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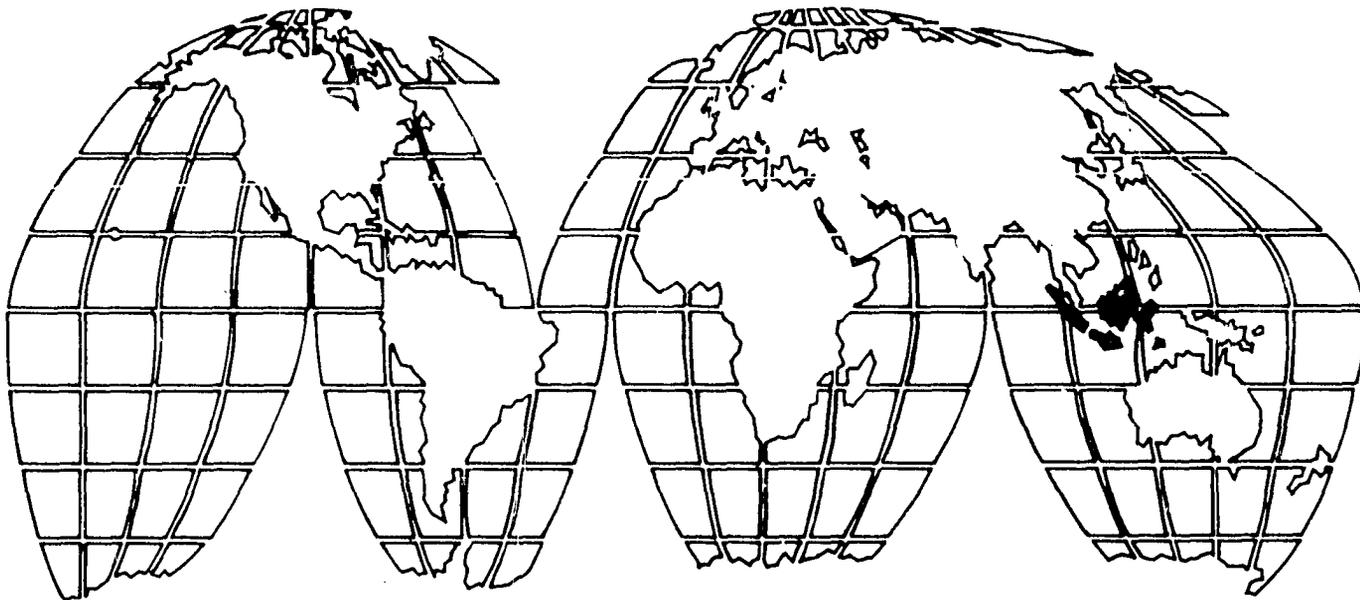
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A.I.D. Program Evaluation Report No.2

AID's Role in Indonesian Family Planning:

A Case Study with General Lessons for Foreign Assistance



December 1979

Agency for International Development

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AID'S ROLE IN INDONESIAN FAMILY PLANNING:
A CASE STUDY WITH GENERAL LESSONS FOR FOREIGN ASSISTANCE

by

James R. Heiby, M.D.

Gayl D. Ness, Ph.D.

Barbara L.K. Pillsbury, Ph.D.

U.S. Agency for International Development

Bureau for Asia

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PREFACE

The Indonesian Family Planning Program is widely recognized as one of the most successful family planning programs in the world. Since 1968 the United States has provided technical and financial assistance to the program through its Agency for International Development (AID). The present study recognizes the well-documented evidence of the program's performance and seeks to identify the reasons for its success. The major purpose of the study, however, is not to evaluate the Indonesian program itself, but to assess AID's assistance to that program and to identify the lessons that can be learned for the improvement of family planning assistance elsewhere. The evaluation concerned primarily the role played by USAID/Jakarta. This report, therefore, does not include detailed analysis of the population assistance program as it operated in AID/Washington.

The study was conceived by the Population Division of AID/Washington's Asia Bureau at a time when the Indonesian program had been in existence for eleven years and U.S. assistance to it had totaled \$43.2 million in grants and \$14.3 million in loans.¹ The immediate stimulus for the present study was the Family Planning Program Effectiveness Study carried out by AID/Washington's Bureau for Program and Policy Coordination.¹ That study identified three broad determinants of program effectiveness: political will, administrative capacity, and sociocultural determinants of fertility and contraceptive readiness. Throughout its investigation the team sought to weigh these key determinants of program performance by asking a wide variety of informants what would have happened had not certain identifiable conditions existed.

The study was carried out during a four week period (April 30 - May 25) through field visits and interviews in Jakarta and in rural Indonesia by a three-person team consisting of one physician and two social scientists (one sociologist and one anthropologist). High- and low-performance communities were visited in four provinces: West Sumatra, Bali, East Java, and South Sulawesi.

Acknowledgements

During its four weeks in Indonesia the team acquired a debt of gratitude to Indonesians. From peasant families to cabinet ministers, Indonesians opened their homes, their offices, and themselves to the team.

¹ "Family Planning Program Effectiveness: General Summary," by Steven Sinding (Agency for International Development, Office of Evaluation, Studies Division; Washington, DC, April 1979).

The staff of the National Family Planning Coordinating Board (BKKBN) at headquarters and in the provinces gave willingly of their time, energy, and interest. They opened their files and records and patiently answered questions that must often have seemed endless. Dr. Suwardjono Surjaningrat, chairman of the BKKBN, gave access to his entire organization. The provincial BKKBN chairmen visited -- Dr. Astawa in Bali, Dr. Abdul Hakim in South Sulawesi, Dr. Pangestuhadi and Dr. Wasito in East Java, and Dr. H. Mahyuddin in West Sumatra -- deserve special acknowledgement for their personal as well as official assistance and hospitality. Through these leaders the team wishes to record deep appreciation to the many other officials who provided effective assistance and warm hospitality.

The USAID population staff -- Mr. Thomas H. Reese III as chief, Mr. Morrie K. Blumberg as deputy chief, and Mr. Michael Q. Philley and Dr. Emmanuel Voulgaropoulos -- deserve special acknowledgement for their assistance and guidance. So too does Mr. Thomas Niblock, USAID mission director, who gave generously of his time and knowledge. Ms. Tini Hadju and Ms. Christina Iswati, Indonesian staff of the population office, provided much appreciated assistance. Gratitude is also expressed to Dr. Jarrett Clinton and Mr. William Johnson, former chief and staff respectively, of the USAID population office, for their comments on portions of this report. Special thanks are owed to Dr. Steven Sinding, population chief in AID/Washington's Asia Bureau, whose initiative made the study possible. The team is also grateful to AID/Washington's Office of Population, Asia Bureau, and Bureau for Program and Policy Coordination, and to the American Public Health Association, for the important support and assistance they have provided.

PART I

EXECUTIVE SUMMARY AND MAJOR FINDINGS

A. EXECUTIVE SUMMARY

Overview. Since 1968 A.I.D. has provided \$43.2 million in grants and \$14.3 million in loans to the Indonesian National Family Planning Program. During the intervening years, prevalence of contraceptive use in Indonesia has increased dramatically and fertility has decreased far more rapidly than was predicted even a few years ago. The national program has clearly played the determining role in this decline. Program achievements on Java and Bali, the two densely settled islands that contain 90 million of the nation's 135 million people, are referred to by respected authorities as a "success story probably unrivaled in family planning history." It is widely acknowledged that A.I.D. support has been a major element in the program's success to date.

Program Impact. Indonesia's population was 40 million in 1900 and had soared to 117 million by 1969 when the national program was launched. During the 1970-1975 period the annual population growth rate averaged 2.4 percent. It has since been brought down to 1.9 percent. The fertility rate of Java and Bali, where the program has until recently been concentrated, has dropped 15 percent. Contraceptive prevalence on the two islands now averages over 35 percent and reaches over 85 percent in some villages. This has been achieved through voluntary participation and without material incentives for acceptors.

Financial Inputs. Funds provided to the program through 1978 totaled \$208 million. Of this the government of Indonesia provided 50 percent, A.I.D. 28 percent, and other foreign donors 22 percent. In the early years Indonesian contributions constituted only a small portion (e.g., 4 percent in 1968), while A.I.D. contributed the major portion. The Indonesian contribution has climbed steadily to 60 percent in 1978. This indicates growing country commitment but also the great importance of A.I.D. funds in the program's early years.

Country Commitment, Capability, and Context. The Suharto government has been unambiguously committed to fertility reduction as an integral part of overall national family planning coordinating board, the BKKBN. Extra-ministerial yet capitalizing on existing social and political systems, the BKKBN has developed the administrative capability, as well as commitment, to achieve measurable impacts. It has done so by providing services at the village level and by tailoring its program to indigenous village organization, leaders, and cultural values. Program achievements are especially remarkable in view of the conditions usually assumed to militate against family planning acceptance -- a national per capita income of only \$180 per year, an infant mortality rate over 100 per 1,000 live births, 50 percent illiteracy among adult women, and a wide diversity of Islamic and other intensely religious and tradition-minded linguistic and ethnic groups.

A.I.D. Effectiveness. A.I.D. has been successful in helping Indonesia's program to reduce population growth because it was able to provide necessary resources at the right time; this has enabled the national program to meet and create popular demand to reward and further build political commitment at all levels. A.I.D.'s ability to be effective has derived from four essential sets of conditions.

*AID/Washington provided consistent support but delegated authority to the mission for virtually all program decisions. It always made readily available sufficient grant funds, technical assistance, training, and commodities to meet and even anticipate the needs of the program and to permit flexibility in the field.

*The USAID Mission in Jakarta assigned high priority to population, created an Office of Population reporting directly to the Mission Director, and made it possible and attractive for key staff to remain in Indonesia for three tours of duty. Strong goal rather than procedure orientation and effective internal delegation of authority by the Mission leadership permitted the Office the flexibility and support necessary for creative innovation.

*The mission's population office has relied primarily on direct-hire staff who have been individually selected for their population and Asian competency and who have developed facility in the Indonesian language and familiarity with the Indonesian context. The staff has evolved a strategy and mode of close collaboration with the Indonesians that permits them to tailor A.I.D. resources to the specific needs of the program and to direct them to the greatest targets of opportunity.

*A mechanism, based on local-cost programming and project implementation letters, was developed by the mission population office to move resources quickly to provincial and rural activities where there is high probability that the resources will be used effectively. The ability of the Office to provide funding for local initiatives within weeks (rather than months or years) has been highly instrumental in stimulating local participation, promoting innovation, and building political commitment. It is this mechanism, together with the successful management-oriented data system developed by the BKKBN and the A.I.D. Mission, that has permitted effective decentralization. If only one element were to be singled out as most important in explaining the effectiveness of A.I.D. support to this particular program, it would certainly be the use of this funding mechanism.

Lesson Learned. A.I.D. support to Indonesian family planning is regarded as one of the U.S.'s most successful foreign assistance efforts. Many lessons can be extracted and should be transferable to programs elsewhere. Most broadly they derive from putting basic development principles into practice. In particular they concern the mechanism for fast, accurate funding. It is the use of this procedure by a technically competent, culturally sensitive goal-oriented staff that most distinguishes A.I.D. support to the program. Legal and administrative provisions for the procedure are standard in the A.I.D. system. The exact importance of certain host-country conditions to the effective use of the mechanism remains to be determined. Its effective use depends, however, upon having a resident staff and upon that staff being given adequate support and authority to act.

zational status of the office has been a major determinant of high staff morale and of the staff's ability to successfully support this high-priority program.

Discussion

The high priority accorded to population by the USAID mission in Indonesia was reflected by establishing a separate office for population with the chief of the population office reporting directly to the mission director. This translated the idea of high priority into effective organizational action in at least three ways. First, the chief was placed in a position equal to other key administrators. He thus had effective bargaining power with financial and legal units, whose natural tendency is to be concerned with administrative procedures rather than program outcomes. Second, population was not submerged under another organizational layer, whose chief would be concerned with a wide variety of different projects and who might have little technical knowledge of or interest in population. Finally, placing population in a separate office gave it access to higher level decision-makers on the Indonesian side. This also gave AID greater credibility in urging Indonesian bureaucratic and political leaders to accord higher priority to population.

c. Goal Orientation

Major AID and BKKBN decision-makers responsible for the program have been intently goal- and outcome-oriented and consistently emphasize that this firm commitment to goals demands flexibility in approaches. Activities are evaluated on the basis of the specific goal of fertility reduction, which is estimated directly or through careful use of surrogate measures.

Discussion

Program managers have clear goals and periodically assess targets for meeting these goals. They frequently admit uncertainty as to what will ultimately be the best means of achieving the goal and accordingly actively experiment with alternative strategies. This is referred to by the USAID population staff as "guided incrementalism."

AID and host-country procedures are respected but not permitted to become ends in themselves. It is recognized that legally binding contracts are necessary for moving resources but that they by no means assure or even promote cost-effective goal attainment. Responsibility is consciously delegated in order to establish performance- and goal-orientation in others. So strong is this goal orientation that both

American and Indonesian personnel alike frequently refer to the program as propelled by a special force.

It is true that population activities lend themselves to quantified measures of outcome, but these are by no means a prominent feature in the day-to-day management of most programs. Examples abound of programs where delays and inaccuracies in data reporting render any cybernetic application virtually impossible. Nor is it unusual for program managers to become distracted by process measures of secondary importance, such as the number of personnel trained or the number of clinics opened. Competing value systems may also reduce the emphasis given to a specific outcome and considerations such as loyalty or status can become distracting factors in a program's management.

In contrast, a BKKBN deputy chairman terms his program's predominant philosophy as management by objective, an orientation consistently apparent in a variety of program contexts. The timeliness and completeness of the data system, for example, is the result not only of a practical design but also of a program-wide, ongoing goal of maintaining an effective system. These data are regarded as essential for outcome-oriented management; budgets, supervision, public recognition, and training all appear to be linked primarily to performance, as expressed in contraceptive use, rather than to friendship, political influence, or any other arbitrary formula.

Certainly, a pervasive political commitment to reducing Indonesia's population growth has also been essential to the present management style. The USAID mission has also played an important role in fostering a program orientation explicitly directed toward measurable outcomes. The very expression "management by objective" is evidence of the impact of the mission-funded long-term U.S. participant training. The data system itself was to a large degree a mission initiative. Similarly, the mission population staff has used its local cost programming mechanism to direct resources to provincial programs largely on the basis of performance. This emphasis on performance has apparently also influenced the manner in which domestic BKKBN funds are budgeted, suggesting that the present management pattern will be sustained beyond the period of large-scale AID assistance.

d. Grants vs. Loans

The fact that most of AID support has been provided through grants promoted success in two ways. First, it permitted activity that the Indonesian government might otherwise have considered unaffordable, and, second, it provided critical speed and flexibility that could not have been achieved through loans alone.

Discussion

For the first ten years of U.S. support to Indonesian family planning, assistance was primarily in the form of grants. Obligations through 1978 totalled \$57,879,000 of which 75 percent was grant and only 25 percent loans signed in 1977 and 1978.

It is highly unlikely that the Indonesian government would have been willing to borrow money for family planning at the inception of the program especially under the extreme economic pressures the government faced at the time. Grant support permitted the government to develop a major family planning program at little cost to its other programs. Grant support has also provided greater flexibility. Loan negotiation is always a more time-consuming process involving the national planning agency, and agreements typically carry rigid specifications for use of funds. Indonesian family planning officers have often expressed frustration over the delays, complexity, and inflexibility they have experienced with other donors' loan arrangements. The availability of grant monies, accompanied by the delegation of virtually all program decisions from Washington to the field, permitted the mission to respond promptly and appropriately to local developments.

e. Fast, Flexible Funding

The mission's population staff has developed an extremely important process, using local cost programming, to move money rapidly -- in weeks rather than months -- to provincial staff. The process necessarily draws mission staff into close collaboration with Indonesians in developing socially sound and cost-effective projects. Although labor intensive, the process is highly rewarding and permits AID staff to respond to the government of Indonesia with confidence. This is perhaps the most innovative and the single most important element in the support AID has given to the Indonesian program.

Discussion

Using local cost programming, the USAID population staff has developed a labor intensive procedure in which it works closely with Indonesian officials to develop sound project proposals for USAID funding. Once proposals are developed, the procedure provides for the movement of money to the provinces that is, by normal bureaucratic standards, unbelievably fast. The procedure relies upon grant funding and the extensive delegation of authority from AID/Washington to the mission and within the mission to the population staff.

The value of this process cannot be overestimated. It provides for intensive interaction with BKKBN officials, in headquarters and provinces, through which AID staff gain a clear understanding of the needs of the program. This permits them to selectively support its

office and the tenure of its staff members has been unusually long compared to AID norms. This has produced a highly competent team and permitted development of the collaborative AID-Indonesian relationship that has been an essential element in the program's success.

Discussion

It is said that AID has been effective because the USAID population office "has had good people." "Good people" are not just circumstance. The population staff have all been hand-picked for their population and Indonesian or other Asian background and have subsequently been given critical support by a mission management.

The mission, the Asia Bureau, and AID/Washington's Office of Population have all been able to play an active role in the appointment of personnel to the USAID population office. On several important occasions this involved overriding decisions made by AID's personnel system and others whose primary concern was not population assistance. The resultant staff has commanded complimentary skills in public health, management and logistics, and social science. Nearly all staff have been direct hire rather than external contractors. Once appointed, all staff have been given Indonesian language training, as have been their spouses. Facility in Indonesian has been indispensable to functioning effectively in Indonesian society and, in particular, to the collaborative program development which is premised on much field involvement and verbal negotiation. The mission management has then helped its key staff to remain with the office for three terms of duty (i.e., six to seven years). This has fostered a cooperative working style, which constitutes the basis of what is widely recognized as the office's successful relationship with the Indonesians. On numerous occasions the team was able to observe how long-term personal relationships between the population staff and their Indonesian counterparts clearly facilitated program development.

No evidence was found to suggest that long-term residence in any way impairs the staff's ability to further U.S. and AID interests. On the contrary, the effective performance of this staff strongly indicates the advisability of AID's assignments precepts being modified to favor three tours of duty when the mission so recommends.

h. Mission Director Support

The active and genuinely outcome-oriented support of the mission director enabled the Population Office to place U.S. money where it could do the most good. The mission director's support has been essential for the decentralization and flexibility that made it possible to adopt the program to local conditions.

Discussion

The ability of the U.S. to assist the Indonesian population program would be severely compromised in the absence of a highly supportive mission director. According to the population staff, this means a mission director to whom they have direct access, who is willing to delegate responsibility to them and then trust it with that responsibility, who is goal- rather than procedure-oriented, and who is willing to get involved in and give time to the program.

i. Program Collaboration and Initiative

The degree to which initiative is lodged in the mission, the central BKKBN office, and local BKKBN offices varies widely, indicating a genuinely collaborative working relationship between the mission staff and their local counterparts.

Discussion

New program initiatives are developed collaboratively and originate, alternatively, in the provinces, at BKKBN headquarters, or with AID. The program's data and logistics system is a major program element based primarily on USAID initiative. The important "village family planning" program was originally proposed by a provincial BKKBN office and was then effectively supported by the mission in the face of initial opposition at the BKKBN central level. In many cases, mission support for workshops and training was largely a response to provincial- or central-level proposals, as was true also for the addition of nutrition and health services to the family planning infrastructure.

The local cost funding mechanism, while stimulating local initiative, does not automatically fund all initiatives. Some proposals are funded in their original form, but in many cases the population office staff negotiates extensive modifications as a prerequisite to funding. Finally, where the staff regards a proposal as unacceptable, even with modifications, it refuses to provide support. Further, the team found no instance in which a proposal rejected by the mission was subsequently supported with Indonesian funds. Although the process leading up to a formal proposal is based largely on verbal exchanges and is not documented in detail, nevertheless there is a consensus among the population staff that the overall acceptability of provincially initiated proposals has steadily increased. This suggests a subtle but important institutionalizing influence of AID on the Indonesian program.

j. Program vs. Project Orientation

The mission population staff is committed to the overall success of the national program and to tailoring AID assistance to meet its

needs. There is little diversional focus on AID projects per se. That the staff consistently place the Indonesians in the forefront, insisting that the program and its successes belong to the Indonesians alone, is in itself a major reason for the success of AID support.

Discussion

There is a significant difference between commitment to a country program and commitment to an AID project. This has important consequences for both AID effectiveness and program impact.

On a formal level, rather than focusing on a limited part of the Indonesian program, or on aspects of it referred to as "AID projects," the USAID population staff has adjusted its assistance to the needs of the program as a whole and generally shares the same overall goals as the Indonesian program managers. The impact of AID assistance has been greater because of this.

On a daily working level, the USAID population staff insists it is playing only a minor role in assisting the Indonesians with their program and that AID cannot claim credit for any of their success. At the same time, however, Indonesians and other donor representatives alike maintain that the present and former USAID staff, and their ability to provide ready support, has been a major factor in the Indonesian success. The same is not said of the other major foreign donors. This suggests strongly that despite Washington eagerness to attribute specific program impacts to U.S. assistance, such a credit-seeking orientation at the field level would be counterproductive.

k. Field Experiments vs. Pilot Projects

The Indonesian family planning program has made extensive use of field experiments to shape its activities while the program has been expanding. It has not made use of large-scale pilot projects that continue for years with extensive evaluation prior to adoption by a national program. The field experimentation strategy has permitted the national program to move ahead rapidly while adapting effectively to distinctive local conditions.

Discussion

Large, elaborately designed pilot projects, continuing for long periods with extensive evaluation prior to possible adoption as a national program, have been a common feature of development strategy. The Indonesian program has bypassed this approach in favor of smaller scale field experiments that can help shape specific portions of the national program while it still moves ahead rapidly. This strategy has permitted the program to accept high-risk ideas when the potential pay-offs are equally high. It permits a fine tuning of the program to local conditions and experimentation with tactics that might become

standard for the entire nation. Village family planning was one such field experiment, tried along with a variety of other potentially useful approaches; its demonstrated success led to adoption as a national model while other less effective tactics were discarded.

In contrast, neither the mission nor the Indonesians have found much utility in large pilot projects conceived outside of Indonesia.

1. Management Oriented Data System

The Indonesian family planning program data system is highly management oriented. It is limited to performance-related data from the field, provides good controls for accurate data collection, is centrally computerized for prompt feedback, and provides field personnel at all levels with data that clearly show the performance of units over which they have responsibility.

Discussion

It is an unfortunate commentary on modern family planning programs that their data systems are usually designed by demographers and are more appropriate for demographic analysis than for program management. The Indonesian program, in contrast, has developed a data system that is highly management oriented. By keeping field reports simple and limited to desired program outputs and by providing central supervision for field data collection, it ensures a high level of accuracy in the data. Through its central computer operation it is able to provide prompt feedback to program supervisors at all levels. The feedback at each level shows program managers the performance of units over which they have responsibility. Subordinate units of each level are shown ranked by performance. This stimulates units at each level to compete with each other in raising program performance. A great deal of work is put into keeping the reporting activity focused on program performance. Reports are sent to, and actively used by, the political and administrative officials with overall government performance responsibility at all levels. Reports are examined in frequent national meetings of provincial family planning managers and in provincial meetings of district family planning managers with the constant goals of both checking reporting errors and searching for reasons for high and low performance. The system was created with USAID assistance. Fully AID-funded at its inception, the system is now 100 percent Indonesian-funded. AID has continued, however, to support the basic management orientation and to resist the common tendency to press for the addition of more demographically useful data in the system.

m. Participant Training

AID spending for training Indonesians in population skills has been a major contribution to program success. Both in-country and

U.S. training have been used to reward BKKBN staff for good performance while building the technical capacity the program needs for self-sufficiency. U.S. training, especially advanced degree programs, has been especially effective. Virtually all trainees have returned to Indonesia and now hold key positions in the BKKBN and other governmental agencies and academic institutions that support the population program.

Discussion

The mission's population office provides approximately \$600,000 annually for short- and long-term population training for Indonesians. Both in-country and U.S. training are used for internal staff development, which provides additional incentives to work well. High quality individual performance can lead to advanced training, which helps individuals to advance in their own careers. Existence of these opportunities helps the program to recruit and retain high-quality personnel and to draw out their full talents. U.S. training, especially for advanced degrees, has been particularly beneficial. The mission reports no loss of overseas trainees to developed countries. On the contrary, approximately 50 individuals who have received advanced U.S. training through the USAID population office now hold key positions in the BKKBN, Ministry of Health, Central Statistics Office, and academic institutions that support the population program. Training has constituted less than 5 percent of the population office's overall budget, yet it has provided much of the high-quality manpower needed for a self-sufficient program. On these grounds, the training is highly cost-beneficial.

It would seem highly advantageous for the U.S. government to continue to support training in the U.S. for promising candidates from those countries that have already demonstrated a high rate of return. The Indonesian program would certainly not be where it is today without this training.

n. Integration of Health and Family Planning

Given the Indonesian context, any attempts AID might have made (but did not) to impose a rigid, preconceived formula for integration of health and family planning services would almost certainly have been detrimental to the program. At best they would simply have failed; at worst they would have obstructed the Indonesians in their own programming. Instead a new alternative for integration has been developed -- the "piggybacking" onto the mature family planning program of health, nutrition, and even income-generating activities.

Discussion

Indonesia's achievements in fertility reduction could not have been accomplished in so short a time had there been insistence on a Washington-conceived prescription for integration of family planning

with health. In fact, at two important junctures decisions were made that have proven critical to program success but that might have been precluded by a rigid formula for integration.

First was the decision to establish an autonomous national family planning coordinating body (the BKKBN) outside and largely independent of the Ministry of Health. While experience from many developing nations indicates that cooperation and coordination with the health ministry is essential for family planning effectiveness, clear evidence also exists that health ministries are often among the weakest of any country's ministries and they tend to be especially ineffective at bridging the gap between the ministry's professionals and the country's poor majority.

The BKKBN was fortunately established outside the Indonesian Ministry of Health, although it has worked very closely with that ministry. It has in fact experienced integration in process without integration in structure. Some observers argue that the cooperation has been achieved because of rather than in spite of the lack of structural integration. In the provinces, family planning services are delivered through the health system down to its lowest existing levels, the sub-district health centers (puskimas) and the maternal and child health clinics (BKIA's). At the national level, it is significant that BKKBN's chairman since 1970, Dr. Suwardjono Surjaningrat, was appointed by President Suharto in 1978 to simultaneously serve as Indonesia's Minister of Health.

The second decision that defies a rigid integration formula was the decision in 1976 to break out of the static puskimas and BKIA clinics in order to bring family planning services and information to the villages where approximately 60 to 70 percent of the Indonesian population was not yet effectively serviced by the government health system (and still is not).

USAID and BKKBN decision-makers, when deliberating the optimal relationship between family planning and health, have made certain important distinctions. These are distinctions in function (services as opposed to planning, administration, or data management), in timing (initial start-up as opposed to later expansion or maintenance phases), and in level (urban, where health facilities exist, as opposed to rural, where they are either non-existent or relatively ineffectual).

All those with whom the question of integration was discussed agreed that progress in curbing population growth would have been possible but immensely slower and more difficult had family planning responsibility been placed in the health ministry or had family planning services been restricted to an integrated health care package. The key variable in permitting the vigorous forward movement of a family planning program not formally integrated with health appears to have President Suharto's -- and thus the Indonesian

government's -- active, unqualified, and unswerving commitment to reduction of population growth as a top national priority.

The U.S. Congress has mandated AID to work toward the goal of reducing population growth. Toward this end it has put forth integration, not as a goal itself but only as a suggested means toward achievement of the mandated goals. The Indonesian family planning experience suggests that U.S. decision-makers would do well to remain similarly goal-oriented in their foreign assistance program development and review.

o. Incentives and Voluntary Acceptance

The careful handling of incentives at all levels of the program has been critical to its success. Voluntary participation without material incentives for acceptors has been a key feature of the program. Symbolic and psychological incentives have proven more effective instead for recruiting and maintaining acceptors and, more importantly, for maintaining high staff effectiveness. High staff performance is also elicited through important career development rewards.

Discussion

Considerable attention is paid in AID/Washington to the ethics and utility of incentives for acceptors in family planning. Relatively little attention has been paid to staff incentives for effective programming or to creating non-material incentives for acceptors.

The Indonesian program provides performance incentives at all levels from the president on down through the BKKBN and USAID mission to informal groups in remote villages. These incentives are premised on both cooperation and competitiveness -- cooperation among members of given units to out-perform other units at the same level. This is evident as Indonesians in general have begun to talk about becoming "number one in the world in family planning" and as governors, mayors, village chiefs, hospitals, and clinics and family planning fieldworkers and provincial chairmen seek to out-rank each other in the BKKBN's monthly performance reports.

Staff incentives come in such forms as trips for outer-island midwives to Bali for IUD-insertion training. Similarly, high performing village chiefs in Bali are awarded visits to the successful East Java program. Incentives for program managers exist in the public recognition and the sense of accomplishment that accrue from being able to get funds from Jakarta and to produce immediate results of benefit to the local constituency. It is quite likely that this is one of the most powerful incentives available in the administration, in part because its rewards are so rare. Administrators in Indonesia as elsewhere

commonly grow accustomed to frustrations and delays that sap their energy and initiative. When a program is able to deliver resources rapidly, to help officials generate real activity in their locality, and to help solve the problems they see daily, it provides rewards and incentives that are as certain and powerful as they are difficult to quantify.

Direct material incentives for family planning acceptors have been experimented with and found not effective. Some small community reward systems have apparently been somewhat effective, but these have been locally developed. While some villages are thus proud to have received communal rewards for high performance -- such as sewing machines or television sets -- incentive schemes designed outside the Indonesian context (e.g., the IBRD's proposed community incentive scheme) have made little headway.

It is the policy of both the Indonesian and the U.S. governments that participation in family planning be voluntary. Nevertheless, the sheer rapidity of the program's accomplishments, together with certain observations earlier on, have led to allegations that the program might be achieving its successes through the use of coercion. For this reason evidence of possible coercion was consistently pursued by the study team. The team concludes that the Indonesian family planning program success is based on voluntary acceptance. The Indonesian government has neither the commitment nor the means to achieve widespread fertility reduction through coercive measures.

p. Contraceptive Supply

Fully adequate supplies of oral contraceptives have nearly always been available to the program, including early on before there appeared to be demand. This was a critical precondition for and even stimulus to the village family planning take-off. Abundant supply permitted central managers to keep local distributors well-stocked with contraceptives.

Discussion

Facilities established for the distribution of oral contraceptives appear adequately stocked and provincial personnel at all levels say they have never experienced shortages of oral contraceptives. Mission staff maintain that the large supply of oral contraceptives that AID/Washington's Office of Population recommended and made available in the early 1970s was an essential element in the rapid expansion of village family planning.

An important part of the supply success has been the BKKBN logistical system. This is an example of an important program element created with AID technical and financial assistance but now an independent Indonesian program activity. Because of this system contraceptive

shortages have been infrequent in Java and Bali. More importantly the system appears capable of keeping up with the rapid increase in demand and extension of services now occurring in many parts of Indonesia's outer islands.

The logistical system includes effective linkages between the program's data system, warehousing, inventory systems and procurement procedures. The logistical system is divided into two components, however, one for consumables and one for equipment delivery.

In the outer-island province of South Sulawesi, for example, there is considerable local interest in the IUD and there is also staff trained for insertion; there are very few IUD insertion kits, however, despite a backlog of these kits in Jakarta.

2. Sources of Concern

a. Organizational Memory

The mission's population office faces the imminent prospect of an 80 percent reduction in its memory. Staff turnover implies a reduction from over 7 years to less than 2 years in direct personal experience with the Indonesian program. Despite extensive routine documentation over the years, retrieving information about the past decade of AID population assistance to Indonesia is difficult. A system of brief annual reports might provide an organizational memory that could transcend the personal memories of staff and thus be less subject to the fluctuations that occur with turnover.

Discussion

The current chief of the population office is scheduled to leave Indonesia this month, to be replaced by an officer with no previous experience in the country. The two remaining regular population office staff have 18 and 8 months' experience respectively in Indonesia. Although extensive program files exist, retrieving specific information from more than two years ago is a formidable task. In addition to the official project documents, actual project activities have been recorded in a large body of population office weekly reports, field trip reports, and memoranda of conversations. Many if not most of these, however, have been discarded or made functionally inaccessible by AID's policy of removing documents older than five years. Moreover, there is virtually no way to obtain from the files any descriptive summary of the office's experience in the Indonesian program. Little organizational memory exists, memories are largely personal and thus subject to fluctuations in depth and content with staff turnover. It is difficult to say how detrimental this is, but a simple mechanism for developing such an

organizational memory can be suggested. Annual reports by each office, which would provide summaries of major activities, problems, plans, and yearly expenditure levels, could provide the mission with substantial organizational memory. If the reports are simple and brief they need not be costly. They would induce officers to take stock of plans and progress in a systematic, periodic fashion and provide new appointees with a ready access to some of the more important events in the history of their office.

The Jakarta mission has made a laudable attempt to use AID's evaluation system in a constructive manner and in creating a library of useful documents and reports. The reports suggested above could be one important part of this growing mission memory.

b. Urban Program Failure

Family planning program services have not been effectively extended to the country's urban areas, particularly Jakarta. Extending effective services, especially to the urban poor, poses a serious problem for BKKBN and for AID support.

Discussion

The considerable family planning success in Java and Bali has occurred largely in rural areas. It has not yet been possible to adapt the successful village family planning strategy to the cities and especially not to servicing the urban poor. Unless effective means are found to reach the urban populations there will be a growing service gap that will be costly in both human welfare and social tension. Much of the service gap appears concentrated in Jakarta, whose five million people constitute about 20 percent of Indonesia's entire urban population. Effective attention to the Jakarta problem could provide both a pilot for other urban programs and a substantial solution to the overall problem.

c. Geographic Expansion to the Outer Islands

Family planning success has been largely confined to Java and Bali where program activities have been concentrated until only recently. The 50 million people in Indonesia's outer islands have a low level of contraceptive use (less than 10 percent of fertile age women) and are widely scattered and ill-served by basic health and communication infrastructures. Extending family planning services to the outer islands constitutes a major, immediate challenge for the national program and for AID assistance.

Discussion

There has always been a deep division between Indonesia's Java-Bali heartland and its outer island periphery. With only 7 percent of the total land area, Java and Bali contain about 65 percent of the total population. The consequent differences in population densities are immense: 600 persons per square kilometer in Java and Bali and less than 50 persons per square kilometer in the outer islands. The family planning program has concentrated on Java and Bali until only recently and its successes remain limited primarily to these two small islands with large populations. Services have not yet been extended to all the other islands, although this is a major feature of the program's expansion plan.

The problems ahead are formidable. With less than 10 percent contraceptive prevalence and with population growth at about 2.4 percent per year there is much to be done in basic service provision. Outer island prevalence rates are about the same as on Java when the program began there. Nevertheless, with the other islands' low population densities, widely scattered settlements, and poorly developed health and transportation infrastructure, the monetary costs and organizational demands will be immense.

d. Expansion of Scope: Nutrition and Health

Family planning success in Java and Bali has led to an expanded scope for the program, adding nutrition and health activities to the family planning service delivery system. The rationale for this expansion is sound but the expansion itself will pose serious problems. Management, technical capacity, logistics, and the data system will require sensitive adjustment to meet the needs of the new activities without simultaneously weakening the family planning services.

Discussion

The success of village family planning in bringing effective services to rural Java and Bali has led to an expansion of the program scope. The plan is to add nutrition and health services to the delivery network through which family planning reaches the rural population. It is argued that because this service network has shown capability for reaching the isolated rural population it should thus be used to provide a wider range of services. It is also hoped that the new services will prevent personnel from becoming complacent through increasing routine activity. Finally, it is argued that success in motivating families to reduce fertility makes it incumbent upon the program to protect the smaller number of children acceptor families now achieve.

These are all well-taken arguments, but the expansion of scope will pose major problems. Family planning workers must be trained in

nutrition and health; new logistical problems will arise in the movement of foodstuffs, medicines, and additional equipment; the data system must be extended to include additional forms of information; and management will be faced with new problems of integrating a larger number of activities under one structure. The BKKBN is aware of these problems and is moving to address them through field experiments. However, current plans for rapid extension to broader coverage will constitute a major challenge for both BKKBN and AID.

e. USAID-BKKBN Relations

Relations between BKKBN and the USAID mission have been very fruitful to date. BKKBN's major reorganization, the current increase of other foreign donor funding, and the very success of the program, however, may pose problems for continuing collaboration.

Discussion

The successful AID support of Indonesian family planning has been based upon highly collaborative relationships between USAID and BKKBN personnel. Several new and pending conditions may challenge the future of this relationship. The BKKBN has recently undergone a major reorganization and expansion of top-level professional staff and its chairman has recently been appointed Minister of Health. The full import of these changes is not yet clear, but it will undoubtedly present USAID staff with both new opportunities and new problems.

Both the IBRD and the UNFPA have greatly increased their financial commitments to the Indonesian program. This promises expanded resources to the program, yet it also greatly increases BKKBN administrative work. Even now BKKBN staff express frustration over the complex, intricate, and different accounting demands of these two major donors and the former is already experiencing difficulty in disbursing its obligations to Indonesia. It is unclear how this will affect BKKBN's need for USAID financial and technical assistance.

Finally, program success itself presents its own peculiar problems. It brings both a flood of new participants seeking association with success and a retreat of others who feel support is no longer necessary. It could also bring unwarranted complacency to both program personnel and external associates causing them to prematurely shift concern from expansion to "simple" maintenance. The success to date will undoubtedly present other new problems that will affect USAID - BKKBN relations, and it is not by any means certain what the outcome will be.

PART II

INDONESIAN FAMILY PLANNING PROGRAM PERFORMANCE,
DEMOGRAPHIC IMPACT AND AID SUPPORT

A family planning program works primarily by creating a distribution network, with contact points at which contraceptives can be supplied to users. Contraceptive use produces a demographic impact by reducing fertility. The Indonesian family planning program has been highly successful on all counts -- establishing contact points, recruiting contraceptive users, and reducing fertility. The success is already well documented and need only be summarized here. Both the documented evidence and the team's own observations present the same conclusion. Fertility in Indonesia has been declining; the Indonesian family planning program has played a large role in that decline; and AID is providing highly effective support to that program.

A. Service Delivery Network

In just over a decade the Indonesian family planning program has created a large, and still rapidly expanding, network for the supply of modern contraceptives. Ministry of Health Clinics (puskesmas) provide basic contraceptive services in all sub-districts (kecamatan). At the village level supply posts have been created and acceptor groups have been organized to bring both supplies and motivation as close as possible to the individual users. Java and Bali are now fully covered by this network and it is rapidly expanding in the outer islands. Summary details of the network are shown in Table I.

<u>Table 1</u>		
<u>Family Planning Program Contact Points,</u>		
<u>1978 and 1979</u>		
<u>Java and Bali</u>	<u>1978</u>	<u>1979</u>
Clinics	2,750	3,200
Village Family Planning Posts	30,000	30,000
Village Acceptor Groups	25,000	55,000
<hr/>		
<u>Outer Islands</u>		
Clinics	920	1,950
Village Family Planning Posts	6,000	12,000
Village Acceptor Groups	-	5,000
<hr/>		
<u>All Indonesia</u>		
Clinics	3,670	5,150
Village Family Planning Posts	36,000	42,000
Village Acceptor Groups	25,000	60,000

(Source: See Appendix Table 1)

B. Acceptors and Users

By March 1979 these contact points had recruited over 13 million new acceptors, resulting in over 5.5 million current users, representing almost 30 percent of the married women of reproductive age. Summary details are shown in Table 2.

	Total New	Current Users	
	Acceptors	Number	% MWRA
Java & Bali	12,172,141	5,001,811	36.8
Outer Islands	1,263,878	539,706	10.6
All Indonesia	13,436,019	5,541,517	29.7

(Source: See Appendix Table 2)

How reliable and accurate are these program statistics? One check is provided by the independent World Fertility Survey carried out in 1976. The program estimate for 1976 was that 20.8 percent of married women of reproductive age were users of contraceptives. The World Fertility Survey estimated the proportion to be 23.4 percent. For Bali and all provinces of Java except West Java the program estimates were slightly less than those derived from the survey. The independent check shows that the program is doing well in recruiting contraceptive users, and perhaps better than the official statistics indicate.

The program officially promotes all modern contraceptive methods except sterilization. Roughly one-quarter of all current users use the IUD; about two-third use the oral contraceptive pill, and the remaining eight percent use other methods, primarily condoms and Depo-provera injections. Table 3 shows details.

Table 3
Method Mix Among Current Users, March 31, 1979

	IUD		Pill		Other		Total
	N	%	N	%	N	%	
Java & Bali	1,412,646	28.2	3,196,882	63.9	392,283	7.6	5,001,811
Outer Islands	81,507	15.1	372,705	69.0	85,494	15.6	539,706
All Indonesia	1,494,153	27.0	3,569,587	64.4	477,779	8.6	5,541,517

(Source: GOI National Family Planning Board Monthly Statistical Summary)

C. Demographic Impact

The demographic impact of a family planning program can be assessed in two main ways. Regular service statistics show the number of acceptors or users, from which estimates of fertility can be made. In addition, separate surveys can be carried out to provide a more direct measure of both contraceptive use and fertility at a particular point in time.

Table 4 shows a recent AID estimate, based largely on Indonesian program data, of the crude birth and death rates for the past few years. The crude birth rate has declined about 23 percent, the crude death rate about 33 percent and the rate of natural increase about 14 percent.

<u>Table 4</u>			
<u>Estimates of Crude Birth and Death Rates and the</u>			
<u>Crude Rate of Natural Increase in Indonesia</u>			
<u>1971 - 1978</u>			
Year	1 CBR	2 CDR	3 CRNI
1971	43	21	2.2%
1976	36	16	2.0%
1978	33	14	1.9%
<u>% Decline</u>			
1971 - 1978	23%	33%	14.0%

Source: USAID estimates from various sources

- 1 Births per 1000 population
- 2 Deaths per 1000 population
- 3 Births minus deaths per 100 population

A recent analysis of the Indonesia program using 1976 World Fertility Survey data, by Hull, Hull, and Singarimbun* provides an additional objective measure of the program's demographic impact. The analysis covers only Java and Bali but is nonetheless useful since these two islands contain about two-thirds of Indonesia's population. It is also useful because it provides both estimates of rates of fertility decline and sources of that decline -- increasing age of marriage and reductions in marital fertility -- which are necessary for an assessment of the demographic impact of the program. Table 5 shows the decline in total fertility for Bali and all of the provinces of Java.

Province	TFR 1967-71	TFR 1976	% Change
Bali	5.8	3.8	-34.5
Jakarta	5.4	4.5	-16.7
West Java	6.0	5.3	-11.7
Central Java	5.3	4.4	-17.0
Yogyakarta	4.7	4.4	- 6.4
East Java	4.6	3.9	-15.2
1 Total Java-Bali	5.3	4.5	-15.1
2 Total Java-Bali	5.3	4.2	-20.8

Source: Provinces: Hull, Hull & Singarimbun, 1977, p 26-7

- 1 Jame Siquefield & Sungkono, "Fertility and Family Planning in Java and Bali, 1967-76," Unpublished Report, September 1977.
- 2 World Fertility Survey, The Indonesian Fertility Survey, 1976: A Summary of Findings, No. 11, October 1978, London SWIWOBS, U.K.

*Terrence Hull, Valarie Hull, and Masri Singarimbun, "Indonesia's Family Planning Story: Success and Challenge," Population Bulletin, Vol. 32, No. 6, November 1977.

Hull, Hull, and Singarimbun also estimate that about 25 percent of the decline in fertility is due to an increase in the age of marriage, a change that accompanies the spread of education and the more general process of modernization. This leaves about 75 percent of the fertility decline explained by reductions of fertility within marriage, the area in which we typically see the direct impact of contraceptive use, and thus of the family planning program. It is not yet possible to estimate how much of the overall fertility decline is directly attributable to the family planning program by itself, but it is clear that the impact is substantial.

D. Indonesian and AID Financial Inputs

Total funds provided to the program through 1978 amounted to \$208 million. The government of Indonesia provided \$105 million (50 percent), AID, \$57.9 million (28 percent), and other foreign donors \$45.9 million (22 percent). The yearly figures, provided in Appendix Table 3, show that the Indonesian contributions constituted only a small proportion of total funds in the first three years -- 4 percent in 1968, 19 percent in 1969 and 29 percent in 1970. By the early 1970's Indonesian contributions accounted for just over 40 percent of the total. Since 1975 the proportion has climbed steadily to 60 percent in 1978. This indicates a growing Indonesian commitment to family planning, but it also shows the importance of foreign donor funds in the very early days of the program.

E. Personal Field Observations

Statistical reports of fertility changes of this magnitude and speed inevitably raise questions about the validity of the data. In field visits to West Sumatra, Bali, South Sulawesi, and East Java, the team employed extensive field observation to assess the validity of the available data. These observations represent more personal energy than statistical rigor in research design. Nonetheless they provide useful evidence relevant to program performance and demographic impact. The following illustrate observations that influenced the team's major conclusions:

- o The modal age of the large number of children attracted everywhere by the team between 8 and 14 years. Extensive questioning revealed relatively few children under 6 to 8 years. There were few children carrying younger siblings on their hips as was previously typical in Java and Bali. Only at clinic immunization and infant weighing sessions were there large numbers of women with infants. In fields, along roadsides, and in markets, women carrying infants were a relatively rare sight.
- o In East Java, where clinic and village post records are especially thorough, many clinics showed population pyramids constructed from field-worker censuses; invariably these pyramids showed deep indentations below the 10 to 14 year age group. Where actual numbers of births were shown, the

typical calculated birth rate showed 15 to 20 per thousand population.

- o In Bali, where the team constantly asked how many acquaintances were not family planning acceptors, typical replies indicated only a minor percentage.
- o Even in South Sulawesi, the province where program data shows the lowest level of current users, the team in unscheduled visits to village family planning posts found them adequately supplied and distributing pills and listing eligible couples and acceptors. User rates of 20 to 30 percent of eligible couples were not uncommon and many influential local women were IUD acceptors.
- o In clinics, shops, temples, markets, and on the street, the team found people knowledgeable about and willing to openly discuss family planning and the contraceptive methods they currently used.
- o In Yogyakarta, lay public, such as young batik artists proudly claimed that Indonesia was the best in the world in family planning and knew details of the program.

The team similarly observed USAID and program personnel in action. At all levels a majority of officials appeared strongly supportive of the program and many were actively involved in promoting it. It was not unusual for the local religious teacher or custodian of the local law (adat) to be serving as the family planning field worker. AID officials observed in close interaction with BKKBN personnel and other administrators in both Jakarta and the field, displayed facility in using Indonesia for detailed planning and review of AID-funded projects. The great amount of administrative activity taking place at all levels in moving money and resources from the center to the provinces and hence to the villages presented evidence that the USAID local cost programming mechanism is working.

In the field the team saw nothing to counter and much to support the available statistical evidence. Fertility is definitely declining in Indonesia. The government's family planning program is definitely playing a major role in that decline, and AID is providing a highly effective support to that program.

PART III

THE INDONESIAN CONTEXT

To understand the success of the Indonesian family planning program and to learn lessons from it requires understanding first the distinct Indonesian context.

There is no single secret to the Indonesian success. What can be observed is the convergence of a number of possibly fortuitous and certainly advantageous conditions. Many of these conditions are distinctly Indonesian and certainly their convergence at this time is unique. Some of the conditions are diffuse throughout Indonesian society, while others are more specific to the family planning program. The precise relative importance of these conditions is difficult to determine. This makes it essential to proceed cautiously in seeking lessons that can be applied to other national programs or other USAID missions. There are important lessons to be learned, but these will be useful only to the extent that they are sensitively informed by the distinctive and dynamic character of the Indonesian context within which the program and AID operate.

This section makes a two-part argument. First, population growth and socioeconomic development have produced powerful forces for fertility limitation in Indonesia. The diffuse political culture and specific political commitments to economic development, family planning and administrative reform have produced an important Indonesian readiness and ability for collective action in fertility limitation. Second, these conditions created a favorable climate for donor support to Indonesian population activities to which USAID responded effectively.

A. Population Growth and Density: A Shrinking Land

An informant in East Java told of the poignant language the peasants use to express one of the most important experiences of their lives:

The land is shrinking,
The children keep coming,
And it is hard to breathe.

Like other developing nations, Indonesia has had more than a century of erratic but generally increasing population growth culminating in a quarter century of very rapid growth with rates hovering around two percent per year. Unlike many developing nations, however, Indonesia's heartland -- the two islands of Java and Bali -- is dominated by wet-rice agriculture, which has immense capacities to absorb labor. In contrast, the outer islands, Indonesia's periphery, are characterized by swidden, or slash-and-burn agriculture.* Beyond relatively low levels of population density, swidden agriculture produces intolerable pressure on the land. If population growth is not siphoned off through

*Clifford Geertz, *Agricultural Involution*, Berkeley: University of California Press, 1963.

migration, continued land use very quickly denudes the soil, leaving gutted hillsides and hard lateritic soils, where only noxious imperata grasses will grow. Rising population density quickly produces dramatic declines in productivity.

Not so with wet-rice agriculture. Where land is built up with small bunds or dykes to contain water, and streams are controlled to bring water to the field additional labor can be easily absorbed in molding the land and moving the water. When valleys are filled, bunded land moves up the hillsides in terraces, which even further increases the land's labor-absorbing capacity. Population growth can thus be accommodated for long periods of time, with no sudden tilt to rapidly declining marginal labor productivity. No single point is reached at which people must clearly move or die. Long experience with the absorptive capacities of wet-rice agriculture has produced expectations that the land can always support more people. When finally it cannot, it is easy to understand the peasant's perception that the land is shrinking, that it is difficult to breathe, and one does not know what to do.

Visual observation and statistics alike support the perception of a shrinking land. Throughout much of Bali and Java, hillsides are terraced to the top; mountains are terraced for rice as high as the water will go and for cassava beyond that. Everywhere there is ample testimony to the immense amounts of human labor wet-rice agriculture can use.

The statistics bear out what is visually evident. At the turn of the century Java and Bali contained an estimated 30 million people, with the already high density of about 230 persons per square kilometer. By 1976 the population of Java had reached 77 million, not including Jakarta's 5 million. This constitutes an overall density of 598 persons per square kilometer without Jakarta, or 635 per square kilometer if it is included. Bali, with a current density of 421, is not far behind. This sheer ecological pressure has worked, if not directly to depress fertility, certainly to produce a readiness for limiting human reproduction. When peasants speak of children coming, land shrinking and difficulty in breathing then surely there is readiness for change

B. Socioeconomic Development and Equity

By comparative standards Indonesia has not, or not yet fully, reached levels of socioeconomic development at which fertility is thought to decline rather automatically. The country is poor, with a per capita gross national product of only about \$200. Life is precarious; infant mortality rates vary from 100 to 150. The population is about 80 percent rural with about two-thirds of the labor force engaged in agriculture. It is also conservative in its adherence to Islam, Hinduism, and local tradition. This is not the general set of conditions believed to precipitate fertility decline.

But Indonesia has not stood still in the past generation. The independence that was proclaimed in 1945 brought the changes that most developing nations

have experienced. Indonesia's new government initiated efforts to provide schools and health services to the population. Literacy rates now stand at 75 percent and primary school attendance at about 50 to 60 percent of the school-aged population. Health services have gradually expanded, bringing the overall death rate down to about 14 per 1,000. Government development efforts have been erratic since independence, but more concerted and sustained in the past decade, bringing per capita growth rates to above 5 percent per annum, however unevenly the growth may have been distributed. Although the country is not, and may never be, self-sufficient in foodstuffs, rice production has risen and yields are now near three tons per hectare, the highest in Southeast Asia.

It is more difficult to deal with the issue of equity, a favored new variable in cross-national analyses of the determinants of fertility decline. Some micro-economic analyses show that the increased use of high-yielding varieties of rice cause greater equality of income distribution.* Others indicate that this change reduces labor demands and throws numbers of people out of work.**

Visual evidence abounds showing rural and urban poverty alongside opulent modern consumption. But visual observation also provides a picture of something less than stark poverty throughout Indonesia. Houses are built of sawn timbers and have tile and zinc roofs. Sufficient numbers of school children wear uniforms and shoes to indicate that many people are indeed sharing some of the wealth. Whether the overall distribution of wealth has become more or less equal, however, especially in the past decade, is simply not known. Nor could one say with confidence what impact income equality, whatever it is, would have on fertility in Indonesia.

C. Culture and Contraception

The Indonesian slogan, "unity in diversity," is not a hyperbole. The nation's one thousand inhabited islands are commonly said to contain more than 300 different ethnic groups, each ordered by one of at least 19 systems of local customary law (adat), each with its own pride and identity, and most with their own languages or dialects. Overwhelmingly Muslim, Indonesia also has other active and cohesive religious groups and Islam itself is differently interpreted throughout the archipelago. The majority of ethnic groups are patrilineal but there are also major groups following strong matrilineal codes.

* Irian Soejono, "Growth and Distributional Changes of Paddy Farm Income in Rural Java," Prisma, No. 3 (May 1976), pp 26-32.

**See William Collier, "Food Problems, Unemployment and the Green Revolution," Prisma, No. 9 (March 1978), pp 38-52.

Given this great diversity, to generalize about things "Indonesian" glosses over many important differences. Nevertheless, there are sources of similarity and unity that make it possible to identify major cultural elements especially relevant for the modern family planning program. An underlying Malayo-Polynesian culture that is shared with the rest of Southeast Asia, the years of Dutch colonialism, and the three decades of independent government attempts to foster a national unity have produced some conditions more or less common throughout the nation. Four seem of special relevance here: traditional values surrounding reproduction, Islam, the traditional position of women, and community solidarity.

As in all agrarian societies, Indonesia's people have numerous indigenous means of fertility regulation, but place much greater emphasis on reproduction than on limitation. A conventional Batak blessing is "May you bear 17 sons and 16 daughters." Women gain status by producing children. A childless union is considered the fault of the woman, and justifies the husband taking another wife. Young married women are pressured by family and friends to produce a well-rounded family, which traditionally meant at least four children. The desired number of children appears to be declining, but village women still laughed whenever the evaluation team asked a young married woman without children if she were practicing family planning.

When the national family planning program began in Indonesia, there was a certain amount of free-floating fear that family planning might be against Islam. This in fact is not true, and eminent Muslim authorities from Cairo to Jakarta have made explicit pronouncements asserting that the Quran itself supports family planning as a means of assuring that all God's children will be cared for. The team found many religious leaders actively supportive of family planning. Islamic leaders are among the members of provincial and lower level family planning coordinating teams and in many rural communities the local religious leader serves as the village family planning post leader (petugas pos K.B.).

There is some resistance to the IUD on the basis of Islam as modified by local traditional values. Given that Islam proscribes display of the genitalia, many rural women resist the IUD out of shame (malu) at being "seen." Malu is usually greater if the IUD is inserted by a male rather than by a female. Where the IUD has only recently been introduced, many women still resist it on grounds they would feel malu because their neighbors would know they had been "seen" by another. The team found no evidence, however, of resistance to the IUD on grounds, found in other Muslim countries, that forbid having a foreign object in the body, especially during prayer. The sense of malu appears stronger in the outer islands than on Java, indicating that such values can be modified under sensitive program direction. There is no resistance to the IUD on Bali, however, where Hinduism provides no obstacle to the method and where a long tradition of male birth attendants apparently precludes the shame felt elsewhere concerning insertion. In several Balinese villages visited by the team as many as 90 percent of eligible women were using the IUD.

The position of women in Indonesia as well as throughout Southeast Asia is one of active involvement in village economic and public life. Although there is some agreement that women are more oriented toward children and men toward public roles, sex-role differentiation is not rigid and women are by no means secluded as they are in other Islamic nations. Traditionally women have played important economic roles, especially in marketing and controlling household finances, and there is extensive female ownership of property.* Engagement in many public activities ties women into social networks through which information, such as on family planning, travels rapidly. The government has also organized women's clubs at the village level, which have been used effectively in the family planning program.

Finally, there exists throughout Indonesia a strong cultural tradition of "mutual assistance for self help", or gotong royong. Local communities frequently act collectively, both for routine cooperative tasks and for emergencies. Thus the village is an accepted arena for mobilizing human resources -- for motivating people and organizing them for action. This tradition of local mobilization has been used with great astuteness by the national family planning program in making family planning the modern thing to do.

D. Political Culture

The most ready explanation given for the success of the Indonesian family planning program is the strong hierarchic power structure, by which central commands produce compliant behavior all down the administrative line to the individual peasant. Scholarly analyses and casual observations support the idea that superiors are accustomed to giving orders and that subordinates, down to the lowest peasant, are accustomed to doing what they are told. Behind these observations lies a political culture in which power is seen to emanate from above. Individuals are enjoined, both by values of proper conduct and calculations of self interest, to imitate the elders, to follow the leaders, and to align themselves with the power that comes from above. This political culture is deeply rooted in traditions of the classical Javanese kingdom, and produces a respect for authority that prevails throughout Indonesia.

The implications for family planning are clear. Presidential support is considered necessary and useful, if not fully sufficient, to program success. At all levels the family planning personnel are concerned about official support and often explain success and weakness in terms of the strength of administrative support.

* See Pauline Milone's "Indonesia Report," which comprehensively describes the position of women (in "A Preliminary Study in Three Countries," International Center for Research on Women, Washington, D.C.)

Given this pervasive respect for authority, there is nevertheless considerable variation in the character of the local organization through which authority gains compliance. The tradition of the classical kingdom, which accorded high compliance to officials, is strongest in its ancient seat of East Java. Islam has brought an additional authority figure in the religious teacher who provides an alternative model of proper behavior in which value is placed on following Islamic tenets. In most parts of Indonesia family planning personnel are careful to gain the support of religious leaders, although this is less important where the ideal of the classical kingdom remains powerful.

In the strength of local autonomous organization, East Java and Bali stand far apart. Village organization in East Java is marked far more by strong, direct links to the center than by spontaneity and autonomy. In contrast, few societies display the strength and autonomy of local organization characteristic in Bali. All Bali is organized.* In each hamlet (banjar) households are automatically members of a self-governing village association in which adult males meet monthly to manage collective affairs, including directing and disciplining individual members. Irrigation, informal savings and loan cooperatives, temple support, and a wide variety of other social and economic activities are organized locally through age-old democratic village institutions. This pervasive spirit of organization and interconnectedness is expressed in what some observers consider the single most important word in Balinese, keikat, literally, "to be tied." For Balinese, human life is fulfilled and comprehensible only as individuals are "tied" to some form of collectivity. Even the gods are considered to have a distinct personality only when they alight at, and thus become "tied" to, a temple. For gods and men alike, identity lies in being tied to others, in being organized.

This view of the political culture provides an important foundation for understanding the success of the family planning program. Everywhere there is a respect for authority, but the strength and autonomy of local organization varies greatly. Any program, therefore, to be successful, must gain central political support and must involve local leaders in the translation of central commands to specific programmatic actions. The family planning program has been effective on both counts. These characteristics of the political culture are only enabling conditions, however. To understand how they were translated into a successful family planning program it is first necessary to understand the source and character of the government's support.

E. Commitment to Economic Development

President Suharto's commitment to family planning is often explained by pointing out that he comes from Central Java and thus has directly experienced that province's high population density. Unfortunately for this line of

*John S. Lansing, "Evil In The Morning World," Ann Arbor, University of Michigan Center for South and Southeast Asian Studies, 1974.

reasoning, Suharto's predecessor, President Sukarno was born in Surabaya, East Java, also an area of great population density. Yet Sukarno was pro-natalist. He eschewed family planning, arguing that Indonesia needed more rather than fewer people. Family planning under Sukarno was a taboo subject, with neither central nor local activity.

The fundamental difference between presidents Sukarno and Suharto lies not in their birthplace, but in their commitment to national economic development. For Sukarno national identity was far more important than economic development. Indonesia's central planning organizations, BAPPENAS, established in the early 1950's under the direction of the development-oriented technocrats, withered under Sukarno. His major plan, the eight-year development plan presented in 1962, consisted of eight books, 17 chapters, and 1945 paragraphs, marking the proclamation of Indonesian independence on August 17, 1945. Its symbolic value was far more evident than its instrumental value and its impact on national economic policy was virtually nonexistent.

With the demise of Sukarno and the rise of the Suharto government, national economic development -- along western models of capital formation and industrialization and with the powerful aim of increased per capita output -- became a major national goal. The technocrats who had gone into exile or seclusion under Sukarno were brought back to the centers of power. BAPPENAS was revitalized, given increased power, and staffed with technically competent economic planners. A series of five-year economic plans was developed in more or less logical succession stating national aims and increasingly mobilizing domestic resources to achieve those aims.

In 1968 a development budget was separated from the routine operating budget. The development budget for that year was 35 million rupiah (Rp), 19 percent of the total government budget, and was financed completely by foreign assistance. The first plan, 1969/70-1973/74, proposed a budget of Rp. 1,164 million, 40 percent of which was financed from domestic and 60 percent from foreign sources. The second plan budgeted Rp. 5,249 billion with 80 percent coming from domestic and only 20 percent from foreign loans and grants. The third plan, beginning in 1979, envisages a development budget of Rp. 42,835 billion, with again 80 percent financed through domestic capital mobilization and 20 percent from foreign sources.

The annual development budget has thus grown from 19 percent to over half of total government expenditures. Even if all the figures are deflated, as they should be to account for inflation, the growth in deliberate development programming with domestic resources has been impressive. These development oriented actions have been expressed in annual presidential speeches, indicating in both words and actions a powerful governmental commitment to national economic development.

The commitment to national economic development led quickly and directly to a commitment to public action for controlling population growth, and thus

to support for family planning. As in the development commitment, words and actions have been consistent. President Suharto was one of the signers of the World Leaders Declaration on Population in 1968. He has emphasized the need for fertility limitation in each of the five-year guideline statements, and in every August 17th speech. In 1976 he opened the presidential office space to a BKKBN family planning display. The display is said to have been important in giving governors and other national elites a clear statement of the president's commitment to population control and, equally important, in showing the leaders just how they could carry out the president's wishes. Suharto has also been willing to respond to suggestions from central BKKBN personnel that he apply pressure upon specific governors in provinces where program progress is judged inadequate.

Translating words into actions, the government created the autonomous National Family Planning Coordinating Board (BKKBN) reporting directly to the president with a program funded by domestic and foreign sources. In the first plan period, family planning was included in the health budget. The two receiving an allocation of Rp. 42 million out of a total plan budget of Rp. 1,059 million. Family planning was allocated 6 million, or about 0.6 percent and health Rp. 36 million, or 3.5 percent of the total development funds. The second plan listed family planning in a separate chapter and allocated the program about 1 percent of total development funds, with health receiving about 2 percent. In the current plan, family planning is again listed with health. The two will receive Rp. 829 million, or 3.8 percent of the Rp. 21,849 million in public development expenditures.* Family planning alone is scheduled to receive Rp. 202 million, or about 1 percent of total government development funds.

In all plans and government statements the link between economic development and family planning is explicit. For Indonesian development planners every problem identified and every program planned is directly affected by rapid population growth. Problems are exacerbated and program costs mount rapidly given past and projected rates of population growth.

Indonesia's present government is thus highly committed to family planning, not because the president comes from a densely settled area but because the president and his government are strongly committed to modern economic development. One can only speculate about the sources of this commitment, but it is likely that the previous government played a vital role in shaping it. Sukarno's rejection of development in favor of national identity and his rejection of western foreign aid had clear detrimental effects on the national economy and, certainly as important, on the resources of the military establishment. The lessons were spelled out in detail and not lost on the present generation of leaders. The technocrats in seclusion under Sukarno supplemented their academic salaries by giving courses to officials at the central staff

*The total development expenditure planned for the period is Rp. 42,853 million, but only about 51 percent, (Rp. 21,849 million) will be in public expenditures for development. The first two plans did not attempt to estimate private capital formation and include this in the national plan. This occurred only in the current plan.

college. President Suharto was one of the students who learned the technocrat's lessons well. It was more likely there than in his densely settled home province, that the current government's commitment to economic development, and hence to family planning was born.

F. Administrative Reform

Independence, a typical new-government commitment to stimulate national development, and President Sukarno's manipulation of authority produced a bureaucracy that was in 1965 bloated and ineffective. The Dutch had ruled Indonesia with a civil service that had grown to about 40,000 persons just before the Second World War. With independence, the new Indonesian government, like most in the new nations, committed itself to the task of directing national economic development. The subsequent government penetration into all affairs produced a rapid increase in the number of civil servants. Nationalization of Dutch enterprises in the 1950's brought more persons onto the government payrolls.

By 1960 the total number of civil servants had risen to about 1.5 million. Sukarno further expanded the bureaucracy to solve disputes, divide opponents, and reward loyalty. In 1968, when the new Suharto government began to reshape the administrative apparatus, it estimated that 2.5 million people were on the public rolls. The process prevailed at the top as well as at other levels. Sukarno's last cabinet contained 104 ministerial positions, held by 98 persons of ministerial rank. Far from being an instrument of development, this overblown structure was capable of no more than protecting its own welfare. As one observer has put it, the bureaucracy had become not the cook, but the meal.*

As part of the Suharto government's "New Order," and its shift from identity to development as the aim of government, the administrative structure was severely reorganized. Drastic measures were taken to reduce the size, and to increase the loyalty and activity of the bureaucracy. Size was reduced through purges of suspected Communists and leftists implicated in the abortive coup of 1965. The "100 Cabinet" was dismissed and a new cabinet one-fourth its size was appointed. Today, the civil service numbers about 1.8 million directed by about 20 cabinet ministers.

Loyalty was increased largely through militarization. Officers were placed in key positions throughout the service, especially in the administrative ranks that passed commands from top to bottom of the authority structure.

*Donald Emerson, "The Bureaucracy in Political Context: Weakness and Strength," in K.D. Jackson and L. Pye, eds., Political Power and Communication in Indonesia, Berkeley: University of California Press, 1978, pp 82-136.

Although the proportion of military in civil positions has steadily declined, younger, well-educated administrators have been given military training and reserve commissions to make them more compliant to orders from above.

Two processes have been directed toward making the bureaucracy an active servant of the central power. All government employees are grouped into a civil servant organization, KORPRI, which is supposed to involve officials during working and non-working hours in promoting government aims. KORPRI has been primarily an instrument to mobilize voter support, and is activated largely during elections. At other times it appears to be moribund. The second process has been more successful. Greatly increased government commitment to economic development, with greatly increased budgets, have given the bureaucracy a large role to play in the development process. Officers are responsible for carrying out government programs at all levels, and are given the resources for action. It is less certain that directives to develop local initiative for development programs are having a substantial impact.

Supporters of the current regime point to the new bureaucracy, which has indeed become an active instrument of central government development stimulation. Detractors point to the coercive stance and the heavy hand often used by officials, who continue to behave as commanders rather than leaders. But there is no doubt that the new bureaucracy has indeed become an effective instrument of government policy.

G. Indonesian Islam and the State

Islam is a potent force in Indonesia, but it is also diverse and complex. Nevertheless, because of this diverse character, together with the government efforts to contain extremism and the BKKBN's sensitive adaptation to local conditions, Islam has not obstructed and in fact has often been brought to support the national family planning program.

The strong extremist elements that exist are balanced, if not overshadowed, by Islamic groups that are strongly modernist. The country has experienced attempts to establish an Islamic state, through both constitutional maneuver in Jakarta and armed uprisings in the field. Past and present governments alike have worked actively to contain the extremists. The state philosophy, Pancasila, proclaims something close to a secular position. Rebellions in the field have been thoroughly put down. Constitutional maneuvers have been contained through the creation of a Ministry of Religious Affairs, which has at times been the largest of all ministries except education. In electoral affairs, the government has worked to contain religious groups in ways similar to those used with opposition parties.

In its own activities the BKKBN has been sensitive to religious groups and values. Statements on official Islamic positions regarding family planning have been widely circulated. Methods objectionable to Islam, such as abortion and sterilization, have not been adopted as official program methods. Religious leaders have been included in the finely tailored information programs the

central BKKBN manages for national elites. Provincial BKKBN officials have been careful to use persuasion and information to gain the support of local religious leaders and to include them in motivation and service delivery activities.

Although other religions have only small followings, they remain influential among certain groups. None actively oppose the national family planning program. The Indonesian Bishops Conference of the Roman Catholic Church for example, determined in 1974 that both family planning acceptance in general and the specific method used should be left to individual conscience.

H. Conclusion

In retrospect, conditions in the early 1970s appeared relatively favorable for family planning program development. Past population growth and density and modern socioeconomic development had produced some readiness for a large-scale change in reproductive behavior. The long-standing, relatively high position of women in Indonesia, as in all of Southeast Asia, was conducive to the introduction of modern fertility limitation. The political culture supported a system in which central authority could provide strong leadership for broad social change. Since 1966-68 the government has been strongly committed to modern economic development, from which an equally strong commitment to family planning followed closely. The government has made a major and largely successful effort to develop an administrative system that functions as an effective instrument of state policy. As a political force the major religion, Islam, is divided between extremist and modernist factions, and has in any event been kept under strong constraint by the ruling military.

These conditions are important, but they were only enabling conditions. They reflected a society ready for change and a government mobilized to direct change, especially toward fertility limitation. Government and society still, however, had to be given specific strategies and means for fertility reduction. Providing these was the task of the national family planning program and its administrative structure, the BKKBN. It is thus to this organization, and to the consistent support provided it by AID, that we must now turn for a fuller understanding of the Indonesian success.

PART IV

THE INDONESIAN PROGRAM

A. A Brief History

The National Family Planning Coordinating Board (BKKBN) is a semi-autonomous government board that reports directly to the president. Since its establishment by presidential decrees in 1970, the BKKBN has been responsible for all government population activities. As its name implies, it functions primarily by directing resources to other agencies, such as the ministries of health, interior, and education. It is largely these agencies that actually implement the program.

The program has undergone significant changes since 1970, but the BKKBN has maintained remarkably steady and rapid growth for most of that time. From 1970 to 1978, the program's domestic budget grew from \$1.3 million to \$33.1 million, accompanied by an increase in foreign donor assistance from \$3.3 million to \$20.8 million. This is reflected in a rise in the annual number of new acceptors from 181,000 in 1970 to 2.2 million in 1978.

By 1974 the national program had expanded to 2400 clinics on the islands of Java and Bali where two-thirds of Indonesia's population is concentrated. The computerized family planning data system that had been established two years earlier indicated a slowing of program growth. This apparently confirmed the fairly widespread impression that a clinic-based family planning program alone would not be able to achieve adequate population coverage, even with the assistance of nearly 7000 full-time family planning field workers to carry on out-reach activities.

The BKKBN consequently instituted a number of experimental service delivery projects, the most successful of which was termed "village family planning." This has involved establishing contraceptive resupply posts operated by trained volunteers and administratively supported by the local clinic. Village family planning initiated a major new expansion of the program with the total number of contraceptive outlets increasing from 4,000 in 1975 to 75,000 at present. This also changed the role of the family planning field worker who assumed much of the responsibility for supervising the village volunteers. Since village family planning is a generic model rather than a detailed blueprint, the BKKBN was able to adapt it to a variety of different local circumstances.

A major geographic expansion of the BKKBN program to the outer islands also began in 1974, intended to eventually bring services to an additional 24 percent of the population. By 1977 the program in the ten islands known as Outer Islands I began expanding beyond the clinic system using what had become a standard village family planning model. The remaining 8 percent of the population, Outer Islands II, is scheduled to follow a similar pattern beginning in 1979.

While the program is expanding in the outer islands, field experimentation is currently underway to prepare for an expansion of scope in the more mature programs of Java and Bali.* These experimental pilot-type projects will evaluate the impact of adding nutrition and simple health services to the village family planning infrastructure. The provincial BKKBN chairmen in charge of the projects leave little doubt that they intend to maintain the BKKBN pattern of rapid expansion. The program recently started in four regencies of East Java will expand to 14 in 1980 and the chairman in Bali, where a 250-village pilot project is just beginning, plans coverage of 3000 villages within four years.

The evolution of these activities will no doubt be affected by two recent changes in the BKKBN. A major reorganization of the BKKBN headquarters took place in 1978. Long-term implications of this are not yet clear, but there is a broad consensus that the reorganization process itself seriously impaired BKKBN's performance for several months. Finally, the recent appointment of the BKKBN chairman as Minister of Health while retaining his BKKBN position, will no doubt influence future efforts to integrate health activities into the family planning village network.

B. Major Characteristics: Flexibility and Decentralization

1. Flexibility

BKKBN belongs to the category of governmental family planning organizations that are independent from the country's Ministry of Health. Among Indonesian government agencies, it is exceptional in its ability to utilize foreign donor assistance without operational control by the planning ministry. As a coordinating rather than an implementing agency, BKKBN's major functions have been to channel family planning resources to other agencies for implementation and to monitor the program's performance. Although BKKBN initially followed conventional patterns by taking advantage of the existing MOH clinic and hospital network, it has never been limited to this approach. Nor has it been particularly limited by the budgetary restrictions characteristic of its sister agencies. Foreign donor assistance has roughly doubled the resources available to BKKBN. The program has also benefited from a network of provincial offices and a large corps of full-time family planning fieldworkers.

Despite these strengths, however, it is difficult to account for the program's remarkable flexibility and diversity without considering the facilitating influence of the USAID program. There is a consensus among BKKBN officials, representatives of other donor agencies, private consultants, and the mission staff that it is the nature and magnitude of AID support that has permitted the present pattern of activity. This view contends that BKKBN has succeeded in attracting increasing GOI support for its activities primarily by first demonstrating the success of various innovations. BKKBN has always had the organizational flexibility to explore new approaches and its reporting

*See Haryono Suyono and Thomas H. Reese, "Integrating Village Family Planning and Primary Health Services: The Indonesian Perspective," USAID, Jakarta, January 1978.

system offers an objective and rapid means of evaluating the results of innovations. AID contributed the financial flexibility by providing rapid support for a variety of initiatives.

This flexibility allowed BKKBN to empirically evaluate a variety of approaches to the delivery of family planning services beyond the Ministry of Health clinic system. Recognizing the financial impossibility of expanding its network of fieldworkers to achieve complete population coverage, BKKBN had little choice but to take advantage of the existing social infrastructure through unpaid volunteers.

A number of approaches simply did not work. Training "satisfied users" as family planning recruiters, for example, resulted in an actual decline in acceptance. A proposed project for industrial workers was rejected after a preliminary survey revealed that the workers already had small families. Training volunteers to establish family planning resupply posts in their villages did result in increased acceptance, however, and variations of this basic model, referred to as "village family planning," became the basis of a major program expansion. The provincial BKKBN offices in Java and Bali have tailored this approach to take advantage of local organizations. Variations in the more recently established village family planning programs in the outer islands appear less pronounced.

The village resupply posts are linked to the Ministry of Health clinic system for supplies and supervision. BKKBN has also taken advantage of the well-developed Indonesian civil administration network for political support for the program. This has involved training officials at a variety of levels in family planning. Similar systematic attempts to win the support of religious and other informal leaders are an integral part of the program. It is difficult to quantify the impact of these remarkable efforts on contraceptive use, however officials in the areas visited by the team were consistently informed and openly supportive of the program, and reports of opposition by religious leaders were minimal.

2. Decentralization

BKKBN flexibility has permitted a pattern of local initiative from the BKKBN offices, which make proposals to the central BKKBN for USAID funding. The central office takes an active role in this process, however, and must approve each project. These interchanges characteristically involve budget items rather than technical issues. Based on past experience, items such as training costs are fairly standardized, facilitating arrival at a final budget. Usually budgets are reduced, but a proposal that has reached the formal written stage is virtually assured of central office approval since extensive prior oral exchanges are the rule. The USAID staff is routinely involved in these discussions from the beginning and has enjoyed unusual harmony with BKKBN at all levels. This has allowed the mission staff to play a facilitating role in the development of provincial proposals.

The extent to which these local initiatives actually originate at the province level appears quite variable, but the central BKKBN effort to foster

provincial commitment is constant. Like the BKKBN's efforts to elicit active support of the local political infrastructure, these efforts to make the provincial offices active participants is difficult to evaluate objectively. Nevertheless, the commitment is evident.

For the outer islands, completion of village family planning coverage constitutes the first priority. In East Java and Bali, where village family planning coverage is virtually complete, field experimentation has produced local pilot projects that are adding nutrition and simple health services to village family planning. This represents BKKBN's first major departure from the single-minded pursuit of increasing the use of modern contraceptive methods. Team discussions with the BKKBN staff involved did suggest a certain continuity with past operations. There is, among both the central and provincial staff, a sense of the necessity to maintain the momentum of the program, to continue to expand, and to "avoid complacency." Such intuitive concepts are consistent with the past BKKBN strategy which has clearly emphasized program expansion over carefully planned and formally evaluated pilot efforts. The role of the program's highly effective data system and steadily expanding budget in this patently successful strategy has been discussed above. That this pattern will be extended to the integration of nutrition and health services with village family planning is clear. Both East Java and Bali's provincial chairmen have formulated plans for rapid expansion of these efforts that are not contingent on any particular outcome.

BKKBN officials offer several additional justifications for proceeding rapidly. One is an essentially intuitive impression that continued fertility decline requires a reduction in Indonesia's infant mortality rate, which continues to exceed 100 per 1000 live births. Another is the obvious merit of the effort itself, particularly in view of the clear inability of the Ministry of Health to provide similar services at the village level: the village family planning infrastructure constitutes a potential health resource that should be utilized. Finally, nutrition was recently made a high presidential priority.

BKKBN is optimistic that the village family planning network can effectively perform additional tasks without impeding family planning acceptance. There is no reason to doubt that the family planning data system will clearly document the impact of these activities on family planning use. Evaluation of their impact on health itself will be considerably more difficult. Eventual adaptation of the data system to routinely monitor health activities, as it does family planning activities, appears essential since no comparable system exists in the Ministry of Health and because of the crucial role of such a system in the basic village family planning model.

C. The BKKBN Family Planning Service Statistics System

It is difficult to overestimate the importance of the BKKBN data system in shaping the present program. At every level of the program, the team found a clear focus on objective, quantified measures of outcome in the delivery of family planning services. These measures are consistently those used in the

program data system, expressed primarily in terms of new acceptors and current users of modern family planning methods. There was a corresponding absence of emphasis on program processes that are only means to the outcome -- no suggestion, for example, that giving enough talks or opening the clinic for enough hours is adequate. Nor did the team detect a tendency to define roles in terms of status: everyone talked first about results.

It seems clear that an effective system for monitoring objective program outcomes requires and interacts with the political will to achieve these outcomes. The political determination to achieve a rapid reduction in population growth has been discussed above. The BKKBN decision in 1971 to utilize data on contraceptive use as an operational measure to monitor fertility decline was subsequently confirmed by the 1976 World Fertility Survey, and has remained the focus of the program since the data system was instituted. The data system allowed a large and diverse program to focus its resources on an explicit objective. This focus in turn has sustained interest in and support for maintaining a vigorous and far-reaching data collection effort. It is not difficult to find examples elsewhere of equally well-designed data systems that have atrophied from lack of use, producing inaccurate, delayed, and largely irrelevant records that compete with service delivery more than they support it.

Although BKKBN has made several modifications in the system, the basic data source has remained the monthly clinic report. The major items comprise new acceptors by method and contraceptive supplies distributed. The BKKBN Reporting and Evaluation Bureau calculates current active users for oral contraceptives and condoms from the quantity of supplies distributed by the clinic. Similarly, it estimates active IUD users by applying province-specific continuation rates derived from acceptor survey data. At present the 12-month continuation rates vary from 0.72 (Kalimantan province) to 0.92 (Bali). New acceptors of surgical contraception are allotted seven years of protection, based on a median age at acceptance of 38. The same bureau monitors contraceptive supplies from central warehouses to the clinic level.

The central evaluation bureau contains only 20 staff members and computerized data processing is done under contract by a private firm. In 1975, the data system at all levels consumed 2.4 percent of total program expenditures. The bureau produces a variety of reports and gives high priority to sending these to the field within one month. To facilitate rapid processing, the bureau monitors the timeliness of clinic reporting. In February, 1979, for example, 96 percent of the clinics in Java and Bali and 78 percent of the clinics in the outer islands had reported within the prescribed 12 days after the end of the month. Non-reporting for the year was only 1 percent and 7 percent respectively. At the province level the team found that data were available within two months of submission, even in the outer islands. Clinic facilities were generally only slightly less current, none with substantial delays.

Two features of the data system's design appear to contribute to this patently successful rapid feedback. The volume of data processed is relatively

small due to a conscious effort to limit the content of the monthly report, maintaining a focus on a small number of variables. This has been further reinforced by limiting the processing of client-specific information. The bureau does collect reports on individual new acceptors, but processes these only on a sample basis at quarterly intervals. The reliability of the Indonesian postal system is an important additional factor in this process.*

The explicit orientation of the reporting system to the needs of the program is also evident in the distribution of reports. Each administrative level receives reports which describe the performance of all the lower level units under its authority. The reports show subordinate units ranked by performance, maintaining the emphasis on outcomes. Political officials as well as health and family planning professionals visited by the team were conversant with the results of local family planning activities.

The village family planning resupply posts do not submit formal reports to the clinic. Instead, oral contraceptives distributed to the posts are assumed to be distributed to users. The team's field visits showed this to be a fair assumption. Posts with oral contraceptive users consistently reached very low levels of supplies prior to their monthly resupply visit. Further, only rarely did a volunteer report distributing more than one cycle to a user. While this arrangement is intended to produce fairly accurate estimates of current use, it raises the possibility of supply problems. The team's field visits, however, revealed no supply shortages in the village posts nor was there evidence of negative results from distributing oral contraceptives by single cycles.

In addition to indirect reporting of village family planning activities through the local clinic, each village post volunteer maintains a simple record that is not reported to higher administrative levels. This consists of a listing of the village's eligible couples and a month-by-month record of pregnancy status and contraceptives received. This record is intended to facilitate follow up of dropouts and supervision of the village volunteers. In the majority, but not all, of the posts visited, these records were well maintained and up to date. The Bureau of Reporting and Evaluation has not yet evaluated this system, but regards it as probably incomplete in terms of eligible couples. This view is supported by the fact that in the posts visited by the team the number of women classified as eligible for family planning services averaged about 10 percent of the population. Nevertheless, the practical contribution of the system at the local level is clear.

The basic reliability of the information entering the data system was substantiated by the 1976 World Fertility Survey for Java and Bali. Indeed,

*An interesting footnote on innovation is that the BKKBN, working with the postal service, introduced prepaid stamped envelopes to the Indonesian postal system in an effort to simplify and make more reliable the BKKBN system of obtaining field reports.

the BKKBN estimate for prevalence of use of modern contraceptive methods, 20.8 percent, was slightly below the survey estimate of 23.4 percent. This is strong evidence against substantial false reporting or non-use of accepted contraceptives. To this, scattered but confirmatory observations can be added from the team's field visits.

One set of observations concerns method failures. Several instances of recorded method failure were found among several hundred active users. This is enough to suggest that the village family planning surveillance system is at least partially effective, but far short of what one would expect from a large population that only politely accepted their monthly cycles and then quietly discarded them. Indeed, one reported method failure was not a failure at all, but a pregnancy that became apparent after a single cycle. It was nonetheless carefully noted by the volunteer. The estimated continuation rate of oral contraceptive acceptors was about 75 percent at 12 months, further suggesting that the distribution figures reflect genuine family planning practice.

Similarly, the provincial BKKBN chairman interviewed openly acknowledged the possibility of occasional falsification, but outlined the highly developed local family planning infrastructure that produces a wide variety of personal contact between staff and users: the intimate and highly autonomous banjar system in Bali, the local mother's clubs of East Java, and the widely scattered volunteers of the outer islands. In each case local contact is further supported by the extensive work of a variety of fieldworkers, supervisors, and clinic midwives. It is highly unlikely that substantial misreporting would elude such a variety and intensity of personal contact. To this can be added conversations team members had with a sizable number of personnel, which consistently confirmed that the program is indeed what it appears to be. The provincial BKKBN officials of East Java, one of the most vigorous programs in Indonesia, themselves expressed a desire to have their impressive service statistics confirmed by regular independent surveys. Finally central BKKBN officials also indicate that at every administrative level, program officials critically examine the data reported by their peers and openly question any figures they regard as inflated.

The Bureau of Reporting and Evaluation has maintained a generally effective and timely reporting system while BKKBN has expanded to the outer islands and implemented an extensive village family program. The prospect of incorporating nutrition and basic health data into the current system presents the bureau with a qualitatively new challenge. There is little doubt that BKKBN activities in nutrition and health will expand in the near future, but the pace of that expansion and the role of the family planning data system remain to be determined. For the present, the bureau seems confident that it can absorb any additional data without reducing the size or frequency of its reports.

D. Personnel

The headquarters and field staff of the Indonesian family planning program display a mix of diverse and highly complementary personal attributes. The

headquarters staff includes highly energetic activists together with calm bureaucratic statesmen. The BKKBN's chairman has shown admirable leadership in support of his staff's attempts to try new ideas. The provincial offices have also been generally staffed with competent, experienced administrators, and often with people of great dedication and vision. Here, too, is a great variety of style ranging from calculated, strategic planning characteristic of the military to missionary zeal and a messianic conviction that the program is predestined to succeed.

Four attributes, over which policy has some control, stand out in BKKBN's successful mix of human talents: military rank, medical training, provincial experience, and social science training. First, the chairman is both a medical doctor and a military officer. Thus he commands trust and respect from the ruling military group as well as from the medical profession whose involvement in family planning services is of vital importance. In addition, others of the top headquarters staff are also medical doctors. This provides BKKBN both with legitimacy in the eyes of the medical establishment and with the technical expertise needed for managing a program with important relationships to health.

Provincial BKKBN offices are staffed by medical officers, many of whom were trained in the provincial university medical schools. In this respect the past U.S. assistance to the Indonesian programs that established universities and medical schools around the country have now begun to pay large dividends. They have helped arrest the typical province-to-capital brain drain and thus provided the BKKBN with local leaders of high talent and competence as well as personal experience with the specific sociocultural conditions in the given province.

Finally, a critically placed top-level headquarters staff member is a social scientist trained in the United States. He brings to the program the sociotechnical expertise needed to implement large-scale experimental projects and to assess program effectiveness and impact. It is noteworthy that this staff member was trained under an AID professional training program. Such programs have come under some criticism as inappropriately training developing world staff in the United States. It would not be difficult to argue, however, that if this staff member were the only appreciable success to emerge from the entire AID training program, it would still have been highly cost-beneficial.

It is important that the headquarters' top-level staff is not homogenous but that it contains a mix of highly complementary talents. In Indonesia the military rank is especially important and in family planning medical training is especially useful. It is also important, however, that top staff were not all medical doctors since the latter almost universally maintain a private practice in non-office hours. While this does not necessarily interfere with normal office work, it does inhibit doctors from making visits to the field. Program momentum is dependent on such visits. The extensive field visits of the top social science staff member in particular have been vitally important in making it a success.

E. Contraceptive Service

In quantitative terms, AID oral contraceptive assistance increased from 1.1 million cycles committed in 1969 to 57.2 million in 1978. This has allowed the program to meet increasing demand while maintaining an in-country inventory of approximately 18 months.

The BKKBN logistics system is highly centralized and directly linked to the service statistics system. Since supplies are shipped on the basis of reported use, local units are not required to make routine requests. All of the clinic outlets visited by the team had the equivalent of several months' supplies, confirming the apparent effectiveness of the system. Village family planning distribution posts, in contrast, maintain very low inventories and rely on regular resupply from the local clinic. This arrangement has worked well in the relatively accessible areas visited by the team, but it seems likely that expansion of the program to more geographically isolated areas will require larger inventories in the distribution posts.

Contraceptive side effects are not unknown in the program, but the team's active questioning of both program personnel and users revealed a remarkably low incidence of discontinuation due to side effects. The most frequently mentioned side effects were, for oral contraceptive users, headache and weight gain, and for IUD users, cramping and intermenstrual spotting. A number of program personnel observed that the occasional changes in the brand of oral contraceptive distributed through the program appear to increase the incidence of reported side effects, at least temporarily. Thus, at least qualitatively, Indonesian women appear to experience a pattern of side effects similar to that seen in programs with lower continuation rates.

Client education about possible secondary symptoms does not provide a satisfying explanation of the program's low rate of discontinuation for medical reasons, since there appears to be a wide variation in philosophy within the program. One deputy chairman strongly advocates informing acceptors only that some side effects are possible, without specifying their nature. He reasons that specific information is suggestive and unnecessary. In contrast, one provincial chairman outlined an explicit policy of explaining all common side effects to each acceptor. He maintains that the occurrence of unexpected symptoms would impair continuation more than would any effect of suggestion.

There is, however, a consistent pattern of explicit organizational concern about side effects that the team found each time it raised the issue. This is manifested by an extensive training program down to the level of community volunteers and acceptor groups combined with an apparently effective referral network. Contraceptive side effects are openly discussed in a variety of local meetings, including those of the civil administration. Fieldworkers, supervisors, and health center personnel all reported that medical and psychological support of acceptors with side effects is one of their routine functions. This is not documented through the data system, but in the team's estimation, this ubiquitous network of support is the most important factor in minimizing discontinuation for medical reasons. The USAID support for this effort consists

primarily of providing extensive support to a wide variety of training, which frequently includes management of side effects. The mission has also supported specific studies, such as the Oral Contraceptive Comparability Study in West Java conducted with assistance from the International Fertility Research Program.

F. The Coercion Issue

The question has been raised as to whether the Indonesian family planning program uses coercive methods in recruiting acceptors. Indications of coercion have been publicized in an influential Population Council working paper,* which cites evidence from an Indonesian study.** Another study of the Indonesian bureaucracy indicated that coercion was used in East Java in both the family planning program and the green revolution.*** Suggestions of coercion are treated with a certain degree of credibility due to press reports of past Indonesian government actions to suppress political opposition. They are also treated with a great deal of concern because of the current U.S. government stance on human rights and because of the devastating effects of coercion in the Indian family planning program in the last year of Mrs. Gandhi's premiership.

Given this concern, the team made a concerted effort to assess the degree of coercion present in the Indonesian program. The conclusion reached is that the success of the program is due to voluntary acceptance and participation. The Indonesian government has neither the intent nor the capacity to achieve fertility reduction through coercive measures. It is equally apparent, however, that, in some instances in East Java, the strong government commitment to fertility reduction, together with distinctive local political culture, produced cases of "special drive" motivation tactics that bordered on coercion. Unlike in India, however, the methods promoted in these campaigns were non-permanent (particularly IUD but also oral contraceptive pills) and did not include sterilization. These general pieces of evidence led the team to the above conclusion.

*Paul Demeny, "On the End of the Population Explosion," Population Council Center for Policy Studies Working Paper No. 39, March 1979, p 35.

**Mardijanto Purbangkoro, "The Special Drive in East Java: An Evaluation of an Indonesian Family Planning Program Intensive Campaign," (Report of research sponsored by the Population Council with the BKKBN), Jember University, East Java, February 1978.

***Donald Emerson, "The Bureaucracy in Political Context: Weaknesses and Strengths," K.D. Jackson and L. Pye, eds., Political Power and Communications in Indonesia, (Berkeley, University of California Press, 1978) pp 82-132.

First, allegations of coercion in recruiting acceptors, as well as in the green revolution program, are almost wholly confined to the province of East Java. No mention of coercion is made in Bali, other provinces of Java, or in any of the outer islands. As noted above, it is in East Java that the authoritarian political culture rooted in the classical Javanese kingdom lives on most powerfully. If the government were ever expected -- either by observers or by the governed -- to act forcefully with a minimum of citizen participation and a maximum amount of silent compliance, it would be in East Java.

It was in East Java that the idea of the "special drive" was born and used with greatest success. During the special drives, targets set at higher administrative levels were passed down to lower levels. Apparently some lower-level officials became considerably zealous in complying with their superiors' orders. As in the green revolution and other special drives in East Java, the military also took up the challenge to assist in spreading contraception. In large part, this exercise of authority was neither uncommon, unexpected, nor popularly resisted in the East Java context.

Second, a systematic field study was carried out in East Java to learn more about the allegations of coercion in the program. This is the study cited in the influential Population Council paper. It is instructive first to note that the study was commissioned by the East Java provincial family planning coordinating board, because board officials themselves were concerned about the allegations. An independent team of academic social scientists conducted the study and its results have been freely disseminated.

It is next important to note that this study was an analytical and not a descriptive study. It was not designed to measure the extent of coercion throughout the entire East Java program, nor would this be possible. It was rather designed to identify conditions affecting the level of perceived coercion among acceptors.

The fieldwork focused on four villages, which differed primarily in the degree of leader involvement in the family planning program. In one village, information and instructions about the special drive came only from the headman and only during the period of the special drive. At the other extreme, the villages showed a wide range of formal and informal leaders, male and female, involved in providing information and instructions on family planning throughout the year. The first village can be characterized as highly authoritarian, the others as more participative or democratic.

Overall, almost half of the special drive acceptors who were interviewed reported they had felt coercion in their own acceptance. But there was a great difference between villages. The highest proportions felt coercion in the more authoritarian village. That is, where the program is able to mobilize a wide range of formal and informal leaders in motivation and information, people feel far more that their acceptance is voluntary. Where there is little participation by village leaders and essentially only the headman transmits government program aims, these aims come to be perceived as orders backed by force.

Two other somewhat contradictory findings from this study are of great importance for understanding the issue of coercion. On the one hand, about a quarter of acceptors felt coerced even in the highly participative villages. And in all four villages, without much variation, people reported that they fear government. Here the traditional authoritarian political culture of East Java is clearly evident: government is feared. On the other hand, when asked if they felt any adverse side effects from the IUD, most acceptors in all villages said they did not. Government is feared and obeyed but not resisted -- not even in the subtle form of complaints of physical discomfort that might be expected from IUD acceptors.

The third and final piece of evidence concerns contraceptive continuation rates. Allegations of coercion were accompanied by stories of women crossing the provincial line from East to Central Java to have IUDs removed or accepting but not using the oral contraceptive pills. This leads to the expectation that, if coercion were extensive, continuation rates would be low. The contrary appears to be the case. Service statistics, field studies, the World Fertility Survey data, and the evaluation team's interviews and observations all indicate high continuation rates and rapidly falling fertility in East Java, just as in Bali where coercion has never been seriously suggested. Further, high continuation rates and low fertility are found among pill acceptors, where the possibility of using coercion effectively is minimal and the opportunity for individual subversion of government program aims is extensive.

PART V

AID SUPPORT TO INDONESIAN FAMILY PLANNING

The Indonesian conditions presented above facilitated the development of effective AID assistance, but much of that effectiveness lies in the specific character of the USAID operation that emerged over 11 years of population assistance. This was not the product of a blueprint determined in Washington and transplanted to Indonesia nor of passive response to Indonesian requests. Nor was it simply the result of a series of happy accidents. Rather the mission's style of population assistance evolved as the mission directors and their population staff came to grips with the Indonesian situation and made a series of important decisions in attempting to carry out the various mandates of U.S. foreign assistance. These decisions were taken deliberately, always required careful analysis and extensive cooperation both within and outside the mission, and often involved conflict over alternatives.

This section describes the mission structure and mode of population assistance and attempts to present some of the alternatives faced and critical decisions made that shaped the character of this successful foreign assistance effort. Essential elements in this effort have been the USAID organizational structure, personnel policies, leadership styles, resources and patterns of resource flow, and inter-organizational linkages.

A. Organizational Structure

In the USAID mission in Indonesia population is the responsibility of an office that reports directly to the mission director. This is the result of a somewhat unusual decision taken when its first population officer was appointed in 1968. Although AID precedent usually calls for a critical mass of personnel before establishing a separate functional office, the high priority given to population apparently led to the creation of what may have been the only one-man office in a major AID mission. The office has grown gradually to its present size of four professional staff and throughout its history continued reporting directly to the director.

This structure provides numerous advantages. It gives the population officers immediate access to the director and his deputy. The needs and the activities of the office are thus not filtered to the top through personnel who may lack technical competence, interest, or the time to represent this activity effectively. This has had direct benefits in terms of staffing. It is unlikely that the high quality and motivation of the population staff could have been maintained without the advantages the office structure offered. Especially in the early 1970's, high quality population staff were in short supply in the world and international organizations competed actively for their services. It is doubtful that the mission's competent staff would have remained in a position where multiple bureaucratic layers would frustrate desires for effective program action. Finally, the existence of a separate population office has facilitated interaction and negotiation with the Indonesians. This

structure provides immediate evidence of the high priority the U.S. attaches to population activities and permits the population officer to interact with high levels in the Indonesian bureaucracy.

B. Personnel Policies

A high quality, technically competent, and culturally sensitive population staff has been a critical element in the mission's successful support. "Good people" have not been simply the result of fortunate accidents in personnel assignments. On the contrary they, and the high morale consistently apparent among them, are the result of deliberate decisions governing selection, training, and tenure. Not infrequently these decisions involved conflict with normal AID procedures.

A number of different offices have fought to assure appointment of personnel suited to the Indonesian program. The first appointment, which was perhaps the most critical, involved conflict in what was then AID/Washington's East Asia Bureau between a population officer and the Indonesian desk officer. The population officer, himself a medical doctor, apparently regarded a medical degree alone as sufficient qualification, while the Indonesian desk officer pressed for proven field capacity as well. After initial disagreements, a young medical doctor with public health training and Peace Corps experience in Pakistan was finally appointed. This talented individual went on to provide six years of sensitive technical assistance to the Indonesian program. His appointment proved highly advantageous both in setting standards of excellence for future appointments and in setting the course of the mission's population assistance effort.*

AID procedures have permitted, though not always readily, population training for promising young staff. Two effective officers came to the program from AID's management intern and International Development Intern programs. Both received leaves for AID-funded M.A. training in population during their early years with AID. In one case the training was smoothly provided by AID/Washington's Office of Population. In the other case, however, the proposal for training was refused on apparently personalistic grounds by the East Asia Bureau's Management Office, which controlled personnel decisions. It required the double intervention of the Indonesian desk officer and the Office of Population to reverse the decision and to provide the needed training.

The mission's policy is to use direct hire personnel for multiple terms of duty rather than external consultants for short periods. The latter is the

*In contrast, the physician-candidate rejected by the Indonesian desk officer for lack of foreign experience and promise in general subsequently performed so poorly in a country to which he was finally assigned that he was removed and recommended for separation from the Agency.

policy of the World Bank, and is considered quite inappropriate for the type of support the mission offers. One major advantage is that the direct hire personnel are part of the AID regular career staff and are, therefore, more effective in dealing with AID procedures. More important is the possibility of keeping them with the resident USAID mission for multiple tours of duty. This provides for a level of experience that can only be gained in the country program and that is especially valuable for providing effective assistance to the program. The current mission director asserts that three tours of duty, implying seven years in-country, is optimal. More rapid turn-over deprives the mission of valuable staff experience and probably reduces overall personnel efficiency by increasing the staff turn-around costs. Professional staff also point out that long terms of duty are probably much more important for technical program staff than for administrative support staff. Effective program assistance requires sensitive knowledge and experience with the country in question. Administrative support requires less country experience and more experience with AID internal procedures.

All mission population staff have facility with the Indonesian language. This has been especially valuable in producing good relations with the Indonesian staff and in drawing out the initiative of provincial and other local leaders. It is also responsible for speeding the process of resource allocation to the provinces, since local requests need not be translated into English. Language facility, like other personnel qualities, is not the result of "fortunate accidents" of staff recruitment. Staff can receive intensive language training (including for spouses) in Washington before coming to the field but, more important, the mission supports an active and very effective language training program of its own. Staff can be posted to Central Java for intensive language training for a month or two. Formal courses are run at mission headquarters and tutors are provided to staff for whatever schedule of language training they need. In effect the mission does a great deal to assure that its staff do have facility with Indonesian.

It should not really be necessary to belabor the advantages of having a staff with facility in the Indonesian language. It is inconceivable that foreign assistance could be given effectively, especially in an area as sensitive as fertility limitation, without such facility. In its field visits the team was able to witness the high quality of AID - Indonesian interaction that flowed from AID staff capacities to speak the national language. Regency chiefs, district officers, a vast array of lower officials and clerks, village religious leaders and local family planning staff were invariably delighted, honored, and amazed at confronting huge Americans who could address them in their own national language. Quite aside from the purely technical and instrumental advantages of language facility, the team saw that it could also help immensely to generate the enthusiasm and commitment of local leaders for the national family planning program.

C: Leadership Styles

The current mission director exhibits a style of leadership that conforms closely with principles of what is called participative management.* He establishes strong performance goals for his staff, delegates authority to the staff and holds them responsible for goal achievement, is accessible to the staff for whatever assistance he can give, and he becomes personally involved in the projects in the field. This not only provides the maximum opportunity for staff to demonstrate their own capacities, it appears to set a style of administration that is reflected in the way population officers carry on their own work.

The style is apparently infectious, since it is found in the population office as well. The office director effectively delegates authority to his staff, both American and local, and thus gains their active commitment to program success. All staff appear willing to pass on both assistance and acclaim to their Indonesian counterparts at all levels. They are, in effect, more concerned with program success than with their own success. Thus they help to assure that Indonesian headquarters and provincial staff and local leaders gain recognition and visibility for the successes of the family planning program. They have been willing to support projects without requiring U.S. recognition, thus helping Indonesian family planning officers to build political support by giving their own national leaders successful programs at little or no cost to these leaders.

As with other conditions, this style is easier to describe than to explain. It is obviously the product of some interaction of the personal characteristics of individual mission directors, and both the mission structure and the country conditions with which they must work. The two mission directors associated with the Indonesian program did not experience equally effective population programming in other countries. In Indonesia, however, their styles of participative management were important elements in the program's success. Their decisions to sustain a separate population office made them more accessible to population staff than they would have been had that staff been placed under intermediate officers. Their desire for personal involvement and field travel were well received and played a crucial role in the capacity of the mission to move resources out of the capital and down to the provincial and local levels where the work would actually be done. The forward movement of the Indonesian program itself made the strong performance goals they set for their staff reasonable and effective goals for the program.

The strong performance goals of the mission in general had an especially clear impact on the type of data system mission staff helped the Indonesians to create. In 1970 the mission decided to support the BKKBN in its decision to establish a new data system independent of that of the Ministry of Health. The

*For a good exposition of this form of management see Rensis Likert, The Human Organization, New York: McGraw Hill, 1961. Likert has been a major proponent of both the theory and practice of this form of management.

decision was hotly contested. Ministry personnel claimed a separate system was unnecessary and that family planning functions could be grafted onto its own existing system. AID and BKKBN personnel maintained that the urgency of the need to arrest population growth demanded a system designed to collect and process for rapid feedback only that minimum data needed for family planning program management. They recognized that the greater the number of demands placed upon a data collection system the less likely it is that data will be collected accurately and used effectively for program management.

Had the decision been made to take what then might have appeared the easy way out -- to yield to the opposition rather than struggle to establish the new system -- the present program would have been deprived of a management tool that has proven critical for accurate monitoring, rapid feedback, and the competitiveness among participating units that fuels the program's enthusiasm. The program would have been similarly handicapped had the data system been designed for the goals and specifications of foreign demographic researchers.

D. Resources and Resource Flows

Of all organizational conditions, those that most clearly define its character are the level and type of resources available and the pattern of allocating resources to specific activities. AID has been able to provide effective assistance to the successful Indonesian program in large part because it has had available a high level of grant funds; it has allocated these to local activities through its local cost programming, providing for rapid movement of money to the lower administrative levels at which program successes are built; and because it has supported the program through training grants and through appropriate provision of commodities. Each of these conditions deserves special consideration.

1. Grant funding. As noted above, the major portion of AID funds to the Indonesian program have come in the form of grants rather than loans. Of the near \$58 million provided to Indonesia over the past 11 years, 75 percent have been in grants.

Grant funding has provided important advantages in three major ways. First, grant funds come at little or no cost to the host government, thus they can support activities without drawing them into competition with other programs. This was especially important in the early days of the Indonesian program, when the government was faced with the immense difficulties of rehabilitating an economy left in shambles by the Sukarno government. At that time everything needed immediate attention, from stabilizing the currency to building the physical and social infrastructure needed by a modern state. It is at least questionable whether the Indonesian government, however committed it was to fertility limitation, would have been able to allocate the necessary financial resources to a national family planning program. That the United States was ready to provide grant funds made it possible for the Indonesians to create the organizational structure necessary for a successful national family planning program. The Indonesian government had demonstrated its commitment to family

planning by increasing its own allocations. These have doubled every two years for the past four years. Although precise assessments cannot be made, it is the considered judgment of many observers that the Indonesian financial commitments have come in part because of the program's success, and that this success was contingent upon the grants available from the United States early in the program's development.

A second advantage of grant funding lies in the speed with which monies can be made available. Grants permit the AID mission to deal directly with the BKKBN. Loans require negotiations that are inevitably drawn out in time by the necessity of involving many different upper level agencies -- the Central Planning Agency, the Finance Ministry and the State Bank. That these levels can be by-passed makes funds to BKKBN available within months rather than years. The team encountered a number of provincial officials who made strong and invidious comparisons between AID grants and the loan processes of other foreign donors. The speed of resource flows permitted by grant funding is considered especially important in drawing out the initiative of local leaders, and this is certainly one of the key elements in producing the broad-based national development that is at least the stated aim of American foreign assistance.

A third advantage of grant funding lies in the flexibility it provides. Loans are inevitably tied to specific forms of activity and to specific repayment schedules. Grants can also be so encumbered, but in the Indonesian case they have not been. Grants are provided in large blocks for general types of projects, and the specific project decisions are made on the ground in intense cooperative interaction between AID and Indonesian officials. This provides for the maximum of sensitive adaptation to the local situation, which is also considered a key to effective development stimulation.

Grant funding in Indonesia has been a two-way process, with important advantages to the AID support program. The Indonesian government has established a trust fund into which it provides annual grant funds to cover local AID mission costs. Thus housing and utilities of American staff are paid for, but more important, the local travel costs of the mission staff are also covered by the trust fund. Mission personnel report that their estimates of local travel for each coming year are readily accepted and added to the annual trust fund requests. In effect the local travel of population officers is drawn from an apparently unlimited source of funds. The only limitations placed on population staff are those of reasonable expectations. As indicated in the following section, AID support to the Indonesian program involves activities that are highly labor intensive and dependent upon extensive field travel for their success. The Indonesian grants have meant that such travel was never constrained by financial limitations.

2. Local Cost Programming. AID support to the Indonesian family planning program is distinguished by the extensive use of local cost programming. The following distribution of grant funds by project categories for FY 1978 and 1979 shows this clearly.

Table G: USIAD/Indonesia Grant Funds for Population
FY 1978 - 1979

	<u>FY 78</u>	<u>FY 79</u>
Technical services	\$ 213,000	\$ 170,000
Local costs	\$2,749,297	\$3,800,000
Training	\$ 518,000	\$ 520,000
Commodities*	\$ 700,000	\$ 700,000

*Does not include \$7 million in each year for oral contraceptive loans.

Local costs are used to support a wide range of Indonesian initiated projects, including workshops, conferences, research, pilot projects and assistance to such innovative program activities as village family planning. It is under local cost programming that the AID mission has developed a mechanism for moving resource swiftly and accurately to the provinces, where program success will be determined. It will be useful to describe this mechanism in some detail since it is probably the most distinctive element of the AID population program in Indonesia. Further, the use of this mechanism clearly illustrates the importance of other organizational conditions described above. Finally, if there were only one lesson to be learned from the AID-Indonesian success story, it would revolve around this mechanism for moving resources rapidly to the provinces. It is important to note here that the mechanism does not rely on specially constructed new legal or administrative procedures. All such elements are already in place throughout AID for the use of this important mechanism. What is required is the will in the mission to use the mechanism and the intelligence to adapt it to specific country conditions.

The procedure for disbursing funds under this mechanism is relatively simple, and by normal government standards anywhere, unbelievably fast. Following normal AID procedures a BKKBN-AID Project Agreement is signed by the mission director and the BKKBN chairman. Thereafter, the mission director delegates to the population officer the authority to sign sub-agreements, or Project Letters of Implementation (PILs). Specific requests are initiated by either BKKBN provincial or headquarters staff for what Washington could consider "sub-projects," but which are locally known as projects. For projects initiated in the provinces the procedure is the following: (1) A formal project request, complete with budget and schedule of activities, comes from the BKKBN provincial office to the headquarters. (2) The national office screens the proposal and if it is approved, forwards the request to the AID mission. (3) The mission prepares a project implementation letter stating that AID will disburse funds for the activities in the project and repeating the legally binding conditions of use and accounting. (4) The mission then requests a check from AID's Bangkok office, to be made out to the appropriate BKKBN headquarters official. (5) When the check is received by the mission, it is hand-carried the same day to the BKKBN for deposit in its own account. (6) Within five days the BKKBN headquarters sends the

funds in full to the provincial office for deposit in a special bank account established for that specific project. For projects initiated in BKKBN headquarters, the first step is omitted, but all others apply.

There are three especially important points to note in this process. First, the funds from AID go directly to the BKKBN. The check is written to an individual official for deposit directly into the BKKBN research account. The funds do not go to the central government, or to any ministry, to be passed down to the BKKBN. It is estimated that this saves an average of six months in allocation time.

Second, the AID project implementation letter to BKKBN specifies that the funds must be allocated to the provincial office in full within five days. This was a stipulation suggested by the BKKBN deputy for research and development. He observed the common Indonesian procedure of disbursing funds in small amounts, with the tendency to demand accounting of one payment before the next would be made. To break this bottleneck, he asked AID to specify quick and full allocation to the provincial operating units. Once the stipulation was written into the implementing agreement, the BKKBN office staff followed it willingly and moved the money quickly to those who were to use it.

Third, the proposals that come from the field to the mission are written in Indonesian, not in English. This saves time and energy in the provinces, since proposals need not be translated before forwarding. More important, it means that Indonesians are making requests in their own language. Thus there is no language barrier to the exercise of local initiative. This also implies, of course, that the USAID population staff must have facility in Indonesian. This is another way in which the broad character of the mission and the facilities it provides help the population staff to exercise their own talents to the fullest. It is difficult to overestimate the extent to which the language facility of the AID population staff helps to elicit the initiative of local Indonesian officials. For Indonesians, dealing with AID population personnel is not rendered difficult by language barriers.

AID's most active involvement occurs in the process leading up to the formal proposal. The mission's population staff often accompany BKKBN officials to a provincial office where they discuss the program with provincial and lower level staff. When specific needs or ideas for action are identified the group begins writing a project proposal. In some cases all involved sit down and draft the project proposal to be carried back to BKKBN headquarters for forwarding to the mission. In other cases, the headquarters staff will leave the local staff to write the proposal for later transmission to Jakarta. This might then be followed by another field visit to work over elements in the proposal that are unclear or unspecified. In effect, AID and the BKKBN headquarters staff are stimulating local groups to plan and organize projects and to submit formal requests for the necessary funds.

The same involvement occurs when the project requests are initiated by BKKBN headquarters. In this case discussions between AID and BKKBN staff

identify activities of mutual interest, which the mission is able to fund. From these discussions BKKBN prepares a request for funds, enabling AID to begin its formal procedures for moving the money.

Table 2 shows an analysis of the time required to move the money through the steps outlined above for the 39 payments made to BKKBN in 1978. Since four different time spans, or sets of steps, can be shown here, it is necessary to explain what each means.

1. Line 1 shows the experience of the full 39 payments made by AID in Calendar Year 1978. In all cases, this is the minimum step, which involves AID requests to Bangkok for the check and receipt of the check. The range was from 7 to 42 days, with the median number being 21 days.

2. The 39 payments shown in line 1 resulted from 30 PILs prepared in 1977 or 1978. Nine of the projects involved multiple payments, agreed upon either in 1978 or a previous year. For the 30 PILs, line 2 shows that the range of days from preparation of the PIL to the receipt of the check by BKKBN was 18 to 49 days with a median at 27 days.

3. Two of the 30 PILs resulted from personal conversations with BKKBN staff, omitting the formal written request from BKKBN in 1978. Thus, there were 28 written requests from BKKBN to AID. Line 3 shows that the range of days from these formal BKKBN requests to receipt of the funds was 20 to 27, with a median at 41.5 days.

4. Finally, for 12 of the PILs the records identify the date of the first written request from the field to BKKBN. (In 21 cases the request was actually initiated in the field, but the AID files do not contain records of all field-BKKBN correspondence.) Line 4 shows that for these 12 field initiated requests the range of days from field request to receipt of the money was 33 to 269 days, with a median at 90 days.

Table 2: Number of days to move money from AID to BKKBN in 1978

	Days		
	Cases	Range	Median
1. AID check request to check receipt	39	7-42	21
2. AID PIL preparation to check receipt	30	18-49	27
3. BKKBN request to check receipt	28	10-227	41.5
4. Field request to check receipt	12	33-269	90

This analysis can be summarized as follows: When personnel in the field get an idea for an activity, they can make a request and have the money for the project in about three months. When BKKBN headquarters staff get an idea for a project, they can make a request to AID and have the funds in about six weeks. When AID agrees with BKKBN to fund a project, BKKBN can have the money in about four weeks. When AID makes a request for funds for BKKBN, those funds can be delivered in three weeks.

The size of the project budgets, or AID payments varied greatly. The smallest was Rp. 1.5 million (U.S. \$2,500).* The largest single payment was for Rp. 85.6 million (U.S. \$143,000). The largest total project was for Rp. 183 million (U.S. \$305,000). Half of the projects were below Rp. 22 million (about U.S. \$37,000), and three-quarters were below Rp. 39 million (about U.S. \$65,000). There is no relationship between project size and time required for allocation.

The process is highly labor intensive and time consuming in the personal discussions and negotiations leading up to the formal request. But once this formal request is made, the money moves quickly. The mission population staff by no means regard this labor intensive process as onerous. Quite the contrary, it puts staff together in close cooperation with headquarters and provincial BKKBN staff and a great deal of personal satisfaction is derived from being closely involved with a program that is having obvious positive impact in the field.

*Rp. = rupiah, at the time of writing about 600 to the U.S. dollar.

This is certainly one of the most important aspects of the process of AID assistance to the Indonesian program. The mission, together with national BKKBN staff can work with local groups to plan their own projects. The incentive offered to local leaders for the time and energy required in project planning is the rapid allocation of funds.

Development programs commonly founder on precisely this point. The aim is to generate local initiative, to induce local groups to take charge of their conditions and plan for change. Typically, however, national leaders are not successful in generating action, because their inducements are seldom followed by timely allocation of the resources needed to carry out projects. Local initiative gets lost in the months and years it often takes to transfer resources into the hands of those who show initiative. Government in these circumstances becomes little more than a taker of taxes represented by officials who make hollow promises. AID and the Indonesians have found a way to produce a rapid translation of promises into realities.

In frequent discussions with provincial officials, the evaluation team often heard AID compared favorably with other international donors. Long delays and insistence upon procedures and activities inappropriate to the local situation made many Indonesians judge assistance of other donors far more trouble than it was worth.

3. Legal Adjustments. The newness of BKKBN, its staff's determination to stimulate local initiative and gain local participation, and AID's willingness to assist in this process as much as possible, led to the development of an unconventional element in the process for moving funds. AID funds were being transferred by check directly to a BKKBN official. This official deposited the funds in a personal bank account, then wrote another check for the full amount to the provincial BKKBN office. From the point of view of the provincial officers the procedure was highly effective since it avoided the long delays in disbursements that have plagued virtually all Indonesian public program financing. From the point of view of public program comptrollers, such a procedure raised serious questions of accountability.

In 1977 BKKBN began a large reorganization which, among other things, pointed to a need for a more conventional procedure for receiving AID field-destined funds. Early in 1978 the mission's comptroller questioned the provision of AID funds directly to Indonesian nationals. A thorough audit of the funds was being made on both sides, showing no irregularities or deviations from AID's federally determined regulations. Comptrollers on both sides nonetheless strongly recommended a change to more conventional procedures.

The mission population office was insistent that whatever change was made not slow down the movement of funds to the provinces, since they viewed this feature as the key to their effective support of the Indonesian program. BKKBN staff were also determined to sustain the rapid flow of funds to the provinces. Both the BKKBN Chairman and the AID mission director were supportive and instructed their comptrollers to work out more conventional ways to transfer funds

without delaying their movement. On the AID side, the result was the Project Implementation Letter (PIL), which the population officer was authorized to sign for disbursement of funds. On the Indonesian side, two staff members were designated as AID liaison. The previous fund recipient would manage day-to-day operations, and another would receive AID checks for transmittal to the provinces. At this point the AID PIL began to stipulate that funds be moved in full within five days to the provinces.

The change was instituted without breaking stride in the transfer of funds. The last of the old procedure instruments, the Letter of Agreement, was dated March 20, 1978; the first PIL came 14 days later, on April 3, 1978.

This episode illustrates a number of conditions that are believed to have been absolutely essential to the effective AID support of the Indonesian program. First, the problem arose in the first place because both sides had a strong interest in moving money rapidly to the people in the provinces who would actually use it. Given the newness of the BKKBN, if the staff had waited for an official decision on an appropriate procedure in the first place, it is highly likely that little money would have moved and BKKBN would have had little success in stimulating local initiative. Second, both BKKBN and USAID directors were committed to outcomes rather than to procedures, were highly supportive of their personnel, and thus instructed their technical offices to develop suitable means to continue a process that had proven so successful. Third, the personal and trusting relationship between BKKBN and AID staff, built up over years of field trips and intense cooperation in support of the family planning program, permitted the change to a more conventional procedure to be worked out smoothly and quickly.

The local cost program mechanism is flexible as well as rapid, and this has allowed AID to take advantage of unanticipated opportunities that would have been lost under more conventional programming. For example, when the central BKKBN office ran short of funds during its reorganization, AID was able to provide funds quickly for an important conference on the realignment of the provincial offices in the outer islands. Similarly, when unplanned delays in processing the refunding of the West Java VFP program resulted in late submission of the request, AID was able to avoid disruption by rapid processing. When health and family planning officials in Bali abruptly settled a long-standing disagreement that had prevented the implementation of a cooperative pilot project, AID was able to act quickly to arrange funding.

The speed and flexibility of the program have proved compatible with acceptable levels of accountability and planning. After a relatively brief period of experimentation with different approaches to extending the coverage of family planning services beyond the clinic system, BKKBN and AID focused on the VFP model. Extensive experience with this approach has allowed a significant degree of standardization of the costs of major items. Outputs, in terms of new acceptors and current users are documented through the regular program data system. The USAID population staff also makes field visits prior to each funding increment, estimating, for example, 188 person days in the field for FY 1979. Audit reports have confirmed the AID staff's impressions that program funds have been fully directed toward the appropriate activities.

It has been noted that this use of local cost programming to fund specific provincial projects is highly labor intensive. Population officers spend a great deal of time in the field, working with provincial officials. The field travel is a vital part of the entire process, for it keeps AID staff current with conditions in the field, and it brings their physical presence and capacity to commit funds on the spot, which helps to draw out local initiative. The 188 person days estimated for the coming year's travel represents about 0.9 person years, which was spread over three full-time staff and a full-time consultant. This poses an interesting question of critical mass in a population office, which the evaluation team can only raise, but not answer. Is there a critical mass of staff, below which it would be very difficult to provide effective assistance? If this program, with its fast and accurate money moving procedures requires 0.9 person years in field travel, it might appear that a two-person office would be too small to provide the kind of effective assistance the office has developed. To put this another way, if the fast money moving procedure observed here is vitally important to effective assistance, as the evaluation teams believe it is, and if this is acknowledged as a labor intensive procedure, then it follows that a certain minimum of staffing must be normally accepted in order to derive the benefits that the procedure offers.

It is difficult to speculate on what the nature of AID assistance would have been without the flexibility and speed of the local cost mechanism. In a very real sense, the flexibility and speed were the program. The mission population staff have not pursued a separate agenda, but have recognized the basic soundness of the BKKBN and provided it with much needed financial flexibility. This helped shape the program by encouraging innovation and commitment at the provincial level. The resulting program has been characterized by rapid expansion and diversity, but it has also been able to maintain a sharp focus on the results of all these activities in terms of contraceptive use through a remarkably effective reporting system.

4. Training. The population office provides approximately \$600,000 per year for training Indonesians in professional skills relevant for population programming. The training is regarded by office personnel as highly effective and useful in building the local capacity needed by Indonesia to manage its population programs. The overall program is divided into two major elements, in-country and U.S.-based training, each funded by a separate budget category.

In-country training programs are funded from local cost programming and are formally managed through the project implementation letter by which monies are moved rapidly to the actual users. Approximately \$100,000 has been allocated each year since 1977 for two Masters Degree programs at Indonesian Universities. In 1977 a two-year program for about 25 students was designed in which students would be trained in Bogor in either Human Reproductive Biology, or Rural Social Dynamics. In 1979 a five-year program was begun to develop a program in Public Health and Population Studies, leading to a Master of Public Health Degree at the University of Indonesia's faculty of Public Health. This program will produce an estimated 50 public health professionals

with specialization in population planning. It is planned to run over the course of the current national five-year plan, 1979-83, and is estimated to cost about \$100,000 per year.

The U.S.-based training program is budgeted at about \$500,000 per year, supporting 40-45 students in a wide variety of advanced professional (Ph.D) courses. A number of critically placed staff in the BKKBN are now products of this type of training, which has been in operation for some years. The current deputy Chairman for research and development, who played a leading role in the move to Village Family Planning, was trained in sociology and demography at the University of Chicago. The current chief of the Bureau for Field Coordination, which will play a critical role in the new expanded family planning, nutrition, and health program recently returned from Ph.D. training at the University of Hawaii. The chief of the Development and Evaluation bureau is a recent Ph.D. from Pittsburg. Outside of BKKBN, the director of the University of Indonesia's Demographic Institute, who plays a vital stimulating role in research and training of provincial demographers, received a Ph.D. from Georgetown University. A deputy director of the country's Central Statistical Bureau is also a U.S. Ph.D. There is now a group of students in the U.S, receiving advanced training in statistics and computer science, who will be returning to play a major role in Indonesia's 1981 census. Students in U.S. training also include people in a wide range of fields, from medical anthropology, to reproductive biology, demography, statistics communications, and public health.

The population office staff report that this type of training has been exceptionally beneficial. They report no losses of students who have been lured away to other countries. All are working in Indonesia in positions, as those cited above, that are highly supportive of the nation's overall population program.

Selection of students for training in both in-country and U.S.-based programs follows closely the pattern of Indonesian-American cooperation in labor intensive project development that characterizes the overall AID-Indonesian relationship in population. Prospective students are identified in the many field programs underway. For example, two students have recently been identified by AID-Indonesian staff who are planning the extended nutrition, health and family planning program in Bali. These are young officials who will receive in-country training to give them the skills needed to assist in the later development and management of the Bali program. When candidates are identified in the field, they make formal application for training to the BKKBN, which formally screens the applicants and sends nominations to AID for funding. As in other cases, however, there is a great deal of informal communication between BKKBN and mission staff concerning applicants before formal nominations are made.

Two additional advantageous elements of the training program should be noted. First, training is deliberately used to reinforce the reward-for-performance system within the nation's population program. BKKBN field and

headquarters staff recognize that if they work well and effectively, they have a good opportunity to advance through additional formal training, either at home or abroad. Further, the extensive cooperative efforts of BKKBN and AID staff in all aspects of the program helps to ensure that the training program will be used to reward performance, and not simply relatives or favorites. In effect, the joint character of the selection process helps to keep both sides honest, and helps both sides to avoid external political pressures to reward favorites.

Second, it is in the training program that some of the most effective cooperation has taken place between AID and other donors, notably the Ford Foundation. Ford field staff have been very helpful in identifying good candidates for advanced training. In addition, the Ford Foundation has often been willing to pay transportation costs for training, which AID is legally not permitted to bear. Under current regulations, foreign travel for training cannot be provided by AID. It is to be borne by local government funds. This presents an additional obstacle to effective programming, since it involves another layer of the Indonesian bureaucracy and another cost, which must be taken from other Indonesian programs. Since the Ford Foundation has been willing to pay foreign travel costs, it has been much easier for the AID population program to make clear and rational plans for training of Indonesian population personnel.

Overall, the training program is considered a great success by both AID and BKKBN staff. Even the long-term advanced degree training is considered highly cost-effective as it is relatively inexpensive and has provided the Indonesian program with much of the trained manpower it needs to be self-sufficient.

5. Commodities

As noted in Part II above, AID has provided over \$20 million in grants and \$14 million in loans for contraceptive supplies. These have been primarily for oral contraceptives and condoms.

The emphasis on supply of AID/Washington's Office of Population has been important for the program. The program has apparently never been obstructed in any way by a shortage of contraceptives and at some points its extension has been hastened by the full adequacy of supplies -- especially at the initiation of village family planning. As early as 1973, before it was apparent that the demand in Indonesia would grow so rapidly as it did, the director of the Office of Population advised the mission's population office to order 20 million cycles or oral contraceptives. The existence of this large supply in Jakarta helped break the common bottleneck in contraceptive supply known as the "cookie jar phenomenon." This holds that short-stocked central officials will be reluctant to send supplies to the provinces for fear of diminishing their own stocks. "If the cookie jar is only half full, you only pass out one cookie at a time. If it is full and overflowing, you can let people take handfuls." The large

supply of contraceptives posed storage problems at the center, producing an "overflowing cookie jar," and made central officers happy to move large quantities out to the provinces. Since 1973, AID commodities support has been consistent and unstinting. The central warehouses are kept full, and the flow to the provinces is unimpeded.

A problem with this otherwise beneficial supply orientation is that the Indonesians do not control the basic procurement decisions. AID is able to provide full support for contraceptive supplies in part because it purchases large volumes in the United States. It is constrained, however, by standard U.S. government procurement procedures, including open tenders and competitive bidding by suppliers. The net effect for Indonesia is that pill brands and dosages have changed from time to time. Contrary to some opinion, peasant women are acutely perceptive of such differences. Some laudable attempts have been made to counter this problem. AID has developed, for example, the standard "blue lady" package that is used for consistency, for all pills regardless of brand or content. This has been useful, but it still underestimates the perceptivity of peasant women to subtle changes in brand names. It would be useful if AID could maintain greater consistency in brand names as well as dosage or, alternatively, give country programs greater voice in determining what contraceptives they receive.

E. Interorganizational Linkages

The Congress has mandated that AID work with other governments and other foreign donors to reduce fertility and mortality in the developing countries. Meeting this mandate and dealing with recent family planning program developments in Indonesia will require new forms of linkages with other agencies and other organized activities. Such linkages are always part of the goal-achieving process of any organization, and they always present both problems and potentials. For the Indonesian-AID cooperation today, three forms of linkages deserve special attention. One concerns the integration of health and nutrition into family planning. A second concerns the linkages between AID and a local organization, supported by AID/Washington, that promotes voluntary sterilization. A third form of linkage concerns interaction between AID and other foreign donors.

One general observation can be made of all these forms of linkages. Little takes place according to some standard blueprints from Washington. The team believes that on the contrary, a major reason for the AID success in Indonesian family planning is the fact that all activities have been worked out on the ground in cooperation with Indonesians, and have been designed and pursued not for themselves but to promote the basic program goal -- the rapid reduction of fertility.

1. Integrating Health into Family Planning

At the village level the AID-supported program has been single-purpose in its service delivery, and thus not "integrated," in that it provided only

family planning services. There is strong consensus that progress in fertility reduction would have been far slower had family planning services been held back from the rural areas until it had somehow become possible to provide a general village-based health care package of which family planning was part.

A new type of "integration," however, is being actively pursued at this time. Now that the family planning program has demonstrated its ability to effectively mobilize rural population and deliver services and motivation to the villages -- something the health system itself has yet to achieve -- experimentation and planning is taking place to "piggyback" nutrition and health services onto the already existing family planning organizational apparatus. The evaluation team was able to observe this important development in the AID-Indonesian effort to promote family planning. It is possible to see both the strengths of this new relationship as well as some problems that will inevitably be faced in sustaining forward drive.

The philosophy of this strategy was explained by the chairman of the East Java BKKBN, who initiated an AID-supported pilot project to add nutrition and health interventions to village family planning in one of the areas visited by the team. The villages selected for the project have high prevalence rates, even for East Java, and active mothers' clubs that support a village family planning program of predominantly IUD users. This reflects an explicit policy to locate the project in areas where the village family planning program is well managed and acceptance is high.

The program design includes the monthly weighing of all children under five to identify malnutrition, and a three-month period of free feeding supplements for those children who are found to be malnourished. These feedings take place on a group basis in the local village hall and provide the opportunity for a second major component of the intervention, nutrition education for the mothers of the malnourished children. In the area visited by the team, the project provided locally-purchased food supplemented with AID-provided corn-soy blend through feedings in the community center about once per week, and CSB in daily packets for home supplementation between group feedings. The project also provided scales, weight charts, and oral rehydration salts. Vitamin A supplements, which are included in the overall project design were not included in these villages for reasons that are unclear. The larger project also includes the administration of anthelmintics which the team did not observe. In addition to 24 countries that receive CSB, the project design includes 23 with local purchase food only and six with no food supplements.

Both villages visited were conducting group feedings and weighings. The weighings took place on a single day, and since each village had over 100 children, the process took some time. Since this was the first or second weighing session for the two villages, the high level of attendance is difficult to interpret. Similarly, like any field intervention project in its early stages, there were departures from the formal project description. In an example of genuine local initiative, one project committee had added sugar and coconut to

the CSB to make it more palatable to village children. In one village, some of the more prosperous residents had contributed to the project even though this was obviously not part of the study design.

Paradoxically, however, the project personnel recorded the children's weights in a notebook without discussion with the mothers, and only later transferred the information to the growth charts. Thus the educational value of the charts was lost completely. In both villages, personnel found that the beam balance provided by the project caused children to resist weighing. Both villages independently decided to use an ordinary bathroom spring scale, which proved easier to use. This is obviously highly inaccurate, particularly when some weights are determined by weighing the mother holding the child, and then the mother alone, while other children are weighed alone. Finally, one of the fieldworkers interviewed was unfamiliar with the importance of being certain that oral rehydration solutions are not too concentrated, a basic point that should be emphasized in training.

These are all relatively straightforward, technical issues, but they illustrate the complexity of nutrition interventions compared to the rather simple tasks of providing family planning services. Further, it is not difficult to identify a number of potential problems that may further complicate management of the project. The direct provision of free food in a poor community can distract attention from nutrition itself. Mothers may bring their children long distances for food supplements, but lose interest when these run out after the initial three months of the project. Project personnel may themselves become complacent given the initial community enthusiasm and fail to carry out the difficult task of nutrition education. The support of the local political leaders may wane as talk replaces food distribution. Or families of well-nourished children may object to what they view as arbitrary discrimination against them. The pitfalls are dishearteningly familiar and persistent.

Nevertheless, the strengths previously demonstrated by BKKBN's performance in family planning are well suited to addressing the difficulties of conducting a large scale nutrition intervention. BKKBN's clear commitment to a specific outcome in family planning can also be applied to nutrition. This alone would constitute a major advance over the many previous programs oriented toward process measures, such as the number of talks given or kilograms of food distributed. BKKBN's experience in supporting an outcome orientation through an effective data system will be of critical importance in maintaining a similar focus in nutrition interventions. The impact of food distribution and nutrition education activities varies enormously. An effective data system will allow the program to refine its nutrition activities as it has its population activities. Delivering nutrition services through the village family planning infrastructure and providing support and supervision based on objective results will require the training of volunteers, fieldworkers, clinic professionals, local political leaders, and the BKKBN staff itself. Except for the relatively simple technical content, BKKBN's experience in training each of these categories should prove directly transferable.

What may be less transferable is BKKBN's tradition of rapid expansion. The political pressure to expand is probably based more on the appeal of food

distribution than on genuine support for an effective and sustainable nutrition program. The operations research component of the East Java program will make an important contribution to refining the design of the intervention, but it also serves to illustrate the large number of important features that have been determined in a largely arbitrary manner. Many of these features are relevant not only to the effectiveness of the nutrition intervention itself, but also to its potential for competing with family planning activities. Certainly the experience of the predominantly IUD program visited by the team can have only limited applicability to programs where maintenance of oral contraceptive users is a major activity.

The strengths of the program are clearly revealed in these initial efforts. The effective collaboration between AID and the BKKBN, the real decentralization that draws out the participation and initiative of local leaders, and the tactic of moving forward through field trial and error, are being extensively used, and severely tested in this new pattern of integration. The problems remain formidable but the Indonesian program is impressive on the ground, and it probably stands a better chance than most programs finding an effective solution.

2. Centrally-Funded and Other Institutional Support

The USAID Jakarta population program includes two other types of support beyond bilateral assistance to the BKKBN program. One is mission funding to other institutions and programs. These include the Population Institute at Gadjadara University, the Demographic Institute at the University of Indonesia, and the Central Bureau of Statistics.

Second are activities that are centrally funded by AID's Office of Population in Washington but coordinated by the USAID staff. The USAID population office does not need to rely heavily on centrally-funded intermediaries because of the strong overt support given family planning by the Indonesian government. Given this, the mission view is that AID can provide more effective support through direct bilateral assistance than through intermediaries, that if activities are important enough to merit doing they should be done bilaterally when possible except in areas where sensitivities still remain, as with surgical sterilization. Centrally-funded intermediaries operating in Indonesia are the Pathfinder Fund, the International Fertility Research Program (which sponsors biomedical research in Bandung), Family Planning International Assistance (which works primarily with the Indonesian Council of Churches), International Program Association for Voluntary Sterilization (IPAVS), and the Program for International Education in Gynecology and Obstetrics (PIEGO).

3. Voluntary Surgical Sterilization

Because of the Islamic-based cultural sensitivities outlined above, Indonesia's national program has not yet adopted sterilization as a program method and BKKBN personnel avoid becoming officially linked with active promotion of sterilization. This is, therefore, a very important area of AID-Indonesian

cooperation which although still small, has potential for considerable expansion. Sterilization training and services are expanding within university medical schools and government hospitals and clinics. In addition, the Indonesian Association for Voluntary Sterilization (PUSSI) has just held a second annual national conference on sterilization at which a keynote address was presented by the BKKBN chairman and Minister of Health, suggesting that the issue is becoming less sensitive.

The AID-supported PIEGO program at Johns Hopkins University played an important early role in training Indonesian physicians in surgical sterilization. Training now takes place instead primarily at six Indonesian medical schools, two supported through Pathfinder and four through IPAUS. These six training centers now have the capacity to train 180 physicians per year. To date about 140 have been trained. PUSSI's objective is to train one physician in every district by 1980. These activities are being pursued quietly because of religious opposition, but some members of the association's executive board, which includes a BKKBN representative, believe that this opposition may decline in the future, particularly as a result of advances in reversal techniques and, interestingly, the development of occlusive techniques that do not involve the actual division of the fallopian tubes.

Even with these restrictions, surgical sterilization accounts for 1.5 percent of the acceptors in the BKKBN data system. The mission, in cooperation with AID/Washington, appears to be providing an appropriate level of programmatic support for this activity at present, and has established an institutional training base capable of rapid expansion. It should be noted that the standardized history and physical examination form developed by PUSSI includes an informed consent section.

4. Linkage with Other Foreign Donors

The World Bank (IBRD) and the United National Fund for Population Activities (UNFPA) have been the other major foreign donors in the Indonesian family planning program. AID linkages with these donors have been minimal. There is little contact with the World Bank because it does not have a resident technical staff for population. The expert teams it brings in for specific loan arrangements do consult with the USAID staff, but there is little opportunity for sustained contact once they depart.

Contact with the UNFPA staff has apparently varied over time. Mission staff report that some years ago there were weekly luncheon meetings of all population donors to exchange ideas and experience. This proved useful for a time, but meetings became less and less frequent. The UNFPA coordinator has at times attempted to play the role of external coordinator for all population activities, but this has not yet been done successfully. Observers report that the UNFPA has experienced a series of disappointing appointments in the position of coordinator, which may indicate a basic problem in the UNFPA structure. Another problematic area concerns the high degree of centralization in UNFPA procedures. The team was informed that all population projects in Indonesia must be cleared by UNFPA headquarters in New York. This is strikingly different

from the USAID program which permits maximum field decision-making on projects and requires minimal involvement of AID/Washington. It is possible that this difference in the degree of centralization of decentralization between UNFPA and AID will preclude useful extended linkages between the two. It is also possible that BKKBN itself can provide whatever linkages are necessary.

Cooperation between AID and the Ford Foundation on population matters has been especially fruitful, as indicated above in training projects. AID also provides funds to the Population Council for a consultant who works with BKKBN on research and development. Another major Population Council project in Indonesia is the Modjokerto pilot project in integrated MCH/FP activity. This is one of a series of pilot projects the Population Council is promoting around the world. AID has been little involved in this project. Provincial officials indicate that the project has been of minimal importance to them, especially since it did not compare well with their own village family planning strategy.

Mission staff are often directed by various Washington offices to work more closely with other foreign donors. It is the team's judgment that the patterns of donor collaboration that have obtained in the past have been those specifically appropriate to the current Indonesian scene. Collaboration with donors has been pursued not for itself, but only insofar as it contributed to a more effective Indonesian program. The expanded role of other donors may require new forms of collaboration or cooperation in the future, but it will be useful to sustain the basic pattern of the past and to remember that donor cooperation is only a means to a better program. It is not to be pursued as an end in itself.

F. How A Fruitful Leader Secures AID Support

It is the BKKBN provincial chairmen who, in accord with the organization's decentralization policy, are expected to develop and implement locally appropriate strategies for reaching the targets set for them by headquarters. Extensive discussions with chairmen of all the provinces visited confirmed the critical importance to the forward movement of their programs of the rapid movement of funds from the center to the province while ideas that have been developed with both other provincial officials and ultimate beneficiaries are still fresh. All four chairmen cited specific examples illustrating how their ability to follow up words with prompt financial action established credibility for them with other local officials. The result of this credibility has been active local government support for family planning.*

*These same provincial chairmen contrasted the credibility and ability to move forward provided them by AID's timely funding with the slowness of other funding sources, notably the World Bank. One chairman told of finally using GOI funds for construction of clinics for which a Bank agreement of about two years earlier still had not produced the promised funds. Another told of two years negotiation with the Bank prior to its even agreeing to funding for mobile medical teams and of a two-year discouraging and as yet fruitless wait since. "They are very rigid and too slow," explained one chairman. "Many times when their support finally comes our programs are already far ahead of what we needed when we began negotiating with them."

This opportunity to realize almost immediate accomplishments also appears to be a major incentive responsible for keeping talented managers in provincial positions as opposed to their moving to Jakarta or succumbing to higher paying positions in the private sector. One energetic young physician, for example, told of repeatedly refusing lucrative offers to work in Jakarta in favor of remaining in the province "where there is real action close to the people." Decentralization thus means that local leaders become involved in and committed to the national program. This mobilizes a great deal of human energy while helping adapt the national program effectively to the different conditions found in the provinces.

To illustrate how provincial managers responsible for program development view and interact with AID, a brief account from one province is provided here. AID has supported, or is expected to be supporting, four separate project activities in West Sumatra according to that province's chairman, Dr. Haji Mahyuddin. These are: West Sumatra Village Family Planning, "Pill Ramadhan," Depo-provera, and Village Family Planning Improvement and Expansion.* According to the provincial chairman and as recorded during a team member's field visit, these activities were developed approximately as follows.**

* 1. Village Family Planning

Dr. Mahyuddin, who came to BKKBN in November 1976, says he became interested in "taking family planning to the village" in January 1977, that is before BKKBN headquarters had developed its outer island program. Upon joining BKKBN he studied the program and concluded that services were quite good in the towns but not reaching the villages where 80 percent of the province's population lives. He wanted to use his budget (the "DIP") to reach the villages.** The DIP was flexible enough that he could "borrow" funds from it for start-up activities but the available funds were too small for his needs. One early perceived need was orientation for religious leaders -- the Islamic ulama and the "adats" (traditional Minangkabau leaders) -- and for a women's organization.

Dr. Haryono from BKKBN and Mr. Reese from USAID notified him they were coming to visit from North Sumatra on April 17, 1977. Together the three made a two-day study tour through villages, where they found considerable knowledge and interest in family planning. Although people in less accessible villages were reluctant to discuss family planning, those in the more accessible villages discussed it quite eagerly. Knowledge of family planning had come from the district health center doctors and midwives, district information offices, and

*In fact, however, Depo-provera is not part of AID project support. While coordinated by BKKBN, it is instead a project of the Indonesian Planned Parenthood Association. (See International Planned Parenthood Federation, "Report to Donors," Oct. 1978, p. 107.)

**Based on field visits to West Sumatra by Barbara Pillsbury accompanied by Mike Philley, May 3-5.

from national and provincial newspapers and radio. Before Dr. Haryono and Mr. Reese left West Sumatra, they said village family planning "could be done" there and encouraged Dr. Mahyuddin to choose 200 villages and draw up a proposal for funding.

A proposal was drawn up by Dr. Mahyuddin requesting funding for all the 1442 villages in the province's 80 districts. He delivered the proposal to BKKBN headquarters in late April. Headquarters subsequently sent the proposal to the USAID mission.

A letter of agreement promising financial support was sent by the mission to BKKBN headquarters dated May 27.

Funds were deposited in the project bank account in Padang (capital of West Sumatra) and thus available for project activities in late June -- about two months after the proposal had been submitted.

2. The "Pill Ramadhan"

In 1971, while in private practice, Dr. Mahyuddin became interested in giving birth control pills to women in such a way as to prevent menstruation during the month of Ramadhan when Muslims are to fast from sunrise to sunset. A menstruating woman is regarded as ritually unclean and thus may neither make the fast nor pray in the mosque. According to custom she may "pay back" missed days after Ramadhan is over but receives less pahala (grace from God) for days fasted after the month than during it. The people of West Sumatra -- about 95 percent Minangkabau -- are relatively devout Muslims and thus many women among them would like to be able to fast straight through Ramadhan in order to receive the maximum amount of grace.

A scheme for giving the pill to delay the Ramadhan menstrual period was presented to Dr. Mahyuddin by doctors from Java while they were all in Jeddah in 1972 as the medical backup for Indonesian pilgrims to Mecca. Many women at that time were taking a "haji (pilgrims') pill" to defer menstruation until after the pilgrimage.

In about 1976 Dr. Mahyuddin discussed the feasibility of a "Ramadhan pill" with Dr. Malcolm Potts (then of IPPF) on the latter's visit to West Sumatra. Potts subsequently sent back information on a three-cycle pill being used elsewhere. Dr. Mahyuddin reasoned that many women would be attracted to use the pill to inhibit menstruation during Ramadhan and, having in this way overcome initial reluctance to use it, could be motivated to continue its use -- or even switch to the IUD -- after Ramadhan was over.

In May 1978 Dr. Mahyuddin took a Ramadhan Pill proposal to BKKBN headquarters. Headquarters approved it in principle but all agreed that support of the ulama would be necessary before proceeding with the project -- and before headquarters would agree to fund it.

Dr. Mahyuddin decided to hold a "consultation" for the ulama using funds he would borrow from his DIP and then subsequently repay once the project had been approved by headquarters and AID funds for it made available to him.

A one-day consultation with the ulama and the "adats" was held on June 29. They were reportedly all pleased to be called to the provincial capital, to receive room and board, transportation, and a per diem, and all agreed to the Ramadhan Pill idea.

In early July Dr. Mahyuddin returned to Jakarta and explained the proposal in detail to a large number of headquarters staff. They gave approval pending addition to the proposal of provision of medication for possible side effects and of specifications regarding supervision.

Headquarters received funding from AID in late July and funds were available for the project the first week in August.

3. Depo-provera

This is a BKKBN centrally-developed research project being implemented in certain parts of West Sumatra and selected other provinces on a pilot basis. It has been enthusiastically received in West Sumatra and demand far exceeds the supply, which is only enough for two years of injections for 3500 women. Dr. Mahyuddin has asked BKKBN for more Depo-provera since many women who would like to get it through the national program must now pay for it at private clinics. Other women who would like the injectable contraceptive cannot afford it. Some, or even many, women who appear to have stopped contraceptive use because of dissatisfaction with pills and the IUD would probably continue to contracept if the Depo-provera were available to them. Headquarters has denied this request of Dr. Mahyuddin, however, insisting the project is only a research activity.

4. Village Family Planning Improvement and Expansion

This proposal was delivered to BKKBN headquarters in October 1978. Funds had not yet been made available, however, at the time of the team visit (May 1979). This inordinately long delay was attributed to the reorganization of BKKBN headquarters and to BKKBN attempts to coordinate the DIP with external funds.

By March 1979, Dr. Mahyuddin had been given reason to believe that BKKBN would soon have funds made available. BKKBN had also announced plans to provide funding by summertime for full-time civil service staff positions at the regency level in West Sumatra and the other outer island provinces. Dr. Mahyuddin, therefore, had it announced that his office was looking for 32 university graduates to be family planning trainers for village personnel (part of the Improvement and Expansion proposal) and to be subsequently given first consideration for the full-time staff positions in the province's eight regencies. On March 18, 32 trainers were appointed and their names apparently submitted to headquarters as designees for the staff positions.

A three-week training of the 32 trainers-to-be was scheduled to begin May 20. Dr. Mahyuddin was planning, at the time of the visit in early May, to

go to Jakarta to talk to headquarters about getting the funds. He was not aware that AID had not yet received his proposal and was surprised that consequently AID would not be able to make the funds available until at least early June. He indicated that he might, therefore, see if he could borrow from his DIP so as not to have to delay the training. He regards himself as ahead of headquarters in this regency-level staffing activity and is not aware of other provinces being similarly ready to leap to the act once the okay comes out from headquarters.

By June 1, 1979, following a visit by Dr. Mahyuddin to Jakarta, the mission had completed a draft Project Implementation Letter No. 7 (West Sumatra Village Family Planning) and forwarded it to BKKBN headquarters. This would provide U.S. \$236,511 and included items (such as midwifery kits and contraceptive cabinets) that family planning workers in several villages had indicated during our field visit would significantly facilitate their effective performance. Mission staff estimated the first disbursement to the provincial BKKBN office would take place by about July 10.

How much of the program activity to date could have been possible without AID assistance? "I couldn't do it on the DIP alone," states this provincial chairman. "The additional funds and the speed with which they come are essential."

The former BKKBN chairman of East Java was similarly emphatic about the importance of rapid support and appreciation of U.S. assistance. When asked to clarify why he preferred working with AID rather than other donors, he responded because they understand us. And because they are acting very quick. He continued:

In 1970 nobody believed we could reach our goal.
We needed help fast. We were very short of supplies
then so we looked for help. They came from you.
Fast. By plane. Only this way can we meet our goals
and have success. And all free. So we thank you tax-
payers.

APPENDIX TABLE 1
Indonesia Family Planning Service Points 1976-1982

Area	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>	<u>1980</u>	<u>1981</u>	<u>1982</u>
Java/Bali (65% of population)							
Clinics	2,700	2,750	2,750	3,200	3,200	3,200	3,200
VSS	25	35	49	115	145	171	285
Depots	10,000	25,000	30,000	30,000	30,000	30,000	30,000
Groups	15,000	20,000	25,000	55,000	56,000	57,000	58,000
Outer Islands - I (26% of population)							
Clinics	884	890	920	1,225	1,250	1,300	1,350
VSS	10	40	62	63	140	165	221
Depots	-	4,000	6,000	12,000	18,000	20,000	22,000
Groups	-	-	-	5,000	8,000	12,000	15,000
Outer Islands - II (9% of population)							
Clinics	-	-	-	700	700	700	700
VSS	-	-	-	27	30	30	30
Depots	-	-	-	-	500	1,000	3,000
Groups	-	-	-	-	-	1,000	3,500
<u>All Indonesia</u>							
Outlets per 1,000 MWRA	1.78	2.38	3.01	4.69	5.03	5.28	5.59
Increasing Service Availability	—————→						

APPENDIX TABLE 2
Family Planning Program New Acceptors 1969-78

Year	Java Bali	Outer Islands	Total
1969	53,103	-	53,103
1970	181,276	-	181,276
1971	519,330	-	519,330
1972	1,078,899	-	1,087,899
1973	1,369,077	-	1,369,077
1974	1,475,016	117,966	1,592,982
1975	1,785,908	180,677	1,966,585
1976	1,979,445	233,345	2,212,790
1977	1,932,431	313,662	2,246,093
1978	1,797,656	418,228	2,215,884
Total	12,172,121	1,263,878	13,436,019

Source: National Family Planning Coordinating Board statistical summaries

GOI fiscal years are reported as calendar years: i.e. April 1 1977 through March 31 1978 is reported as 1977.

APPENDIX TABLE 3
 Indonesian Population and Family Planning Program Financial
 Resources GOI and Foreign Donor
 1968 - 1978

	<u>1968</u>	<u>1969</u>	<u>1970</u>	<u>1971</u>	<u>1972</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>1976*</u>	<u>1977*</u>	<u>1978*</u>
GOI Family Planning (\$000)	75	300	1,323	2,300	5,134	5,885	8,400	12,500	15,600	20,700	33,100
%	4%	19%	29%	44%	53%	41%	40%	49%	48%	54%	61%
Foreign Donor Inputs (\$000)	2,051	1,288	3,319	2,913	4,600	8,552	12,636	13,000	16,600	17,700	20,800
%	96%	81%	71%	56%	47%	59%	60%	51%	52%	46%	37%
Total GOI and Foreign (\$000)	2,126	1,588	4,642	5,213	9,735	14,437	21,036	25,500	32,200	38,400	53,900
Total per capita (\$)	.028	.021	.060	.076	.120	.177	.263	.297	.272	.324	.395
Total per acceptor (\$)	80.90	29.90	25.61	10.04	9.02	11.02	14.26	15.40	14.55	16.64	21.22

Source: USAID estimates from various sources.

* Includes Java and Bali plus 10 Outer Island Provinces.
 Prior year figures for Java and Bali only.

Appendix Table 3
Indonesia Family Planning Program Inputs, 1968-1978 (\$ in thousands)

	<u>1968</u>	<u>1969</u>	<u>1970</u>	<u>1971</u>	<u>1972</u>	<u>1973</u>	<u>1974</u>	<u>1975</u>	<u>1976+TQ</u>	<u>1977</u>	<u>1978</u>
A. <u>USAID Bilateral Assistance by Fiscal Year</u>	270	1500	430	1759	2686	9224	6406	4232	17,043*	3548	13,880*
B. <u>Assistance by Organizations Receiving USAID Support</u>											
UNFPA	--	--	--	404**	436	1347	2495	2601	1374	1606	5182
IPPF	--	--	--	542	1128	918	1500	1500	1141	1232	1370
Pathfinder Fund	--	--	--	84	140	197	223	234	378	221	1219
Population Council	--	--	--	324	296	106	257	282	43	53	70
Family Planning International Assistance Association for Voluntary Sterilization	30			75	90	n/a	n/a	107	189	826	
	--	--	--	--	--	--	--	98	10	161	604
C. <u>Assistance by other Countries and Organizations not Receiving USAID Support</u>											
Japan	--	41	131	37	55	27	138	250	0	0	17
Netherlands	--	--	136	84	150	150	0	0	0	0	n/a
Norway	--	--	--	6	105	27	0	0	0	0	53
Ford	--	245	37	92	83	40	0	0	0	0	422
IBRD***	--	--	--	--	270	1467	2500	2600	1400	1600	n/a
D. <u>Host Government Inputs to Family Planning</u>	75	300	1323	5212	9734	14,437	12,000	15000	15,900	20,700	n/a
E. <u>Combined Monetary Inputs</u>	345	2086	2057	8574	15,108	28,030	25,519	26797	37,394	29310	n/a

* Includes \$7300 loan for oral contraceptives

** Cumulative through 1971

*** IBRD loan funds in joint project with UNFPA and GOI, by year of disbursement

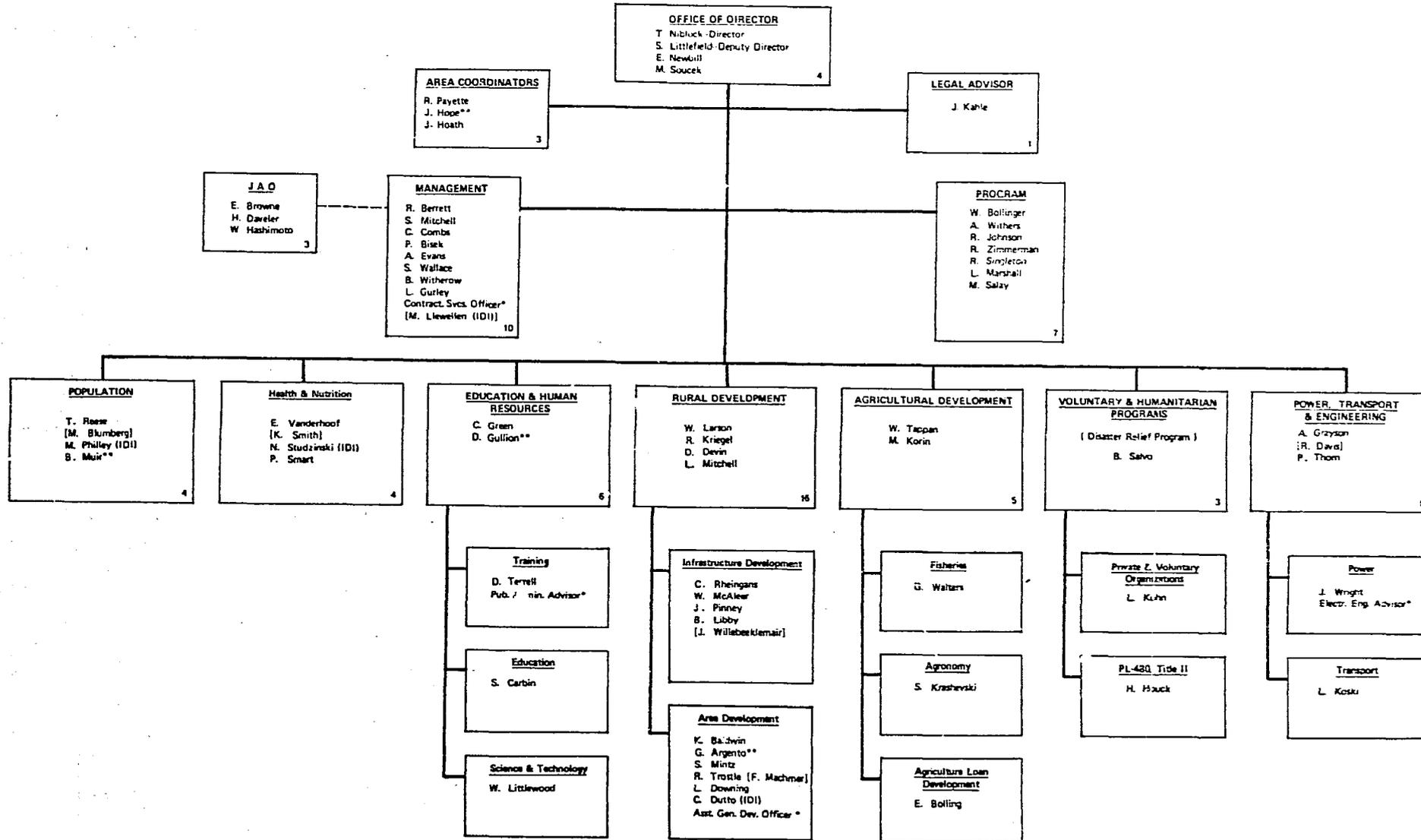
Source: Family Planning Services Division, Office of Population, A.I.D.

APPENDIX TABLE 4
 USAID Population Program Activities FY 68-78
 (Thousand of US \$)

Project Series	1968-71	1972	1973	1974	1975	1976+TQ	1977	1978	Cumulative Total
<u>188.0</u>									
Family Planning Services	3,379.4	2,158.4	5,320.6	1,764.7	1,683.0	950.0	2,905.0	--	18,160 (31.5%) ¹
Oral Contraceptive Loan (045)	--	--	--	--	--	--	7,300.0 ⁵	--	
<u>270.0</u>									
Family Planning Development & Services	--	--	--	--	--	--	--	4,180.0 ²	
<u>271.0</u>									
Oral Contraceptives (053)	--	--	--	--	--	--	--	7,000.0 ⁴	
AID/W Commodities (oral contraceptives & condoms)	--	--	1,751.0	3,500.0	3,018.0	7,549.0	2,421.0	2,700.0	20,939 (36.4%) ³
Totals	3,379.4	2,158.4	7,071.6	5,264.7	4,701.0	8,499.0	12,626.0	13,880.0	
Cumulative totals	<u>3,379.4</u>	<u>5,537.8</u>	<u>12,609.4</u>	<u>17,874.1</u>	<u>22,575.1</u>	<u>31,074.1</u>	<u>43,700.1</u>	<u>57,580.1</u>	
Cumulative summary:	Grants, F.P. (1+2)		22,340		(33%)				
	Grants, Contraceptives (3+4)		20,939		(36%)				
	Loans (4+5)		14.3		(25%)				

Appendix 5
Organization Chart for USAID Indonesia

USAID INDONESIA



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*Vacant
**Position being eliminated FY78