of 286,608 BKKBN fieldworkers, volunteers and community leaders over a three year period. Fieldworkers and volunteers were trained to distribute non-clinical contraceptives for a small fee, refer clients to private providers, promote the use of long-term contraceptive methods (LTM) and set up community contraceptive funds to help families not able to afford contraceptives. Community leaders were oriented to the importance of couples having the opportunity of becoming self-reliant in matters of family planning (KB Mandiri).

Surveys of the outcomes of this component prompted the PSFP project staff to categorize CBD and social marketing as one of the most successful project interventions. There has been a remarkable change in attitude among field worker and rural family planning acceptors away from the previous idea of free services to a willingness to pay. The concept of KB Mandiri is fairly well known as is the Blue Circle logo (although often confused with the BKKBN's "two children are enough" slogan). Forty percent of survey respondents had visited a private provider; however, only 31 percent actually used the private provider for FP services. Each province developed a distribution system to provide commercial contraceptives to rural communities.

The PSFP project utilized practical operations research studies to monitor progress and identify problems. Many studies dealt with problems faced by the new village midwives (bidan di desa), the group projected to become the lynch pin of a successful rural KB Mandiri effort in the future.

Three issues concern future sustainability of CBD. First is the fragile and not especially profitable private sector contraceptive distribution system in rural areas. Second, bidan di desa will need continuing refresher training to assist them in persuasion skills and managing their small businesses. Third, there may be an economic incentive problem because CBD workers have more to gain financially by promoting short-term methods rather than long-term contraceptive methods.

The major lesson learned is that a significant number of rural couples are willing to pay fully or partially for quality contraceptive products. Secondly, the BKKBN has demonstrated that it can organize and implement massive training programs with only limited donor technical inputs.

C. Social Marketing - Blue Circle Campaign

In terms of national and international recognition, this component is the flagship of the PSFP project. Managing this complex set of interventions involved USAID, BKKBN, the PSFP project contractor and sub-contractor, a management sub-contractor, four large pharmaceutical companies and their distributors. Efforts to reach urban middle and lower income customers for contraceptive sales included market research, strategic planning, mass media advertising, public relations, and establishing credit systems for providers.

Blue Circle (BC) activities were managed by The Futures Group and their Indonesian partner, P.T. Mecosin, whose name was changed later to P.T. Unggul Wiryadicitra (UWA). Under the PSFP project, this component was under the direction of BKKBN's Bureau of Information and Motivation (BIPEN).

BKKBN and USAID initiated a social marketing program in the mid-1980s, beginning with the Dua Lima condom. The BC campaign began a few years later, first with a mass advertising campaign to identify the BC logo with private providers. The next step was to introduce specific BC contraceptives, a pill, IUD, injectable and condom. Under the PSFP project, the BC program was planned for three years and later extended an additional six months.

Results were remarkable. The 1994 IDHS showed that 28 percent of eligible couples were using the private sector for their contraceptive needs, compared to only 12 percent in 1987. While the BC contraceptives were mainly distributed in urban areas, mass media advertising reached nation-wide, facilitating efforts of CBD workers to penetrate the rural private sector. The BC campaigns and service providers convinced a majority of survey respondents that BC products were accessible, affordable and high quality.

There are three elements necessary for success and sustainability of contraceptive social marketing: affordable and accessible products; quality providers and quality products; and effective promotion. The Indonesia program had all three components until April 1995 when BC advertising ended as scheduled.

Similar to the CBD component, the major lesson learned is that people are willing to pay for good quality contraceptives. A second lesson is that without mass media promotion, the private sector share of the contraceptives market would not have more than doubled. A third lesson is that what happens in the private sector should be important to BKKBN; for future sustainability and self-reliance, BKKBN needs to consider additional ways of supporting the private sector provision of FP services. In view of the importance of product promotion to the expansion and sustainability of the private sector component, the Mission should discuss the importance of continued support for promotion to the success of both the CBD and commercial sales aspects of the private sector.

D. Long-Term Contraceptive Methods

The overall objective of this component was to increase the use of long-term contraceptive methods (LTM) by improving the quality of clinical services. Under prior projects, USAID funds helped renovate and equip hundreds of clinics for LTM, especially voluntary sterilization (VS), trained doctors, and supported the Indonesian Society for Secure Contraception (PKMI) to promote VS and to establish, introduce and monitor quality control.

Because long-term contraceptive methods (LTM) tend to be more effective, cheaper in the long-run, and provide more couple years of protection per unit, the BKKBN and USAID set two targets for this component:

- Increase the proportion of current users of LTM (IUDs, VS, and implants) from 35 percent in 1987 to 41 percent by 1994; and
- Increase annual VS procedures from 130,000 in IFY 1988/89 to 292,000 annually by IFY 1993/94.

Most of the USAID and BKKBN funds under this component were used for VS. The LTM component was the largest of the four components. BKKBN funds were utilized for reimbursements to hospitals for each VS procedure. This BKKBN subsidy is now about Rp. 5 billion annually (approximately US\$ 2.2 million). The Indonesian Society for Secure Contraception (PKMI) managed VS activities in coordination with BKKBN's Bureau for Contraceptive Services (BISEP). IUD and implant training for private sector general practitioners was implemented by the Indonesian Medical Association (IDI) in coordination with BKKBN's Bureau of Integrated Program Services (BINSI) under the Private Sector Delivery project component.

Component targets fell short of planned levels. Use of LTMs increased only marginally to 36.5 percent in 1994. The number of VS procedures has declined steadily each year since 1989. The use of IUDs has also fallen from 13.2 percent of eligible couples in 1987 to 10.3 percent in 1994. Only increased use of contraceptive implants kept the percentage of LTMs from declining.

The number of VS procedures reached a high point of 154,294 in IFY 1989/90 and has fallen each year since to only 103,026 procedures in IFY 1994/95. Tubectomies accounted for 72 percent of all VS procedures in IFY 1989/90; by IFY 1994/95 they represented 84 percent. Causes of the rapid decline in VS are numerous: prohibition by the government of mass media promotion, the continuing ambiguous family planning status of VS (a medical procedure, not a family planning program method), opposition from Islamic leaders because of its permanent nature, and competition from IUDs and implants which provide women with long-term protection without an operation. According to the 1994 IDHS, VS remains the least known family planning method.

Part of the decline in both VS and IUD use may be due to the vigorous promotion by BKKBN of the contraceptive implant and its acceptance by increasing numbers of women. Implants represented only 5 percent of eligible couples according to the 1994 IDHS, up from 3 percent in 1991. BKKBN estimates that implants will reach 1.2 million annually by the end of its current five year plan (IFY 1998/99).

Although VS is still not considered an official family planning program method BKKBN continues to provide a subsidy to public and private providers for each VS procedure, a significant drain on its resources.

USAID and AID/W contractors have supported PKMI for almost two decades, yet it remains completely dependent on donor funds. Little effort was focused for most of that time on financial sustainability; rather, the aim was to help introduce and promote VS. PKMI provides some valuable services, such as training, introducing the latest technology, developing and implementing quality assurance standards for VS, and monitoring VS program performance. Little has been done so far to have the costs of these services assumed by the BKKBN. A sustainability analysis was done in 1994, and showed that PKMI was not self-sustainable. With USAID funding through the SDES project, ending within three years, the issue of PKMI's future role and funding need to be addressed and resolved. A good start was made at a meeting held at PKMI on December 14, 1995.

The major issue regarding sustainability of LTMs is not the role of a particular method, but the mix. According to a proposed revision of its five year plan, BKKBN anticipates slight annual increases in VS and IUDs, and a 300 percent increase in implants. By IFY 1998/99, BKKBN proposes to insert 1.2 million implants compared to 350,000 this year. This creates a huge demand for both insertions and removals of implants and will require a major training effort.

The major lesson learned is that a successful VS program requires publicity and strong government support. Expansion of facilities, provision of equipment, training staff, and development of standards and monitoring capability are not enough. For the most part, VS as a percent of CPR has been declining throughout Asia, markedly so in Bangladesh, the Philippines and Indonesia. In part, this is a result of couples having other long-term choices and in part that more young couples who want to space are entering the system. As more and more low parity couples begin contracepting in Indonesia, VS will decline further as a percent of CPR. USAID should cut its losses on further investment in this area.

I. INTRODUCTION

A. Project Context: Situation in Indonesia

Indonesia now ranks as the fourth most populous country in the world with more than 200,000,000 persons. In the first half of the 21st century Indonesia is likely to pass the United States to become the third most populous nation.

President Soeharto demonstrated concern for the country's rapidly growing population when he signed the 1967 Declaration of Presidents. In 1970 the Indonesian National Family Planning Coordinating Board (BKKBN) was established to coordinate government efforts to promote family planning as part of an effort to create the small, healthy and prosperous family. Interestingly, BKKBN leadership has recently undertaken a new program of family welfare (KS) to promote the healthy and prosperous family to stimulate greater use of family planning.

The U.S. Agency for International Development mission in Jakarta (USAID) has provided over \$300 million in technical and financial support to the Indonesian national family planning program since 1968.

During the past 25 years, millions of couples have received information and the contraceptives needed for them to control their own fertility. The national program has expanded to cover all 27 provinces; more than half of all Indonesian couples now use modern contraceptives; and the birth rate has declined steadily. Some provinces now have birth rates at or below replacement level fertility. The BKKBN and the Indonesian national family planning program are recognized internationally for their achievements.

B. Project Description

The Private Sector Family Planning project (PSFP) was designed as a five year project to support efforts of the Indonesian national family planning program to become more self-sufficient and reduce fertility. The project originally was to cover fiscal years 1989-1994 (later extended to December 31, 1995) with a total estimated budget of \$28,553,300 of which USAID committed \$20,000,000. Indonesian public and private sources were committed to provide the equivalent of \$8,553,000 through cash or in-kind contributions. BKKBN provided over 84 percent of the host country contribution with costs of project-related organizational operations and support for international trainees with Indonesian pharmaceutical companies providing about 16 percent through a return-to-project fund based on sales of Blue Circle contraceptives. USAID planned this project to be its final bilateral support for the Indonesian national family planning program.

USAID project funding was divided into two roughly equal parts. The first part was a direct grant of \$9,853,000 to BKKBN for its local project costs, Blue Circle promotion and indirect grants to four professional Indonesian organizations: Indonesian Medical Association (IDI), Indonesian Midwives Association (IBI), Indonesian Pharmacists Association (ISFI), and the Indonesian Society for Secure Contraception (PKMI). The grants were designed to strengthen the organizational capacity of each organization to promote increased family planning services through the private sector providers. The main project activities of each organization were training of FP providers, development of training materials and monitoring.

The second part was a \$9,400,000 contract awarded after competition to University Research Corporation (URC) and its sub-contractor, The Futures Group (TFG). URC/TFG provided seven long-term technical advisors: a team leader who served as head of the Project Support Group (PSG), two technical advisors for social marketing, two for CBD and one each for the other two components. They and six administrative support staff, constituted the PSG. Through the PSG, URC/TFG also provided short-term experts to all four components and administrative and technical assistance to BKKBN, IDI, IBI, PKMI and P.T. Mecosin/UWA. The contract also funded the Blue Circle Products Campaign, managed by Mecosin/UWA, with technical assistance from TFG.

Additional funds were utilized for the 1994 IDHS (\$300,000) and USAID evaluation, audit and program management costs (\$447,000).

Organizationally, the PSFP project was under the direction of the BKKBN with the PSG located in BKKBN's Bureau of Planning. USAID funds allocated to BKKBN for project activities were managed by the specific bureau with responsibility for that portion of the project:

- Private Sector Delivery - Bureau of Integrated Program Services (BINSI);
- Community-Based Delivery - Bureau of Community Institution Development (BIPIM);
- Social Marketing (Blue Circle Campaign) - Bureau of Information and Motivation (BIPEN); and
- Long-Term Contraceptive Methods - Bureau for Contraceptive Services (BISEP).

Project activities were concentrated in the eight most populous provinces of Indonesia: West Java, Central Java, East Java, Bali, North Sumatra, South Sumatra, Lampung and South Sulawesi. However, the Blue Circle campaign covered 41 large and middle-sized cities throughout the country. With pressure from BKKBN to expand to over 300 cities, Blue Circle promotion reached many rural areas as well, even though products were not always available. Promotion of LTMs, especially VS, was similarly national in scope.

C. Project Goal, Purpose and End of Project Status Indicators

The **goal** of the project was to assist public and private sector actions leading to a self-sustaining system for reducing fertility from 3.4 to 3.0 by 1994 and 2.4 by the year 2000.

The **project purpose** was to expand the availability, quality, sustainability and use of private sector family planning service in Indonesia.

The overall **end of project status indicator (EOPS)** was an increase in contraceptive prevalence from 48 percent in 1987 to 53 percent in 1994. Other broad EOPS include increasing the percentage of eligible couples using private doctors, midwives and pharmacies stores as their source of FP services from 12 percent in 1987 to 20 percent nationally by 1994. The percentage of couples paying for family planning services and supplies from the private sector was to increase from 23 percent in 1987 to 50 percent in 1994 for urban couples and 40 percent for rural couples. The proportion of eligible couples nationally paying all or part of the cost of family planning services and supplies was expected to increase from 36 percent in 1987 to 45 percent in 1994.

The EOPS for the major project components include the following:

1. Blue Circle Campaign

- Increase couple years of contraceptive protection (CYP) by private commercial sales from 1.3 million in 1988 to over 3.0 million by the end of 1994.

2. Community Based Distribution

- Decrease in current users obtaining fully subsidized family planning services in rural areas from 71 percent in 1987 to 60 percent by the end of 1994.

3. Private Sector Delivery and Professional Organizations Development

- Training in modern family planning methods and providing technical contraceptive manuals by the end of 1994 for:
 - 2,500 private doctors
 - 2,500 private midwives
 - 2,000 private pharmacists

4. Longer Term Methods (Improved Clinical Services)

- Increase in the proportion of current users of long term contraceptive methods (voluntary sterilization, IUD and implants) from 35 percent in 1987 to 41 percent by end of 1994; and

- Increase in voluntary sterilization procedures from 130,000 in IFY 1988/89 to an estimated 292,000 in IFY 1993/94.

II. EVALUATION DESIGN

A. Purpose of the Evaluation

This is the final evaluation of the Private Sector Family Planning Project. The purpose of the evaluation is to highlight the major accomplishments of the project, identify family planning program strengths and weaknesses, and make suggestions for incorporating some program activities into the Service Delivery and Expansion Support Project (SDES) project which is implemented by the Pathfinder Fund and BKKBN with USAID funds. A detailed mid-term evaluation was completed just two years ago; this brief evaluation draws upon that evaluation and does not attempt to provide the level of detail contained in that report. The excellent reporting system developed by the PSG provides a wealth of information for the interested reader or student, as do the many operations and other research studies sponsored by the PSG.

B. Evaluation Team

The evaluation team consisted of two persons. Charles Johnson, MA, MPH, served as team leader. He is a retired AID population and health officer with extensive experience in project design, evaluation and management and specifically with the Indonesian national family planning program. Keys MacManus, JD, MPH, is also a retired senior USAID executive with long experience in managing family planning and national development programs.

C. Evaluation Methodology

The evaluation was carried out in Indonesia. Mr. Johnson was in Indonesia from November 28 to December 23, 1995; Ms MacManus from December 2 to 14, 1995. The principal methodologies utilized for this evaluation included a comprehensive document review, interviews with individuals and groups, and participation in a three day evaluation review of the PSFP project conducted by the BKKBN which included BKKBN representatives from all 27 provinces and most headquarters bureaus, Indonesian professional organizations and non-governmental organizations (NGOs), and members of the Project Support Group. Due to time restraints, team members were not able to visit project sites in the provinces.

See Annex 3 for a list of the documents reviewed and Annex 4 for a list of persons interviewed.

III. FINDINGS

The Indonesian national family planning program has continued to expand to provide information and services to an ever increasing number of women and men. Some overall goals have been reached or exceeded, based on information in the 1994 Indonesian Demographic and Health Survey (IDHS). The total fertility rate fell to 2.86 children per average woman by 1994 compared to a goal of 3.00. The contraceptive prevalence rate (CPR) rose to 54.7 percent of eligible couples by 1994 compared to a goal of 53 percent. The more specific targets and achievements are included in the sub-sections below.

The major quantitative goals and achievements of the project are summarized in the table below.

<u>MEASUREMENT</u>	<u>TARGET BY 1994</u>	<u>ACHIEVEMENT</u>
Total Fertility Rate	3.00	2.86
Contraceptive Prevalence Rate	53 %	54.7 %
Long-term Method Users	41 %	36.5 %
Voluntary Sterilizations per year	292,000	103,026
Acceptors Utilizing the Private Sector	20 %	28.1 %
Urban Acceptors Fully Paying for FP through the Private Sector	50 %	NA
Rural Acceptors Fully or Partially Paying for FP through the Private Sector	40 %	43 %
Commercial Sales of Contraceptives by Couple Years of Protection (CYP)	3,000,000	3,000,000+
Midwives Trained in Family Planning	2,500	5,428
Doctors Trained in Family Planning	2,500	1,682
Pharmacists Trained in Family Planning	2,000	2,000

A. Private Sector Delivery

1. Inputs and Outputs

The project paper (PP) allocated \$5,250,000 from USAID and \$1,196,000 from host country sources to promote and expand the delivery of family planning services through the private sector and to strengthen the capacity of three professional associations to promote the private sector delivery of family planning services. After revisions and in addition to the long-term and short-term TA provided by the contractor, USAID made a grant to BKKBN of \$2,161,000 for training, IEC materials, commodities and local program costs. The BKKBN and the three professional organizations provided the rupiah equivalent of \$1,146,000 for office space and staff, support of international trainees, and indirect costs of the professional organizations.

The main activity under this component was training of doctors, midwives and pharmacists in family planning in an effort to increase the number and quality of family planning providers offering services through the private sector. Specific activities included training of trainers, development of training materials, and support for training classes. In addition, the project provided technical assistance and financial support to IDI and IBI to strengthen their capabilities to promote family planning through the private sector.

2. Component Achievements

The training targets have substantially been met, with the exception of doctor training in IUD and implant insertion and removal. Specific training results are as follows:

<u>Category</u>	<u>Training Target</u>	<u>Number Trained</u>
Doctors	2,500	1,682
Midwives	2,500	5,428
Pharmacists	2,000	2,000

Training of doctors was wisely terminated when it became apparent that many general practitioners were not interested in the training and provided little FP in their practices. Research studies demonstrated that woman much preferred to visit a midwife for an IUD or implant insertion or removal; if a woman preferred to see a doctor, it would more likely be an obstetrics/gynecological (OB/GYN) specialist rather than a general practitioner.

The project met the target for training pharmacists, but later experience indicated they play a minor role in promoting FP. Many of those trained did not own or work in pharmacies and few of those who worked in pharmacies had direct contact with customers. Training should have been focused on assistant pharmacists who are the real pharmacy managers and order supplies, including contraceptives and counsel customers.

Thus, the emphasis of this component shifted to midwives. With courses developed with project TA and implemented by members of IBI, the number of midwives trained in FP was nearly twice the project target. The aim of the midwife training was to increase the number of midwives offering FP in the private sector; however, most of those trained already had established private practices. Among midwives, enthusiasm for the FP training was high. The project technical advisor reported that often midwives would split their small per diems so additional persons could attend the training courses.

Results of the 1994 IDHS indicate the importance of midwives in providing FP services in the private sector; they are the leading providers serving nearly 58 percent of private sector clients. Doctors are a distant second, serving 18 percent and hospitals 11 percent. Family planning clinics, pharmacies and other sources provide the remaining 14 percent of the market. Midwives are the leading private sector providers of oral contraceptives, IUDs, injections and implants. Pharmacies provide most of the condoms sold while private hospitals account for most VS

procedures. Between 1991 and 1994, private sector midwives increased their share of the market by 60 percent; doctors less than 6 percent. In this largely Moslem society, women much prefer to consult with midwives rather than doctors (mostly men). The PSG, USAID and BKKBN staff wisely shifted funds to enable more midwives to be trained in FP.

With project TA and financial support, IDI and IBI were able to develop good training manuals, train trainers, and carry out the training programs. IBI staff developed a system of peer review, using trained midwives to review the techniques used and the care provided by other midwives; provide feedback to the midwives; and use results of the peer reviews to refine continuing education to help midwives overcome the deficiencies noted. Through TA and financial support, some institutional strengthening was achieved, although both IDI and IBI are run by volunteers with small headquarters staffs and limited capability. Both lack professional management. But even with limited staff, IBI has managed its project grant well. Moreover, IBI is the only professional organization available to tackle the sustainability issue with practical measures.

With PSFP project support and external TA, IDI has opened several model clinics which are designed to demonstrate that comprehensive health clinics under JPKM will significantly increase the private sector provision of FP services and will do so in a manner that is sustainable. With PSFP TA, IDI staff prepared a series of three manuals and computer programs for use in the IDI model clinics. The manuals serve as guides for development of administrative systems, information systems and quality control of services. Similarly, IBI staff, with TA, developed manuals for use in training midwives in FP and conducting peer review to increase the quality of services provided by midwives, especially the younger, less experienced midwives.

3. Critical Issues Related to Sustainability of Activity

Two recent policies of the MOH hinder provision of FP services by placing important limitations on the authority of private sector midwives. One regulation allows those midwives to insert IUDs only under supervision of a doctor while the other allows removal of a contraceptive implant only after prior screening by a doctor. There remain questions about what type of doctor is required and what constitutes supervision or prior screening. Until these issues are resolved, the role of private midwives in promoting family planning is under a cloud. We understand that the implant policy has been changed; the problem now is getting the change operationalized.

There is a need to provide additional support to strengthen IBI headquarters staff capability as well as to strengthen its provincial and district chapters where most midwife training is carried out. USAID has secured limited technical assistance and institutional support for IBI through the MotherCare project, but far less than is needed in order to implement IBI's five year development plan.

There is still a need to institutionalize FP training for private sector providers. Most training is still donor funded, much of it by USAID. Under the PSFP project, national training needs assessments were completed for IDI and IBI. There needs to be continuing efforts made to

include adequate training budgets within the MOH and BKKBN or develop a mechanism whereby private sector providers can pay for training.

The Ministry of Health (MOH) is moving rapidly to privatize the delivery of health services in Indonesia. If successful, this could have profound consequences for future financing of family planning services in the not too distant future. Formerly all newly graduated doctors were employed by the MOH upon completion of 2-3 years of service at provincial or district hospitals or at sub-district health centers. Now only 10-15 percent of these young doctors are employed by the MOH; the others must find private employment. A system of managed care health services is rapidly developing under the general guidance of a managed care concept known as Guaranteed Community Health Services (JPKM). A recent health law established the managed care concept (JPKM) and a second law has established a mandated minimum benefits package which includes all family planning services. As the number of managed care health service providers are established, employment opportunities for doctors should rise quickly. And as more workers and dependents are enrolled, the costs of providing FP services will shift from government to the managed care organizations.

4. Lessons Learned

Midwives play a much more important role in providing FP information and services through the private sector than any other providers.

General practitioners are unlikely to be important provider of FP services through the private sector, at least until private managed care clinics become an important source of health services to a large sector of the population. Even then, the doctor may employ or go in partnership with a midwife to provide family planning services. General practitioners are important FP providers in government health facilities.

Pharmacists play a marginal role in promotion of family planning in the private sector; pharmacists assistants are a more useful group to train since they manage the pharmacies, order supplies and have more customer contact. Contraceptives are a low profit margin item; thus there is little incentive for pharmacies to promote FP.

5. Recommendations for PHN Sector Transition

USAID support and promotion of the expansion of managed care, including FP, is probably the most important contribution it can make to expanding health coverage, improving the quality of health services, reducing the burden of health costs on the government, and opening up new opportunities for employment of doctors and midwives. Increased USAID involvement in health financing is important not only to assist the GOI in its transition from public to private provision of health services but also to serve as a model for other countries which may want to make the same transition.

However, managed care is not likely to provide health services, including FP, for the majority of Indonesians until the next century. Continuing support for IBI to upgrade training materials and standards, train midwives and monitor their contribution to private sector delivery of FP services remains important.

The SDES project may be the appropriate vehicle for USAID support for managed care and assistance to IBI, particularly as the assistance relates to promotion of FP. If USAID extends its current Health Sector Financing project or designs a new financing project, that would then become the proper vehicle for financial and technical assistance for managed care.

Future assistance to IDI should be limited to help IDI set up a unit to manage the development of comprehensive health clinics and a franchising system that will promote the JPKM concepts of managed care materials and speed the transition to greater private sector health and FP service delivery.

B. Community Based Distribution

1. Inputs and Outputs

The PP allocated \$4,014,000 from USAID and \$2,682,000 from host country sources to develop and expand community based distribution of contraceptives. With revisions and in addition to contractor TA and other support, USAID provided \$3,339,000 for the CBD component while host country contributions were estimated at the rupiah equivalent of \$2,842,000.

This large component in eight provinces managed entirely by BKKBN's Community Institutional Development Bureau (BIPIM), involved a massive amount of training of BKKBN fieldworkers, volunteers and community leaders (286,608 out of the planned 296,922) over a three year period. The fieldworkers and volunteers were trained in several interventions, including distribution of non-clinical contraceptives for a small fee, referral to private providers, promotion of long-term methods and setting up community contraceptive funds. Community leaders were oriented to the importance of couples having the opportunity of becoming self-reliant in family planning.

2. Component Achievements

The outcomes of this component were verified by two surveys (1995) which covered the potential beneficiaries in the eight focus provinces. The survey results prompted PSFP to categorize this component, along with social marketing, as the most successful project interventions. In brief, the long standing behavior of field workers, volunteers and rural acceptors of treating contraceptive services as a no cost benefit, has been modified to a remarkable degree. Of the eligible women interviewed during the eight province surveys, more than 40 percent said that they had been referred by a field worker to a private sector provider. Additionally, 30 percent had been offered contraceptives for a small delivery fee by a field

worker or volunteer. More than half accepted this offer and of these, almost two-thirds paid for the service. Only slightly more than 25 percent of respondents said that a contraceptive fund had been established in their community with 85 percent of those interviewed being members of the fund.

Although the results varied widely (from 45 percent in West Java to 91 percent in Bali), the term KB Mandiri (Family Planning Self-Reliance) was known by 72 percent although fully understood by only 15 percent of respondents in the project areas. Although Blue Circle is promoted primarily in 41 cities, 78 percent of those of who had heard of KB Mandiri had also seen the Blue Circle logo. Its meaning was generally confused with the government's well known and long promoted "two children are enough" slogan.

In addition to increased knowledge, CBD served to increase private sector use in rural areas. Four of ten respondents reported visiting a private provider. This ranged from a high of 62 percent in Bali to a low of 30 percent in South Sulawesi. A significant part of this variation may well be the availability of private providers. Overall, 41 percent visited a private provider. Actual use (purchasing contraceptive services/supply from a private provider) was 31 percent. Here the range fell between a high of 38 percent for East Java and 10 percent for South Sulawesi.

In addition to the already noted massive training of fieldworkers, volunteers and community leaders, activities included getting political understanding and commitment in every province and district through a series of meetings. These meetings were completed before CBD training was undertaken. Each province developed supportive IEC materials and operational how-to manuals which were used along with KB Mandiri and Blue Circle materials developed by other family planning groups.

Likewise, each province developed a contraceptive distribution system to provide commercial contraceptives to rural communities. The manual developed for this aspect of CBD can be utilized by the other Indonesian provinces if CBD is expanded nation-wide.

In addition to learning how to refer to private providers, field workers and volunteers were taught how to provide fee-for-services delivery and how to provide supplies to private midwives for a small fee. Field workers and volunteers helped in the establishment of community contraceptive funds for eligible families not able to afford contraceptive services.

Throughout, project staff of the CBD component was kept informed by a series of practical operations research (OR) efforts. Most of these studies dealt with the problems faced by the new village midwife as she is projected to become the lynch pin of a successful rural KB Mandiri effort.

3. Critical Issues Related to Sustainability of Activity

Both USAID and BKKBN have strong policies in favor of self-reliance which are reflected in the project goal of the PSFP Project which states "The goal of this project is to assist public and private sector actions leading to a self-sustaining system for reducing fertility from the current total fertility rate of about 3.4 to 3.0 by 1994 and 2.4 by the year 2000." It should be noted, however, the PP section dealing specifically with the CBD component does not set full self-reliance as a target. Rather, the aim was to "support diverse efforts to enhance the quality of FP services, increase access to clinical methods and bring about greater levels of individual and community participation in the Village Family Planning Program".

The PP suggested that funds collected through the CBD program could be used to pay transportation costs for low income acceptors to receive clinical methods or treatment for side effects; innovative outreach efforts; or defray costs formerly borne by BKKBN. Nevertheless, the activities mandated for a new CBD philosophy as implemented under the PSFP project support sustainability by motivating community leaders, BKKBN fieldworkers and volunteers to set up contraceptive funds, deliver non-clinical contraceptives for a fee and make referrals to the private sector for clinical methods.

Three issues of future sustainability need to be considered. First, the distribution system for rural areas is fragile. Increased use of the private sector depends on these providers having a reliable source of contraceptives to sell. Innovative TA is needed to investigate how to establish a fully functioning and economically profitable private sector logistics system for the rural areas.

Second, now that the new model CBD system has shown itself to be effective in motivating many rural couples to become self-reliant, the system should be nurtured through refresher training for midwives, especially in the skill of persuasion and managing a small business. This can be done best by helping IBI to set up its peer review-fundraising-training-continuing education system in all its chapters.

Third, there may be an economic incentive problem whereby CBD workers have more to gain financially by promoting short-term methods, such as pills and injectables, rather than promoting and referring women to clinics for long-term methods. This is an area ripe for research.

These three sustainability issues should be "fixed" before the new model CBD program is expanded.

4. Lessons Learned

By far the most important lesson learned is that a significant number of rural couples are willing to pay the full or partial price for what they perceive as a quality product. Their decisions in part may have been influenced by the pride which comes with self-reliance (KB Mandiri). In order to design future media and face-to-face promotion in the most effective way, more

research is needed on the types of clients who responded to the offer to pay for a quality product and the reasons for their doing so,

The second most important lesson learned is that a very satisfactory outcome in a difficult area involving the training of more than a quarter of a million people can be achieved through a BKKBN managed effort with minimal input from CAs and without long-term advisors. It is to be hoped that a well-deserved pride in this accomplishment will prompt BKKBN to take the three steps noted in the preceding section toward real sustainability. After this is achieved, nation-wide replication should be phased in. Since 65 percent of couples still obtain contraceptive services from the government, there is a long way to go along the sustainability continuum in rural areas where 61 percent of the population resides.

In summary, this component has demonstrated that rural self-reliance has a much greater chance of success in communities in which there are trained private providers, whose services and products are promoted by mass media and who have a reliable supply of contraceptives. Without these essential characteristics, sustainability will be compromised.

5. Recommendations for the PHN Sector Transition

Several areas of concern regarding the sustainability of this successful effort toward increasing the quality and use of the private sector were identified in section 3 of this component. Given the importance which both USAID and BKKBN place on self-reliance via private sector efforts, the evaluation team strongly recommends that USAID, AID/W, BKKBN and SDES should develop a transition strategy which seeks to insure that:

- IBI receives needed support to set up its peer review/fundraising/training/continuing education system in all its chapters to provide refresher training to midwives, especially the bidans di desa. SDES and MotherCare projects could fund these costs, while World Bank and Asia Development Bank projects may be able to pick up part of the costs.
- Innovative TA is provided to design a reliable private sector contraceptive delivery system for rural areas;
- Fieldworkers and perhaps village midwives are given short, practical and regular refresher training.

Additionally, the operations research devoted to the role of the new village midwives should be combed for insights into how best to increase their effectiveness as the chief outlet for private sector sales.

C. Social Marketing

1. Inputs and Outputs

The PP allocated \$5,738,000 from USAID and \$660,000 from host country sources to carry out a campaign to promote the Blue Circle line of reasonably priced and readily available contraceptives through private sector sources. With revisions and in addition to contractor TA and other support, the sub-contract to The Futures Group of \$2,321,177, USAID provided \$475,000 for local costs while the return-to-project fund added the rupiah equivalent of \$660,000 for the host country contribution to promote social marketing through the Blue Circle Campaign.

In terms of national and international recognition, this component, is undoubtedly the flagship of PSFP Project. Managing this complex set of interventions has involved USAID, BKKBN, the prime and sub-contractors for the PSFP, a management sub-contractor for promotion, four major pharmaceutical companies and their distributors. Major interventions to reach urban middle/lower income customers (classed as income groups B, C and D in Indonesia) included market research, strategic planning, mass media advertising, points of sales, public relations, training and contacting hundreds of private sector providers, mostly midwives, establishing credit systems for providers to stock pills, injectables, IUDs and condoms.

2. Component Achievements

USAID and BKKBN have collaborated for nearly a decade to develop social marketing sales of contraceptives and demonstrate that the private sector can play an increasingly important role in the delivery of FP information and services. In the mid-1980s, social marketing of the Dua Lima brand of condom was initiated. This was followed by a campaign to identify the Blue Circle logo with private FP providers and later with a BC line of contraceptives, including a pill, IUD, injectable and condom. Although the PP envisioned four years of support for the Blue Circle campaign, this component was planned and implemented over three and one-half years.

The accomplishments in terms of private sector market penetration were remarkable and in every instance exceeded the established targets. Most importantly, by 1994, according to IDHS data, 28 percent of married couples were using private sector sources for their contraceptive needs compared with the PP target of 20 percent. It should be noted that with the exception of injectables, BC products were distributed largely in urban areas. The mass-media BC advertising campaign reached nation-wide, thereby facilitating the CBD workers in penetrating the rural private sector too. This is just one example of the symbiotic benefits of this well-designed program.

Two years into the PSFP, BKKBN initiated the Gold Circle (GC) logo and invited many contraceptive producers to identify products with the new logo. Gold Circle products were

to be aimed at the rural market, thus not in competition with BC products. However, the Gold Circle contraceptive producers soon discovered that penetrating the rural market was expensive and difficult. Even when BC mass media advertising was modified to include the GC logo and products as well, GC sales did not increase significantly. The GC contraceptive producers focused their marketing attention on the urban areas, directly competing with BC products, although the BC contraceptives producers had cut their prices by 50 percent and had been assured of special advertising funds and some exclusivity.

The indicators associated with reaching the PP target between 1989 and 1994 can be seen from the following chart:

Table 1: Blue Circle survey results in four cities

Item	1989	1992	1994
Awareness of Blue Circle logo	78%	94%	94%
Ever used BC product	9%	18%	39%
Currently using BC product	7%	13%	28%
Awareness of BC advertising	48%	80%	68%
Likelihood of buying BC	42%	31%	52%
Image of BC			
• Affordable	39%	41%	61%
• Good quality	61%	63%	68%
• Reliable	60%	61%	68%
• Expensive	32%	31%	19%
• Suitable for me	41%	35%	47%
• Recommended by Dr./Midwife	67%	73%	80%
• Have fewer side effects	47%	44%	55%

Blue Circle pill sales increased in a spectacular way, from 337,878 monthly cycles in 1989 to 2,553,859 in 1994. This 655 percent increase helped persuade the company (Schering) to

open a new pill factory in Jakarta in late 1994. The evaluation team was advised, however, by the Schering staff that they believed that Blue Circle sales would have been even higher if promotion had continued after the May 1995 close out of PSFP's Blue Circle advertising component. Indeed, pill sales since August of this year have been lower than last year. If sales continue to fall, Schering staff indicated they will not be able to advertise this pill which they are selling at 50 percent of their regular price. The company could raise the price of the BC pill to cover advertising expenses or join other BC producers to encourage BKKBN to reallocate return-to-project funds for BC advertising. After all, the fund is provided by the four BC contraceptive producers.

Injectables (Upjohn) rose rapidly through 1992 until the two Gold Circle injectables were introduced. Sales fell even further after mass media promotion was discontinued. Upjohn officials advised the evaluation team that their margin on the Blue Circle product was so small that they could not afford the cost of advertising them.

IUD sales jumped 400 percent only to fall back after a stock-out of Blue Circle product occurred when P.T. Kimia Farma shifted production to Gold Circle IUDs. Blue Circle IUDs are back on the market, but without mass media promotion have not regained their former high of almost 70,000 IUD sales in 1994.

The small proportion of sales commanded by condoms plus a major stock-out make condoms nearly irrelevant in this evaluation, although in terms of name recognition, the Blue Circle Dua Lima condom still ranks number one.

In addition to the key achievement of exceeding the private sector target by eight percentage points, a number of other indicators of changes in knowledge, attitude and action can be attributed at least in part to the Social Marketing Component. These findings are presented from three surveys of 4,000 men and women from five cities during the years 1989-1994. Among the most interesting survey findings about Blue Circle are:

- Awareness of midwives as private sector providers increased for 32% to 59%;
- Awareness of Blue Circle advertising has decreased from 80% in '92 to 68% in '94;
- Only one-tenth of eligible women are aware of Gold Circle, and they are from the higher socio-economic groups;
- Awareness of female sterilization has dropped from 50 percent to 43 percent in 1994; (Not attributable to Blue Circle, but interesting)

- Sub-district health centers (Puskesmas) have dropped from 78% to 74% as a potential source of services while private midwives have increased from 30% to 45% during the same period;
- Puskesmas have dropped as a actual source from 30% to 18% while private midwives have increased from 11% to 23%. This trend is similar for all economic classes except A and E where the use of midwives has actually declined;
- Brand name recognition is very low and still falling with 75 percent being unable to name a brand in '94; Logo recognition, however, is high.
- The main cause for brand switching was having to take whatever was available at the Puskesmas;
- Awareness of Blue Circle logo fell in all economic groups from '92 to '94 but still remained relatively high at 87 percent while Gold Circle was recognized by only eight percent;
- All other private sector sources for obtaining Blue Circle products fell by almost 50 percent except midwives which nearly doubled;
- Interestingly, Blue Circle products were perceived as more affordable than Gold Circle which indeed they are although Gold Circle was originally positioned to meet the needs of the rural poor;
- Equally interesting, Blue Circle was perceived as more easily available and having a good range of brands by more than a three to one margin over either BKKBN free brands or Gold Circle;
- Blue Circle was thought to be recommended by doctors and midwives by 85 percent of respondents compared to only 19 percent for BKKBN free brands.

In summary, the Blue Circle campaigns and service providers had definitely convinced a vast majority of eligible male and female respondents over a five year period that their products were accessible, affordable and of high quality. Fifty-four percent had actually purchased them and nearly 30 percent were currently using them, that is, current use of private sector sources of contraceptives had more than doubled from 1989 when private sector sales accounted for just 12 percent of the market.

3. Critical Issues Relating to Sustainability

Sustainability has become a major issue in social marketing projects although originally they was conceived of as just another channel through which to broaden access to contraceptives.

Early projects were thought to be well designed and implemented if they promoted a quality product to sell at a reasonable price through a reliable distribution system but with little or no concern for sustainability. The Blue Circle component, however, always contemplated sustainability.

The PP reserved the right to examine the social marketing component: "The project support for advertising, market research, and administration will last four years. At the end of that time, an assessment will be made about how and whether this activity should be continued and how it should be funded". An assessment was made by USAID and the PSG in 1994 and concluded that the social marketing component had achieved its objectives and no further USAID support was warranted. However, there was great concern that BKKBN's Gold Circle campaign would give the impression that the Blue Circle line was being replaced by the Gold Circle line. USAID and PSG made a concerted effort to convince BKKBN to broaden their ads to include both Blue and Gold Circle.

Through the PSFP project, the social marketing program in Indonesia has the three elements necessary for success:

- Affordable, accessible products;
- Quality providers and quality products; and
- Effective promotion.

Until April 1995, the three essential characteristics remained in place in the Blue Circle component, but at that point, promotion ended as scheduled although the companies continued to contribute to the special return-to-project fund held by BKKBN. The team was told that BKKBN has used funds from this source to market both Gold and Blue Circle products and that the current balance was less than Rp. 1,000,000.

It is too soon to be sure that lack of promotion will have a serious adverse effect of sales and therefore the sustainability of the Blue Circle products, but there are enough signs to suggest the need of an independent assessment by the spring of 1996. If the assessment indicates the need for continued promotion the findings should be shared with BKKBN leadership as a matter requiring urgent attention and funding support if the highly successful social marketing is to be continued and indeed expanded. As noted in the previous section, Blue Circle promotion is also essential to the further success of the CBD component.

Another cause for concern is "leakage" from BKKBN's stock of contraceptives to private providers. The evaluation team was not able to ascertain the amount of "leakage" but the team was told repeatedly that this was a significant problem. As long as BKKBN remains the largest supplier of contraceptives, it will dampen efforts to promote private sector sales. The shift to full KB Mandiri modifies this somewhat and potential future growth of managed

health care, including FP services, over the next 5-10 years, may greatly alter current contraceptive distribution patterns.

4. Lessons Learned

The most important lesson is that a fairly high proportion of couples are willing to shift from free contraceptives to paying when they are convinced that the product has quality, is affordable, accessible and provided by a well trained provider. The thought that they are helping their country by becoming KB Mandiri may also influence their behavior change somewhat.

The second lesson is that without mass media promotion, the percent of contraceptive sales through private sector channels would not have more than doubled from 12 to 28 percent between 1987 and 1994, substantially exceeding the PP target of 20 percent by 1994. This kind of success must not be put in jeopardy.

The third lesson is that what happens in the private sector is important to BKKBN. The BKKBN leadership must be aware of what is happening. They may even agree that promotion must be resumed without having an assessment made. If requested, USAID should consider providing technical assistance in an assessment of mass media marketing.

The final lesson learned is that even major companies, national and international, may be willing to take the fiscal risks necessary to participate in new ventures. Thus, the private sector can make a significant impact toward achieving program sustainability. This will only happen if BKKBN senior management demonstrate a genuine interest in progress of their endeavor. Without that expression of interest, it becomes a marginal matter to the companies. USAID has played a key role in the development of social marketing; but now it should withdraw to let Indonesian entities resolve future problems.

5. Recommendations for PHN Sector Transition

Even though this component of the PSFP is complete, USAID should continue to promote the effective use of the private sector as one of the surest roads to sustainability.

The team believes BKKBN will continue to support the role of the private sector particularly since the special feature of the Indonesian social marketing scheme is that BKKBN creates the demand for contraceptives and contraceptive services while the private sector provides the supplies and services at reduced prices. This is symbiotic convergence at its best.

D. Increased Use of Long-Term Contraceptive Methods

The overall objective of this component was to increase the use of long-term contraceptive methods by improving the quality of clinical contraceptive services. At the same time, the

aim was to increase the proportion of current users utilizing longer-term and highly effective contraceptive methods which include voluntary sterilization (VS) for men and women, intra-uterine devices (IUDs) and contraceptive implants (NORPLANT). The Indonesian Association for Secure Contraception (PKMI) was responsible for activities related to VS in coordination with BKKBN's Bureau for Contraceptive Services. Project activities related to IUD and implant training for private sector general practitioners was implemented by the Indonesian Medical Association (IDI) in coordination with BKKBN's Bureau of Integrated Services (later changed to the Bureau for Contraceptive Services) under the Private Sector Delivery component of this project.

1. Inputs and Outputs

The PP allocated \$4,998,000 from USAID and \$3,855,000 from host country sources to promote the use of long-term methods. With revisions and in addition to contractor TA, USAID allocated \$3,878,000 for this component and host country contributions were the rupiah equivalent of \$3,605,000, mainly BKKBN reimbursements to hospitals and clinics for VS procedures.

The major focus of this activity and the recipient of the largest allocation of funds was to increase the utilization of VS by both men and women. Promoting greater use of IUDs and contraceptive implants fell mainly to the BKKBN. PKMI was responsible for most of the VS activities under this component including the following tasks:

- Train 540 medical teams in VS techniques;
- Train 592 VS counselors;
- Train 68 quality assurance teams sufficient staff to establish and maintain quality assurance and supervision teams in all 27 provinces;
- Develop and test a quality assurance system for all three long-term methods;
- Conduct operations research on IUD and implant service quality; clinic management; and VS data collection; and
- Promote and develop private sector VS services.

The planned output for this component was increased use of long-term contraceptive methods, from 35 percent of all users in 1987 to 41 percent in 1994. At the end of project, a national system of quality assurance for VS, IUD and NORPLANT services would be established and functioning and national systems would be in place for field staff to refer clients for clinical methods, including referral to private sector providers.

2. Component Achievements

The project fell short of its 1994 goal of 41 percent of current users utilizing long-term methods. Overall utilization of long-term methods increased slightly from 35 percent in 1987 to 36.5 percent in 1994, mainly due to vigorous promotion of NORPLANT in recent years. Use of the IUD declined from 13.2 percent of eligible couples (ELCO) in 1987 to 10.3

percent in 1994; use of VS increased slightly from 3.3 to 3.8 percent during the same period. However, the annual number of VS procedures has dropped steadily over the last five years. The declines have been for both tubectomy and vasectomy as shown in the following table:

Number of VS procedures by Year

<u>Year</u>	<u>Tubectomy</u>	<u>Vasectomy</u>	<u>Total</u>
1989/90	112,174	42,120	154,294
1990/91	100,480	45,441	145,921
1991/92	93,106	41,978	135,084
1992/93	89,969	36,020	125,989
1993/94	85,949	32,203	118,152
1994/95	86,824	16,202	103,026
1995/96*	26,491	3,672	30,163

* data for four months, April-July 1995

Number of New Acceptors of IUD and Implant by Year

<u>Year</u>	<u>IUD</u>	<u>Implants</u>
1990/91	903,150	332,032
1991/92	789,992	284,117
1992/93	675,461	294,309
1993/94	660,117	341,755

Some training goals fell short of planned levels. Training goals established in the late 1980s were not always realistic as the project progressed. Only 501 VS medical teams were trained compared to the target of 540 teams; 457 VS counselors were trained compared to the target of 592. The project reached its target of training 68 VS quality assurance teams.

A national system for external QA for VS was introduced and a pilot of that system tested in four provinces for all long-term methods. An evaluation of the external system concluded that it was too time-consuming and expensive to be replicated nationwide. A pilot test of an internal QA system in a number of hospitals concluded that this system would not work as designed, limited to family planning. It would need to be expanded to encompass all hospital services and units. A QA Design Team developed a four-part plan in 1995 that is being considered. Similar systems for the IUD and contraceptive implants have not been put into operation.

3. Critical Issues Related to Sustainability of Activity

USAID and AID/W have provided substantial financial and technical support for nearly two decades for development, maintenance and expansion of a national VS program. Funds have been provided to improve clinic operating theaters, provide modern equipment, train staff and develop sound monitoring and evaluation systems. Yet the VS program is in a steady decline. There are a number of factors which have inhibited the growth of VS and may have contributed to its recent decline as well:

- GOI policy is ambiguous. VS is not considered a part of the national family planning program; rather it is viewed as a medical issue to be handled by the Ministry of Health. At the same time, BKKBN provides subsidies to hospitals and clinics for each VS procedure.
- There is growing competition from other long-term methods, especially the vigorous promotion of implants by the BKKBN and the longer useful life of IUDs.
- There is a lack of publicity for VS; mass media campaigns have not been permitted and VS remains the least known of all family planning methods.
- The use of mobile teams was stopped by the MOH in early 1991 because of higher complication rates, no client counseling and no village preparation for the mobile teams.
- The reimbursement by BKKBN for VS is considered by public and private doctors as too low, although some recent studies indicate the opposite.
- There is no incentive for the doctor or the clinic to promote VS; indeed there may be economic incentives for CBD workers to promote short-term methods rather than referring clients for LTMs.
- BKKBN proposes a revision to its current five year plan which would sharply increase use of implants, from 350,000 annually at present to 1.2 million annually by IFY 1998/99.

Without resolution of some of these issues, the future of VS is not bright. Current BKKBN plans show a slight increase in the number of VS procedures performed annually during the remainder of the present five year plan.

A separate, but related, issue is the future role and financial viability of PKMI. After almost two decades of substantial technical and financial assistance, PKMI remains nearly totally dependent upon AID funding. Little has been done to redefine a role for PKMI and secure funding for PKMI from BKKBN. USAID has indicated that its support for PKMI will end

within the next three years but this impact appears to have only recently been assimilated by PKMI and BKKBN officials. The future role of PKMI and sources of financial support should now be left to Indonesian authorities, not USAID.

PKMI has been an important factor in promoting VS, training staff, and developing and monitoring quality assurance standards.

The BKKBN has opted to promote contraceptive implants as the main LTM available to Indonesian women, although in the next few years the IUD is likely to have a larger number of new acceptors. The trend for VS is down and there is little reason in the short-run to see any change in direction. In terms of cost, VS is the least expensive method, especially if accepted by younger women who have determined to end their fertility. The IUD, now effective for 10 years, is cheap, has few side effects, can be inserted and removed by trained midwives and can be made available at a wide range of facilities and midwives offices. On the other hand, the implant is fairly expensive and problems of insertion and removal have plagued the Indonesian program. The high up-front costs of the implant will continue to be a major financial burden for the BKKBN.

4. Lessons Learned

A successful VS program requires publicity and strong government support. Expansion of facilities, provision of equipment, training staff and development of standards and monitoring capability are not enough.

5. Recommendations for PHN Sector Transition

USAID should make every effort to promote the burgeoning managed care market under the JPKM rubric and encourage the inclusion of VS in all insurance programs. This would free up funds from BKKBN and MOH which could be used to subsidize the poorest segments of society.

The number of hospitals and clinics offering VS services needs to be consolidated. Far too many VS sites perform less than 6 procedures per month and about 200 facilities provide more than 100 VS procedures monthly. Consolidation could save money, ensure that doctors have enough clients to maintain their skills, and still offer VS to anyone seeking it. PKMI and BKKBN should collaborate on a study to determine the number of VS service sites required to meet likely demand.

USAID should encourage BKKBN and the MOH to segment the VS market, fully subsidizing costs for the poorest groups within the country and eliminate subsidies for higher income acceptors.

There is need for good operations research to determine the economic incentives and disincentives for each group of FP providers to promote each FP method.

There is an important role for PKMI (or another group) in the future to:

- introduce the latest technology;
- improve standards for training;
- supervise quality assurance standards and monitor its implementation;
- train and certify doctors, especially under JPKM managed care health facilities.

The issue is who will provide funding in the future to assure that these activities are carried out. USAID financial support to PKMI through the SDES project is scheduled to terminate by 1999. During the next several years, USAID should encourage BKKBN to determine what resources it is willing to put into the on-going VS program, what role it wants PKMI to play, and how BKKBN will provide a budget for PKMI. USAID should make it clear to BKKBN and PKMI that the problem is one for those two organizations to resolve, not USAID.

IV. GENERAL PROJECT CONCLUSIONS AND RECOMMENDATIONS

A. General Project Conclusions

1. The PSFP project accomplished its targets within the planned time period with exceptions noted previously in the report,
2. The PSFP contractor provided excellent technical advisors and an outstanding chief of party. The PSG devised and carried out operations research that provided high quality analysis and information to BKKBN, USAID, local organizations and the CAs. In addition, the PSG developed a mini-MIS that provided timely and accurate information on all project activities. It will be a loss for all parties if this mini-MIS is not continued. Either USAID or SDES should assume responsibility for maintaining the well-established data base. The PSG staff also played an important background role in facilitating the coordination with the growing number of CAs; it is not clear who will assume this function when the PSG staff leave at the end of December.
3. The new emphasis within BKKBN on family welfare may put a strain on staff ability to carry out its family planning mandate. Since the family welfare and poverty alleviation mandates for BKKBN are rather new, it is not clear what direction they will take. But without additional staff, this could be a matter of concern for its abilities to meet the difficult challenges of increasing contraceptive prevalence.
4. Development and marketing of Blue Circle contraceptive products was successful; Blue Circle has high brand awareness and sales expanded quickly.
5. The PSFP project was the USAID "guinea pig" to shift from advance of funds to pre-financing by BKKBN. This had disastrous consequences for the project, holding up funding for at least a year. Most delays in project implementation stem from USAID, BKKBN and Ministry of Finance problems in implementing this new AID-mandated financial system. After a slow start, these problems were largely overcome.
6. USAID project management staff were viewed by the contractor and BKKBN as supportive and responsive.
7. Demand for removal of contraceptive implants will accelerate rapidly in future years as BKKBN continues to promote vigorously this method. There will be a need for rapidly increasing numbers of midwives and doctors to be trained in proper removal techniques.

B. Recommendations

1. Given BKKBN's vigorous promotion of contraceptive implants and the growing need for more trained staff to remove implants, USAID plans to allocate most of the remaining PSFP project funds for training midwives in implant removal and for payments to midwives and doctors for the removals. USAID should discuss this growing issue with BKKBN and SDES project staff to determine how SDES funds can be utilized for this increasingly important program element in the future.
2. USAID should encourage BKKBN and PKMI to determine the future role of PKMI and identify future sources of funding. Both parties need to be convinced that USAID funding really will stop soon.
3. With growing interest in managed health care (JPKM), USAID and SDES project staff should review how future SDES activities can contribute to expansion of FP services through managed care and assist BKKBN in the transition to this new type of financial support for FP.
4. USAID should encourage BKKBN to review mass media promotion for Blue and Gold Circle contraceptives to determine how these programs will operate in the future, what additional funding may be needed, and at what level of sales no future government subsidies are needed. In the same vein, BKKBN should review the options for strengthening private sector contraceptive distribution opportunities in rural areas.
5. The continuing large-scale procurement of contraceptives by BKKBN limits expansion of a real commercial sector. This is an important area for USAID and BKKBN policy dialogue.

V. SUMMARY OF LESSONS LEARNED

- A. Midwives, rather than doctors, are the most important providers of FP services through the private sector, and that role will likely increase in the future. Except for VS, doctors have a limited role in the private sector. Pharmacists have almost no role in FP; assistant pharmacists play a more important role, especially for sales of condoms.
- B. A large majority of both urban and rural couples are willing to pay some or all of the costs of their FP needs, provided products are perceived as high quality, are affordable, accessible and provided by a well trained person.
- C. BKKBN has an unusual capacity to train large numbers of people throughout the country.
- D. Without mass media promotion, private sector sales would not have grown from 12 to 28 percent of all contraceptive users in just 7 years.
- E. Major pharmaceutical companies are willing to make major price cuts for socially significant causes as long as there is a profit potential.
- F. A successful VS program requires strong government support and adequate publicity. Facilities, equipment and trained staff are not enough.

* *See the PSFP Final Report for other lessons learned.*

ANNEX 1
SCOPE OF WORK
FINAL EVALUATION
PRIVATE SECTOR FAMILY PLANNING PROJECT
NOVEMBER 1995.

A. BACKGROUND

1. Goal and Purpose:

USAID's Private Sector Family Planning (PSFP) Project (No. 479-0355) is aimed to support the National Family Planning Movement in Indonesia, in order to increase the availability, quality, sustainability and use of family planning products and private family planning services, especially longer-term contraceptives (IUDs, implants, and voluntary sterilizations). The project is managed with the assistance of University Research Corporation (URC)/Project Support Group (PSG) under a contract with the Mission.

An external mid-term evaluation of PSFP was carried out in August 1993.

The project activities are implemented in 8 selected provinces: North and South Sumatra, Lampung, West, Central and East Java, Bali and South Sulawesi provinces.

There are four inter-related components in the PSFP: (1) Private/Professional Organizations Development, (2) Community Based Distribution, (3) Social Marketing/Blue Circle Information, Education and Communication (IEC) and Blue Circle Product Campaign, and (4) Long Term Contraceptive Methods.

The PSFP project is under the direction of BKKBN, which manages local BKKBN costs and provides grants to four professional organizations i.e. Indonesian Doctors Association (Ikatan Dokter Indonesia/IDI), Indonesian Midwives Association (Ikatan Bidan Indonesia/IBI), Indonesian Pharmacists Association (Ikatan Sarjana Farmasi Indonesia/ISFI) and Indonesian Association for Secure Contraception (Perkumpulan Kontrasepsi Mantap Indonesia/PKMI) for their services.

URC and its subcontractor, The Futures Group, provide technical and administrative assistance to BKKBN, IDI, IBI, ISFI, PKMI and P.T. Unggul Wirya Adicitra (formerly PT Mecosin Kasita Bahagia) a private company, through a Project Support Group (PSG). The contract also funds the Blue Circle campaign, medical commodities, and international participant training.

PSFP is a six-year (8/10/89 to 12/31/95) project budgeted at \$28,553,000: \$20,000,000 grant from USAID/Jakarta and \$8,553,000 from GOI in rupiah equivalent amount. From USAID funds, BKKBN receives \$10 million with the other \$10 million going to URC. A summary budget of the PSFP project is attached to this SOW.

The Mission's Semi Annual Project Implementation Review (SAPIR) in April 1994 agreed that the date for accomplishing the end of project status (EOPS) is changed from December 31, 1994 to December 31, 1995.

Project objectives for accomplishment by end-of-project date (December 31, 1995) are:

- a. The project will generate 3 million couple years of protection (CYPs) of commercial sales of contraceptives.
- b. Private family planning services will be provided through the training of 2,500 doctors, 2,500 midwives and 2,000 pharmacists.

Note:

Based on the PSFP mid-term evaluation recommendation and the Mission's Semi Annual Project Implementation Review (SAPIR) in April 1994, doctors training was suspended as of December 1994. The number of doctors trained was 1,682.

- c. At the village level, 45 % of family planning acceptors will obtain family planning products and services from private sector sources and providers; at least these products and services will be partially paid for by the acceptors.
- d. Forty-one percent (41%) of the acceptors will adopt a longer term method of contraception, (i.e. IUD, implant, and voluntary sterilization)
- e. There will be 292,000 voluntary sterilizations each year.

Note:

SAPIR in April 1994 noted that beginning of January 1994 the annual VS target will instead be 129,000 cases.

- f. At least 20 % of the eligible couples nationwide will obtain family planning services and supplies from private sector sources and providers.

2. Project Strategy:

To achieve its purposes and goals, the project employs the following strategies:

- a. **Private Sector Development (PSD) Component.** This component is managed and implemented by BKKBN/Bureau of Contraceptive Services which provides grants to IDI, IBI and ISFI. The objective is to increase the number of private doctors, midwives and pharmacists engaged in family planning services, as well as improve the quality of services they provide. This component also aims to improve the management and technical capability of these professional organizations.

The activities under this component are: development of professional organizations, IUD insertion training for midwives, management and clinic development for IDI, IEC development, monitoring and supervision, and operations research.

- b. **Community-Based Distribution (CBD) Component.** This component is managed and implemented by BKKBN/Bureau of Community Institution Development and Provincial BKKBN. The objectives are: (1) to increase community self-reliance in family planning and (2) to increase the provision of family planning services by village midwives.

Under this component, the project introduces at the community level the concepts of fee-for-service, community financing of family planning services and contraceptives, and retail sales of contraceptives.

The activities are: training and orientation in these concepts for local government administrators, BKKBN workers and volunteer Sub-District Heads (Camat), Family Planning Field Worker Supervisors (Pengawas Petugas Lapangan Keluarga Berencana/PPLKB), Family Planning Field Workers (Petugas Lapangan Keluarga Berencana/PLKB, Village Heads (Kepala Desa), Village Family Planning Volunteers (Pembantu Pembina Keluarga Berencana Desa/PPKBD) and Sub-PPKBD, and operations research on the Bidan di Desa.

- c. **Social Marketing/Blue Circle Information, Education and Communication (IEC).** The activities managed and implemented by BKKBN/Bureau of Information and Motivation are mass media and promotional activities and materials in support of private providers of family planning services.

Blue Circle Products Campaign. The campaign is implemented under subcontract to PT (Perseroan Terbatas [the limited company] Unggul Wirya Adicitra (PT UWA). The main objective was to increase demand for family

planning services through commercial marketing of contraceptives, especially in 35 cities around the country.

The activities which support the Blue Circle campaign are product packaging; pricing policy, campaign and promotions (mass media, public relation); market research; and IEC for private doctors, midwives and apotiks.

In addition, PT UWA maintains funds contributed by contraceptives manufactured under a "return to project funds" concept to pay part of the advertising, promotion and other social marketing costs.

- d. **Long Term Methods (LTM) Component.** The activity is managed by BKKBN/Bureau of Contraceptive Services but largely implemented through a grant to PKMI. The objective is to increase the number of acceptors of long term methods: IUD, implants and voluntary sterilization.

The component is also aimed at improving the quality of services in providing long-term methods; improving PKMI's monitoring and quality assurance management system; and developing a plan for social marketing of voluntary sterilization.

The activities are voluntary sterilization medical and counseling training for the field workers, supervision and quality assurance, and management training.

This component operates in all 27 provinces.

3. **Current Project Status:**

Although the project agreement with BKKBN was signed in August 1990 and the URC contract was signed in October 1990, BKKBN's activities began officially in April 1991, and did not really fully get underway until the end of CY 1991. Funding of the Blue Circle campaign changed from central AID to PSFP about the same time. The sub-contract with PT UWA for the Blue Circle campaign ended in October 1994. The URC contract was extended for one year from November 1994 to December 1995 to enable the contractor to assist BKKBN and other professional organizations to complete their project activities.

A mid-term project evaluation was carried out in 1993; the evaluation report is available in the Mission.

A summary of project outputs and accomplishments under each component as of June 30, 1995, can be found in the Quarterly Progress Report prepared by the Project Support Group/URC in July 1995. A copy is available in the Mission.

During the life of the project, several studies and evaluations of project component activities were undertaken, such as PKMI sustainability, implementation of contraceptives community based distribution, and status of external quality assurance. Reports on these are available in the Mission.

The PSFP project activity completion date (PACD) of the PSFP is December 31, 1995, so this is the final project evaluation.

B. PURPOSE OF THE EVALUATION

1. Verify final qualitative and quantitative achievement of project objectives, specific outputs and end-of-project (EOP) indicators.
2. Synthesize and document the end of project status (EOPS) of key PSFP project component activities and their sustainability status, e.g.: Blue Circle social marketing campaign; IBI organizational and professional development; community-based distribution of contraceptive services and products and its institutionalization within the GOI/BKKBN family planning program; prospects of PKMI's continuing role and influence in promoting voluntary sterilization and other long-term methods in Indonesia.
3. Assess and document the extent to which project results and lessons learned from PSFP are being built upon by the SDES Project during the two-year overlap period (1994-1995). Suggest how SDES can further build upon the achievements of PSFP in the next three years in pursuing SDES strategies and objectives. Identify issues and policy obstacles that need to be overcome.
4. Provide lessons learned and recommendations as input for the Mission PHN sector transition phase-out plan.

C. DETAILED SCOPE OF WORK:

For each of the major components of the project outlined below, the evaluation shall assess results among major activities; identify remaining critical issues related to sustainability of activities; outline lessons learned for improving the SDES project; and make recommendations for PHN sector transition.

1. Private Sector Development:

To support and increase the private sector service delivery, the activities are also aimed to improve the management and technical capability of the professional organizations through training. The team should evaluate and give particular attention

to assessing the appropriateness and effectiveness of support and technical assistance provided to IDI and IBI.

Key questions to be addressed:

- What support and technical assistance can be given through SDES to professional organizations to make them more sustainable?
- What lessons learned on professional organization development can be used by SDES to develop professional organizations supported by SDES, especially IBI?
- Should any further support be given to IDI and ISFI? If so, what should it be and what would be the rationale and objective? Is there a role for IDI and JPKM?

2. Private Sector Contraceptives:

A large effort has been put into this project to promote commercial Blue Circle contraceptive sales in urban areas and to improve distribution and use of private sector products and services in rural areas. Some areas have introduced fee-for-services for the family planning volunteers, village drugs post, KUD or midwives-in-the-village (bidan di desa).

Key questions to be addressed:

- Is the commercial contraceptives now sufficiently developed to be able to grow without further assistance? If not, what type of assistance would be required?
- Assess the effect of BKKBN contraceptive purchases and "leakage" on the growth and stability of the private sector market?
- Assess the affect of Blue Circle on the development of the commercial market (overall commercial sales).

3. Long Term Methods:

The focus of this project component has been on voluntary sterilization (VS) and the role of PKMI. However, the evaluation should also look at LTM in a more comprehensive way. Trends in acceptance and continuation rates of LTMs should be studied especially the decreased use of IUDs and VS. VS promotion, including pilot hospitals VS social marketing, the new VS promotion strategy, provider training in LTM, and pilot VS mobile services; and service quality activities should also be reviewed to assess their effectiveness and replicability.

D. COMPOSITION OF THE EVALUATION TEAM:

The final evaluation will be conducted by a team consisting of two senior family planning program evaluators and one junior level professional. This team will work with designated staff of BKKBN, the Project Support Group (PSG) and USAID.

The two senior family planning program evaluation specialists shall have the following qualifications:

- a. Graduate level educational background in an area related to population, demography and family planning or program management.
- b. At least 10 years organizational or management experience in population, family planning or health program including some experience in Indonesia and South East Asia countries.
- c. Experience in developing or evaluating program and institutional sustainability.

One senior evaluator who is also the evaluation team leader will be contracted through a buy-in.

The other senior evaluator will be from USAID/Washington - G/PHN/POP which will cover the cost.

The junior level professional should have an MPH or related degree, and be proficient with using computer technology, and have some knowledge of international family planning, social marketing program (e.g. Michigan Fellow or other Fellow working in G/PHN/POP). This person would assist the team in reading background materials, conducting interview, and preparing final report.

SPECIFIC TASKS:

Specific tasks to be performed by the team include:

1. Interview relevant central BKBKN staff.
2. Interview central IDI, IBI and PKMI staff.
3. Interview a sample of private doctors, midwives and pharmacists.
4. Interview the pharmaceutical companies marketing and sales managers.
5. Meet with URC/PSG staff, especially to look at the "informal" role that URC/PSG played in coordinating CA TA. Will this role be needed in the

future, and if so, what mechanism would the team suggest that is feasible within the current structure and resources?

6. Meet with Pathfinder International/SDES staff.
7. Consult the following documents:
 - a. PSFP Project Quarterly reports produced by URC/PSG.
 - b. PSFP Project Issue papers produced by URC/PSG.
 - c. CAs Meeting reports.
 - d. Reports of research and evaluations and other relevant documents, such as PSFP Mid-term Evaluation Report, 1993; PKMI assessment by Reynold et al.; VS assessment by Lubis and Ross; Pathfinder International Evaluation Report (Poptech No. 95-038-025), and others.
 - e. Survey results (IDHS, IFLS, consumer survey, retail audits).
 - f. Year 1 and Year 2 SDES reports.
 - g. Mission Country Program Strategy.
 - h. PHN Sector Transition Framework.
 - i. BKKBN 5 Years Development Plan.
 - j. Other research and strategy reports as provided by URC and USAID.

E. DELIVERABLES:

1. Midway through the work period, the evaluation team shall provide an oral progress report to USAID, URC/PSG and Pathfinder International/SDES relating work accomplished, any problems encountered with proposed solutions and the preliminary conclusions.
2. The evaluation team shall submit the final report in draft form to USAID prior to the departure of the team for preliminary review and discussion by USAID and GOI. Any additions, modifications, or clarifications to the draft report mutually agreed to by USAID and the team are to be made by the team. The final report shall then be resubmitted in final form to USAID. Additionally, an oral briefing to the Mission, BKKBN, URC/PSG and PI/SDES will be given by the team prior to departure.

The report shall comply with and contain the following:

- a. Executive summary to include: purpose of activity, purpose of assessment and methodology used, findings and conclusions, principal recommendations, and lessons learned.
- b. Project identification data sheet.

- c. Table of contents.
- d. Body of report which will include: Project rationale and objectives, including revisions and rationale; Project activities and significant changes, including rationale; Project achievements, including variations by province, agency, etc.; Factors affecting under and over achievement of objectives (including USAID, BKKBN and contractor management); Highlights of success, failures and unanticipated opportunities (taken and missed); Implications for the future (for SDES, for CAs, and for the Transition Plan).

The outline for the body of the report will be discussed and established after the midway progress report.

- e. Appendices containing a copy of the assessment scope of work, current project log frame, list of documents consulted and individuals and agencies contacted, discussion on methodological and technical issues.
3. Final report: 10 copies of the final report, plus the computer file in WP 5.1., will be submitted by the team within 30 calendar days after the completion of the assessment.
 4. A draft version of the Project Evaluation Summary (PES) (attached), section re abstract and summary, should also be submitted together with the final report, on a floppy disk.

F. TIME PERIOD:

The preferred time for conducting this assessment is for a 3 week period beginning O/A November 25, 1995.

Project Title: PRIVATE SECTOR FAMILY PLANNING

Date Prepared: June 5, 1989

NARRATIVE SUMMARY	OBJECTIVE VERIFIABLE INDICATORS	IMPORTANT ASSUMPTIONS	MEANS OF VERIFICATION
<p>Program or Sector Goal: To assist Public and Private Sector actions leading to a self-sustaining system for reducing fertility from the current total fertility rate of about 3.4 to 3.0 by 1994 and 2.4 by the year 2000.</p>	<p>Measures of Goal Achievement: Reduction in fertility 1988 - TFR = 3.4 1990 - TFR = 3.2 1994 - TFR = 3.0 2000 - TFR = 2.4</p>	<p>Continued GOI commitment to fertility reduction demonstrated by political support, adequate budget and assignment of competent staff. Increasing contraceptive prevalence will have major impact on fertility.</p>	<p>Census: 1990, 2000 Intercensal Survey: 1995 Contraceptive Prevalence Surveys (With fertility Module) 1990 1993</p>
<p>Project Purpose: To expand the availability, quality and sustainability and use of private sector family planning services.</p>	<p>Conditions Expected at End of Project: - Contraceptive coverage among couples of fertile age increases to 53% by end of 1994. - 20% of family planning acceptors receive services/supplies from private sources by end of 1994. - CYP from commercial sales increases to 3.0 million by end of 1994. - Use of clinical contraception increases to 41% of all current users by end of 1994. - # of VS procedures increases to 292,000 by end of IFY 1993/94. - Rural FP users receiving free services declines to 60% in 1994. - 2,500 private doctors and 2,500 private midwives trained in modern FP methods by end of 1994. - 2,000 pharmacists and pharmacist assistants trained in modern family planning methods by end of 1994. - # of FP acceptors paying in full or partially for services/supplies increases to 45% in 1994.</p>	<ul style="list-style-type: none"> - There is substantial unmet demand for family planning services. - New acceptors will continue use of contraceptives. - Target groups will be willing to pay for contraceptives/services. - Information and Education campaign will be successful. 	<ul style="list-style-type: none"> - DKKBN service statistics reports. - Surveys of contraceptive prevalence. - BKKBN budget allocation trends. - Private Sector Organization's records on contraceptives sales. - Commercial pharmaceutical companies' records of contraceptive sales.

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Project Title: PRIVATE SECTOR FAMILY PLANNING

NARRATIVE SUMMARY	OBJECTIVE VERIFIABLE INDICATORS	IMPORTANT ASSUMPTIONS	MEANS OF VERIFICATION																										
<p>Outputs:</p> <ul style="list-style-type: none"> - Social Marketing: <ul style="list-style-type: none"> o Blue Circle Campaign o Community Based Distribution With Fees for Service in Rural Areas. - Strengthened Private Organizations' Role in the National Family Planning Program. - Increased Use of Long Term Methods. 	<p>Magnitude of Outputs:</p> <ul style="list-style-type: none"> - Expanded contraceptive sales through commercial manufacturers and distributors, pharmacies, shops, private doctors and midwives in all major urban areas. - Fee-for-service CBD systems established in rural areas of up to 10 provinces. - PKMI, IDI, IBI, ISFI, actively participating in the National Family Planning Program. - A national system of quality assurance for VS, IUD and Norplant services established. - National systems in place for field staff to refer clients for clinical methods, including referral to private sector. 	<ul style="list-style-type: none"> - Economic conditions will remain stable, making consumer participation in financing contraceptives feasible. - PO's can play a significant role in transferring contraceptive coverage from the public sector toward the private sector. - Receptivity of private doctors and midwives to active participation in this improved clinical contraceptive technology. 	<ul style="list-style-type: none"> - Project evaluations. - Special reports and surveys. - BKKBN service statistics. - Review of participating PO records. - Survey of participating private doctors and midwives. - Baseline, follow-up, and rapid surveys of CBD activities. 																										
<p>Inputs:</p> <table border="0"> <tr> <td></td> <td style="text-align: right;">(\$000)</td> </tr> <tr> <td>IEC</td> <td style="text-align: right;">4,715</td> </tr> <tr> <td>Technical Assistance</td> <td style="text-align: right;">5,934</td> </tr> <tr> <td>Training</td> <td style="text-align: right;">4,566</td> </tr> <tr> <td>Commodities</td> <td style="text-align: right;">640</td> </tr> <tr> <td>Other Costs</td> <td style="text-align: right;">4,145</td> </tr> <tr> <td>TOTAL</td> <td style="text-align: right;">20,000</td> </tr> </table>		(\$000)	IEC	4,715	Technical Assistance	5,934	Training	4,566	Commodities	640	Other Costs	4,145	TOTAL	20,000	<p>Implementation Schedule (Target Dates)</p> <table border="0"> <tr> <td>RFP for TA Contract</td> <td>- 1st Qtr FY90</td> </tr> <tr> <td>CP Satisfied</td> <td>- 1st Qtr FY90</td> </tr> <tr> <td>Develop 1st Year Work Plan</td> <td>- 2nd Qtr FY90</td> </tr> <tr> <td>Initial PILs Issued</td> <td>- 2nd Qtr FY90</td> </tr> <tr> <td>Contract Team on Board</td> <td>- 2nd Qtr FY90</td> </tr> <tr> <td>Second Year Work Plan</td> <td>- 2nd Qtr FY 91</td> </tr> </table>	RFP for TA Contract	- 1st Qtr FY90	CP Satisfied	- 1st Qtr FY90	Develop 1st Year Work Plan	- 2nd Qtr FY90	Initial PILs Issued	- 2nd Qtr FY90	Contract Team on Board	- 2nd Qtr FY90	Second Year Work Plan	- 2nd Qtr FY 91	<ul style="list-style-type: none"> - Appropriate qualified TA will be available. - Funds will be available. - USAID will have adequate staff to plan, manage and evaluate its inputs. 	<ul style="list-style-type: none"> - Project documentation. - Evidence of TA contracts in place. - USAID O/PII staffing pattern.
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ANNEX 3

DOCUMENTS REVIEWED

A. USAID Documents

Aten, Robert H.; Why Economics is Key to Successful USAID Support for Improved Health Care: The View From Indonesia; September 1995

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Galway, K. and Reynolds, J.; Contraceptive Method Mix in Indonesia: An Analysis of the Fertility, Health and Programmatic Implications of Greater Promotion of Voluntary Sterilization; November 1994

Linnan, Dr. H.W.; Final report for Training Evaluation and Assessment, Private Sector Family Planning Project; June 1992

MacDonald, P.; The Peer Review Program of the Indonesian Midwives Association - Final Report of Phase Two of the Pilot Project; August 1995

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Marzolf, Dr. James; Alternative Financing Mechanisms for Voluntary Sterilization (VS) Family Planning Methods - A Brief Review; December 1995

Marzolf, Dr. J.; Financing Long-term Family Planning Methods Through JPKM Managed Care; September 1995

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ANNEX 4

NAMES OF PERSONS INTERVIEWED

INDONESIA MEDICAL ASSOCIATION (IDI)

Azrul Azwar, President

INDONESIA MIDWIVES ASSOCIATION (IBI)

Yanna Annas, 2nd Chairperson

Wastidar Musbir, General Secretary

INDONESIAN SOCIETY FOR SECURE CONTRACEPTION (PKMI)

Azrul Azwar, Executive Secretary

**JOHNS HOPKINS UNIVERSITY PROGRAM FOR INTERNATIONAL EDUCATION
IN REPRODUCTIVE HEALTH (JHPIEGO)**

Margie Ahnan

Patricia MacDonald

Russell Vogel, Director, South East Asia Office

NATIONAL FAMILY PLANNING COORDINATING BOARD (BKKBN)

Sardin Pabbadja, Deputy for Program Planning and Analysis

Ratna Tjaya, Chief, Bureau of Planning

PATHFINDER INTERNATIONAL

Does Sampoerno, Pathfinder/Jakarta

POPULATION COUNCIL

Valerie Hull, Country Director

P.T. KIMIA FARMA

Endang Suyarti Z. N., Product Manager

Hms. Ramly

P.T. SCHERING

S. Lorenz

Iudri

P.T. UNGGUL WIRYA ADICITRA

Toto Budiono, Coordinator of Blue Circle Products

P.T. UPJOHN

Stephen A. Udy, President Director

Jordan Ter, Marketing Director
Devrina Yuselia, Associate Business Manager

THE FUTURES GROUP/SOMARC

Lynn F. Hill, Asia Regional Manager
Anton Schneider, Asia Deputy Regional Director
Robby Susatyo, Resident Advisor

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)/JAKARTA

Vivikka Mollrem, Mission Director
Joseph Carney, Director, Human and Institutional Resources Division (HIRD)
Leslie Curtin, Chief, HIRD/P
Lana Dakan, HIRD/P
Bambang Samekto, HIRD/P
Robert Aten, Public Finance Advisor

UNIVERSITY RESEARCH CORPORATION (URC)

Jack Reynolds, Director, Project Support Group

YAYASAN KUSUMA BUANA (YKB)

Firman Lubis, Executive Director
Yoedo Prihartono

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